CDC 6|18 Initiative: Accelerating Evidence Into Action

Association of State and Territorial Health Officials (ASTHO)
January 4, 2015
1:00 PM – 2:00 PM ET
Monica Valdes Lupi

Chief Program Officer,
Health Systems Transformation
Webinar Objectives

- Describe the 6|18 project.
- Identify ways in which the state health agencies can support the 6|18 Initiative.
- Describe Rhode Island’s interagency collaboration between state Medicaid and public health.
- Demonstrate success-to-date in implementing the targeted interventions with state Medicaid beneficiaries.
Speakers

John Auerbach, MBA
Associate Director for Policy
Centers for Disease Control and Prevention
Speakers

Nicole Alexander-Scott, MD, MPH
Director of Health
Rhode Island Department of Health
Q&A

Please type your question in the chat box.

Speakers:

- John Auerbach (CDC)
- Nicole Alexander-Scott (RIDOH)
THANK YOU!!

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WEBINAR WILL BE POSTED HERE:
http://www.astho.org/Health-Systems-Transformation/Medicaid-and-Public-Health-Partnerships/

Funding support provided by the Health Resources and Services Administration
The 6|18 Initiative: CDC Collaboration with Health Care Purchasers, Payers, and Providers to Improve Population Health

John Auerbach
Associate Director for Policy
Centers for Disease Control and Prevention
CDC Strategic Directions

Improve health security at home and around the world

Better prevent the leading causes of illness, injury, disability, and death

Strengthen public health/health care collaboration
Get to the Table ... Then What?
Meet Fran Edwards:

- Newly insured
- At MD for first physical in 5 years
- 55 years old, married, smokes, overweight, little exercise
- Asthmatic, high blood pressure
- Stopped taking medications in past due to cost
Insurance and Quality Care Help...
But the Following Also Contribute to Her Health

• **Income** - Low income, family of 5

• **Barriers to Fitness** - Rising crime rate, few parks, no nearby supermarket

• **Under stress** - Child with behavioral health concerns, worried about money

• **Sub-par Housing** – Mold and ventilation problems
The 3 Buckets of Prevention

http://journal.lww.com/jphmp/toc/publishahead

1. Traditional Clinical Prevention
   - Increase the use of evidence-based services

2. Innovative Clinical Prevention
   - Provide services outside the clinical setting

3. Total Population or Community-Wide Prevention
   - Implement interventions that reach whole populations

Health Care  Public Health
The First Two Buckets are Patient Centered
The “6|18” Initiative

Promote adoption of evidence-based interventions in collaboration with health care purchasers, payers, and providers

High-burden health conditions

6|18

Evidence-based interventions that can improve health and save money
SIX WAYS TO SPEND SMARTER FOR HEALTHIER PEOPLE

1. Reduce tobacco use
2. Control blood pressure
3. Prevent healthcare-associated infections (HAI)
4. Control asthma
5. Prevent unintended pregnancy
6. Control and prevent diabetes
### The 6|18 Interventions Are Varied

<table>
<thead>
<tr>
<th>Bucket 1: Improving access to covered services – in office</th>
<th>Bucket 2: Paying for services not traditionally covered – out of office</th>
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<tbody>
<tr>
<td>Elimination of cost sharing for key services (e.g. key meds)</td>
<td>Home visits for asthma care – reduction of triggers</td>
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<td>Comprehensive tobacco cessation coverage</td>
<td>Home self-monitoring of blood pressure</td>
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<td>No barriers to long acting reversible contraceptives</td>
<td>Diabetes Prevention Program</td>
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Progress on CDC’s 6|18 Initiative

Understanding Partner Landscape
- Train CDC employees and those in other public health agencies

Medicaid & Medicare Engagement
- Build strong CMS-CDC Partnership
- Link Medicaid directors and SHOs/PH

Commercial Payer Engagement
- Commercial Payers creating pilots & considering coverage

Public Health & Other Partners
- Provide support to states and locals
- Link with community wide prevention
The 6|18 Initiative: Accelerating Evidence into Action

CDC is partnering with health care purchasers, payers, and providers to improve health and control health care costs. CDC provides these partners with rigorous evidence about high-burden health conditions and associated interventions to inform their decisions to have the greatest health and cost impact. This initiative offers proven interventions that prevent chronic and infectious diseases by increasing their coverage, access, utilization and quality. Additionally, it aligns evidence-based preventive practices with emerging value-based payment and delivery models.

By 6|18, we mean that we are targeting six common and costly health conditions – tobacco use, high blood pressure, healthcare-associated infections, asthma, unintended pregnancies, and diabetes – and 18 proven specific interventions that formed the starting point of discussions with purchasers, payers, and providers.
Are There Other Clinical Steps Beyond the 6|18 Interventions?

- Yes – “6|18” interventions will increase
- The 6|18 approach is replicable:
  - Understand needs, processes, priorities of payers/providers
  - Establish evidence base – less than 5 year impact, actuarial methods
  - Find and get to the table
  - Make the case
  - Cover and link all 3 buckets
What about Bucket 3?
CDC Resources: Community-Wide Health Improvement

COMING SOON!
Development of a total population 6|18-like Initiative
### What Each Sector Can Do

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<th>Payers and Purchasers:</th>
<th>Public Health:</th>
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<tr>
<td>• Adopt, incentivize 6</td>
<td>18 interventions</td>
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<tr>
<td>• Link with public health</td>
<td>• Develop complementary PH initiatives</td>
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<td>• Measure impact using PH data</td>
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<th>Providers:</th>
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<tr>
<td>• Promote 6</td>
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<tr>
<td>• Monitor/provide feedback on use &amp; results</td>
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<table>
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<tr>
<th>Patients and Community Partners:</th>
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<tr>
<td>• Support 6</td>
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<tr>
<td>• Link to community &amp; pt engagement</td>
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How Can Each Sector Help Ms. Edwards?

• **Payers and Providers**
  • *Bucket 1*: No co-pay for her blood pressure and asthma medication
  • *Bucket 2*: Home visits to reduce asthma

• **Hospitals**
  • *Bucket 3*: Investments in healthy housing options; support for community policies

• **Public Health**
  • *Buckets 1 & 2*: Participation in state and local meetings of insurers and support for 6|18
  • *Bucket 3*: Support for health-promoting policies in lower income communities & to eliminate disparities
A Vision for the Future:

Strengthened Linkage Between Public Health and Clinical Care
6|18 in Rhode Island

Nicole Alexander-Scott, MD, MPH
Director of Health

Julian Rodriguez-Drix
Manager, Asthma Control Program

Erin Boles-Welsh
Manager, Tobacco Control Program
6|18 in Rhode Island

- Strong interest from RI in all 6 areas of 6|18
- Initial focus on asthma and tobacco
- 6|18 efforts will build off long-standing work in these areas
- 6|18 an opportunity to move forward existing initiatives that align
Rhode Island has been coordinating already on related efforts:

- Preventive health services and screenings
- Evidence-based programs
- Community Health Workers
Background: Medicaid in RI

- Predominately through managed care (RIteCare)
- Two managed care organizations: United Health Care RI and Neighborhood Health Plan of RI
- Reinventing Medicaid: Governor Raimondo convened a task force to shift RI from a volume-based system to one that pays for better outcomes and value
Background: Healthcare reform in RI

- SIM grant (State Innovation Models)
- Strong patient-centered medical home initiative: Care Transformation Collaborative (CTC) and PCMH-Kids pediatric initiative
- RIDOH Health Equity Zones: partnering with community organizations on issues including social and environmental determinants of health, community-clinical linkages, and community health teams
Community Health Workers

• A frontline public health worker with close understanding of the community served

• Improves the quality and cultural competency of service delivered

• Builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities, such as outreach, community education, counseling, social support, and advocacy
RI Medicaid Asthma Costs

Total Medicaid cost burden
• 9.4% treated for asthma (19,200 people)
• Annual Medicaid asthma costs: $40 million
  (Includes office visits, medications, and hospital/ED utilization)

Pediatric asthma-related hospital and emergency department utilization:
• 253 asthma hospitalizations at $12,500 each: $3.16 million
• 2,303 asthma ED visits at $1400 each: $3.2 million
One of the four 6|18 asthma interventions:

“Expand access to home visits by licensed professionals or qualified lay health workers to improve self-management education and reduce home asthma triggers for individuals whose asthma is not well-controlled with guidelines-based medical management and intensive self-management education.”
HARP: Home Asthma Response Program

• Goal: Reduce preventable asthma ED visits and hospitalizations among low-income pediatric asthma patients through home visits to provide asthma education and reduce home asthma triggers

• 3 home visits with a Certified Asthma Educator (AE-C) and Community Health Worker (CHW), with environmental supplies
HARP: Home Asthma Response Program

– Identification of children with >1 ED visit or inpatient hospitalization for asthma
– Referral for home visit for asthma education and healthy home assessment (AE-C, CHW)
– Two follow up visits with CHW: supplies and remediation of allergens and triggers
– Referrals to appropriate services and supports
– Feedback and follow-up with primary care provider; coordination on asthma action plan
HARP

RIDOH: HARP claims data analysis

- Initial analysis: 49 of 83 children available for analysis (consistent claims data available for 1 year pre, 1 year post HARP)
- ED visits reduced from 81.6% to 16.3%
- Inpatient hospitalization reduced from 12.2% to 0%
HARP: Return on Investment

Initial ROI analysis

• 53.4% reduction in overall asthma costs, average reduction of $1,059 per patient
• 92% reduction in ED/hospital costs, average reduction of $1,175 per patient

Cost Savings for high utilizers

• 80% reduction in overall asthma costs, average reduction of $2,528 per patient
• 92.6% reduction in ED/Hospital asthma costs, average reduction of $2,267
Technical Assistance for RI Medicaid

• Requesting TA for data analytics and economic analysis
  – Review existing evaluations and Medicaid asthma data
  – Compare and combine with results from similar interventions (regional, national)
  – Develop realistic projections for cost savings

• Implementation: Support on decision making and logistics in Managed Care environment
Removing barriers to tobacco Cessation benefits:

• Access to all seven medications FDA-approved for smoking cessation (over-the-counter and prescription)
• Access to individual, group, and telephone counseling
• Prior authorization is not prerequisite to accessing tobacco cessation treatment
Removing barriers to tobacco Cessation benefits:

- Provision of medications is not linked to enrollment in counseling
- Stepped care therapy not required
- Limits on duration of treatment
- Annual limit on quit attempts
Goal - Medicaid and RIDOH work together to:

- Communicate tobacco cessation coverage to healthcare providers and recipients
- Reinforce support for comprehensive tobacco cessation coverage policies. Remove barriers to accessing tobacco cessation treatment
- Increase utilization of tobacco cessation benefits