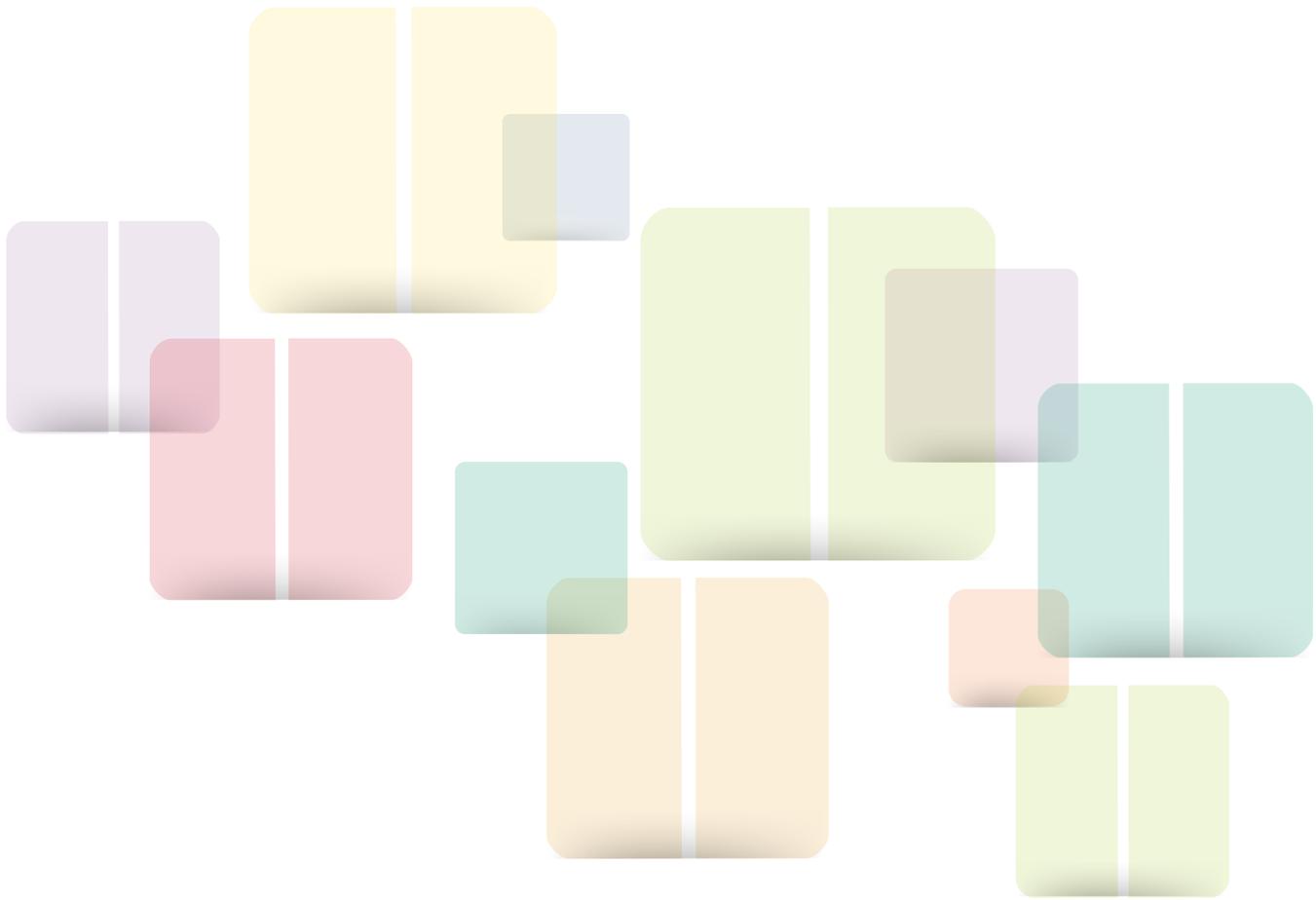


INTEGRATION OF PUBLIC HEALTH AND PRIMARY CARE:

# A Practical Look at Using Integration to Better Prevent and Treat Sexually Transmitted Diseases



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**CDC/DSTDP National Partners Collaborative**

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

*Funded by:* Association of State and Territorial Health Officials  
CDC Division of STD Prevention  
National Association of County and City Health Officials

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National Coalition of STD Directors

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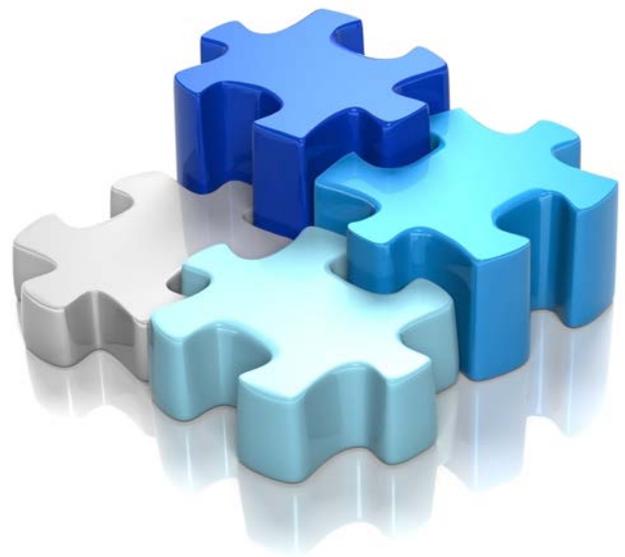
## Introduction

As the country begins to thoughtfully prepare for the Affordable Care Act's (ACA) next stage of implementation 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 healthcare 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 ACA by the end of 2014.<sup>1</sup> 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 more vulnerable populations.

CDC, under Director Tom Frieden, has prioritized improved collaboration between public health and primary care. At a National Press Club luncheon in September 2013, Frieden 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."<sup>2</sup> 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



## 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 meeting, this effort's sponsors set out to understand the real challenges and opportunities for better integration.

### The project goals 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 Multidisciplinary Teams

A team of researchers identified a sample of 10 cities, counties, and states that represent the range of experiences in public health and primary care across the country. Within each state, city, or county, senior 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:

<b>Medicaid expansion</b>	With the implementation of the Affordable Care Act, many states will expand Medicaid for their residents, which will greatly increase the percentage of residents with health insurance coverage. As of December 2013, 25 states and DC had agreed to expand Medicaid eligibility, while an approximately equal number had not. <sup>3</sup> This project includes teams from both expansion and non-expansion states.
<b>Region</b>	The project includes representatives from each U.S. geographic region.
<b>Size and population density (i.e., rural or urban)</b>	Provision of public health and primary care services varies depending on concentration of the population. Rural and urban areas face different cultural and logistical issues when it comes to healthcare service delivery. This project incorporates densely populated urban areas, as well as frontier states.
<b>STD rates</b>	State- and county-specific rates were reviewed to ensure a range of STD concentration across the project sites.

**FIGURE 1. OVERVIEW OF JURISDICTIONS EXAMINED**

		<b>Data Review</b> June 2013	<b>Interview</b> July 2013	<b>Meeting</b> 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)	✓	✓	✓
<b>Total</b>		<b>16</b>	<b>12</b>	<b>10</b>

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

1. Data and Literature Review
  - To identify 10 final teams, 16 local and state jurisdictions were examined. Extensive data were gathered comparing the jurisdictions on region, Medicaid expansion, population density, and STD rates.
  - A literature review was conducted to better understand recent efforts on integration, specifically as it relates to STD service provision.
2. Stakeholder Interviews
  - Overall, 21 interviews were held with public health and primary care leaders or leadership teams in 12 jurisdictions.
  - 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 34 individuals were interviewed.
3. National Meeting
  - The process culminated with an in-person meeting.
  - Seventy-five attendees met in Atlanta for one-and-a-half days.
  - Five state teams and five local teams convened to further explore their current states of integration and ways to improve STD service provision.
  - Teams included senior management from 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 state teams also included a leader from the state's primary care association.

**The literature review is included in this report on page 7; the stakeholder interviews and 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 leaders from a diverse group of public health agencies and community health providers. Each state, city, or county faces its own set of unique challenges when it comes to integrating STD 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. Understanding efforts to integrate public health STD and primary care services/functions.
2. Identifying challenges, opportunities, successes, and lessons.
3. Determining what would help future efforts and developing resources to assist this work.

The subjects covered in the interviews included:

- How are STD services provided in the jurisdiction? What is the division of labor 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 45 to 60 minutes. Questions were general and were similar for both public health and primary care participants. See Appendices 1 and 2 for lists of specific questions.

### INTERVIEW PARTICIPANTS

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

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

**FIGURE 2. LOCATIONS OF INTERVIEW PARTICIPANTS**



## ■ Facilitating a Deeper Discussion: National Meeting

The in-person national meeting in Atlanta was intended to further explore issues identified in the interviews. The meeting lasted one-and-a-half days.

The meeting’s stated purpose 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 healthcare 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. (See Appendix 4 for a detailed agenda.) The topics covered included:

- **Integration definition and examples:** An explanation of the integration model as described in the 2012 Institute of Medicine (IOM) report “Primary Care and Public Health: Exploring Integration to Improve Population Health.” A panel of state and local representatives also 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 with an opportunity to identify solutions and action steps. (These case studies are included as Appendices 6 and 7.)
- **Resources:** Participants were asked to identify resources that would be helpful as they work to integrate their work with each other and partners in their home states, counties, or cities. While a session was dedicated to this topic, related questions were also integrated into the case studies and panel discussions.

### MEETING PARTICIPANTS

Seventy-five people attended the meeting. Ten teams attended representing five states and five cities/counties. Each team consisted of three to five 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 10 state and local teams, many federal agencies and national associations were represented, including the sponsors of the project—the CDC 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 U.S. Public Health Service, the Health Resources and Services Administration, and other divisions within CDC.

## Background and Literature Review

Primary care and public health share the goal of promoting the health of all individuals.<sup>4,5</sup> 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 toward prevention and health promotion at the community and population level through funding from governmental sources, often in the form of grants.<sup>6,7</sup>

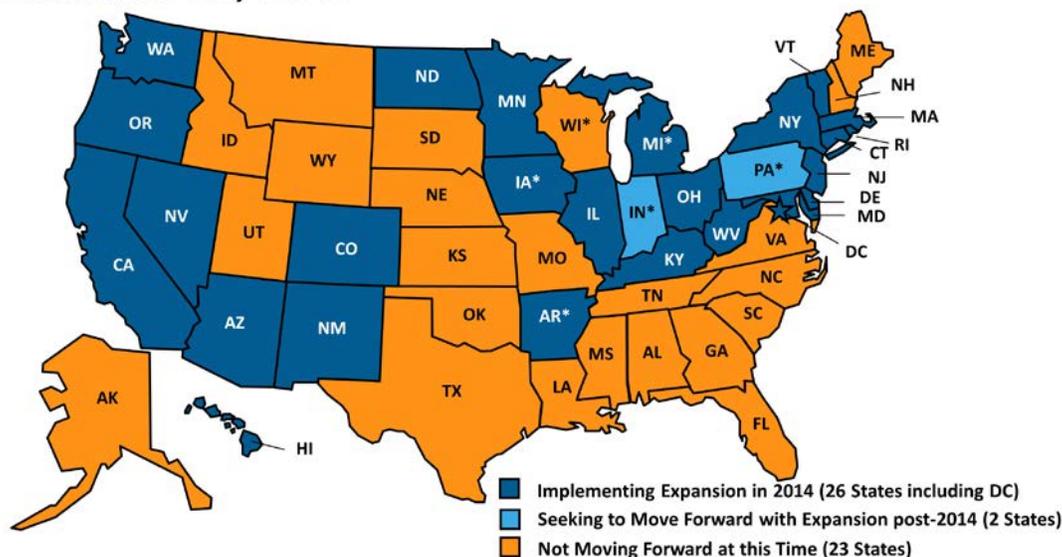
More recently, opportunities have begun to increase for the integration of these two systems. These opportunities are the result of recent developments including increased emphasis on controlling healthcare costs, growing recognition of the importance of the social and environmental determinants of health, the availability of health information technology to inform the connection between clinical and community level health issues, and, perhaps most significantly, ACA's passage and implementation.<sup>8</sup>

### ■ ACA

ACA's passage 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 who will become insured. The Congressional Budget Office estimates that 14 million people will become insured during ACA's first year, growing to almost 30 million after three years. States' decisions to expand Medicaid are central to what the increase will be and will change the experience for many states. According to Kaiser Family Foundation, 25 states and DC have committed to expanding Medicaid (Figure 3) as of Dec. 11, 2013.

**FIGURE 3. MAP OF MEDICAID EXPANSION STATES, DECEMBER 2013**

### Status of State Medicaid Expansion Decisions, as of December 11, 2013



NOTES: \*AR and IA have approved Section 1115 waivers for Medicaid expansion; MI has a pending waiver for expansion and plans to implement in April 2014; IN and PA have pending waivers for Medicaid expansion plans that would be implemented post-2014; WI amended its Medicaid state plan and existing Section 1115 waiver to cover adults up to 100% FPL in Medicaid, but did not adopt the expansion. SOURCES: State decisions on the Medicaid expansion as of December 11, 2013. Based on data from CMS, available at: <http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html>. Data have been updated to reflect more recent activity.



## ■ Institute of Medicine Report

The release of the 2012 IOM report “Primary Care and Public Health: Exploring Integration to Improve Population Health” reflected and accelerated this emerging phenomenon.<sup>9</sup> The report was prepared by the IOM committee assigned by CDC and the Health Resources and Services Administration to examine the current 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” that takes place on a continuum ranging from isolation to merger, with mutual awareness, cooperation, collaboration, and partnership in between. The continuum represents different degrees of integration and may serve as an informative indicator for the systems to reflect on their current level of integration and identify areas that need improvement 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 and gray literature and through discussion with stakeholders. It then identified a set of key principles 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 emphasized the importance of implementing initial action—if necessary, starting out with just one of these principles.

### The ASTHO strategic map highlights five specific foci:

- Identify and create examples of demonstrated success.
- Realign funding to support coordination and sustainability.
- Disseminate effective approaches and systems.
- Implement meaningful measures of population health.
- Creating infrastructure to support collaboration and sustainability.

## ■ 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 ASTHO convened meetings between leaders of the two systems and developed a two-year strategic map to strengthen integration.<sup>10</sup>

Similarly, collaboration between NACHC and NACCHO resulted in a guide designed to introduce a planning process and various models of partnership between federally qualified health centers (FQHCs) and local health departments in creating a community-based system of care.<sup>11</sup>

A subsequent study published on integration efforts among nine selected FQHCs across the United States<sup>12</sup> indicated that these FQHCs provided good primary care coordination with a focus on community orientation and integrated many essential public health activities into their practices. The study also identified specific elements necessary 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.

NACCHO published a white paper describing opportunities and challenges for local health departments in light of ACA implementation and integration efforts.<sup>13</sup> 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.<sup>14</sup>

### ■ Integration and STDs

In the current changing climate, the concept of integration is particularly relevant to sexual health. State and local public health departments have traditionally played a critical, major role in providing STD programs and services, including prevention, epidemiology, laboratory work, clinical services, and disease intervention specialist services. These have generally been provided without charge to patients and without health insurance collection to reduce barriers to access.

Many but not all primary care settings also provide clinical STD services such as screening, diagnosis, and treatment, billing for them as they do other services. ACA implementation will increase the health insurance coverage of millions of individuals, providing them with additional opportunities to receive preventive, screening, and treatment services, including those for STDs, at sites other than 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 continuing to ensure access to services for individuals who are in need.<sup>15</sup> In the light of ACA implementation, ASTHO’s Infectious Disease Policy Committee, for example, has worked with its members and partners to examine how the changing healthcare system will affect the role of state and territorial health departments and potentially promote the integration of infectious disease programs and services. The committee’s effort resulted in the report “Infectious Disease Integration of Public Health and Primary Care: Findings from the December 2012 Integration Meeting.”<sup>16</sup> The document identifies key components for moving toward integration, including developing partnerships, ensuring a safety net, and promoting efficient and meaningful data management systems. The report also identifies possible sites for integration such as workplaces and schools and provides examples from some states.



### ■ Stigma and Discrimination

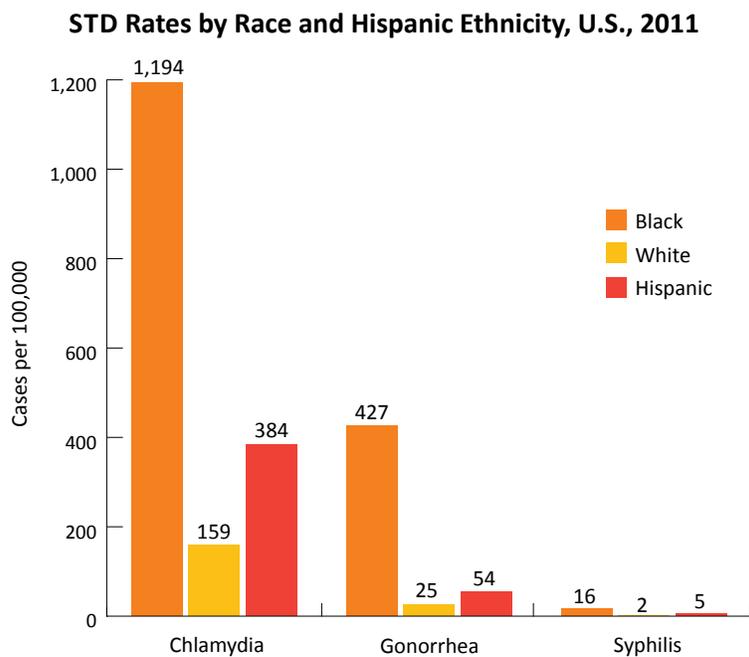
But while integration is on the horizon for STD programs and other public health areas, disparities and stigmas associated with STDs present unique challenges.

The general public and those at risk for STDs both hold the attitude that STDs are a result of poor choices or promiscuity or that STDs could be prevented. In a review of the literature, researchers Julia Hood and Allison Friedman found that stigma leads to delays in testing and seeking treatment.<sup>17</sup> Studies found

that patients were hesitant to have an honest conversation with their healthcare provider because they anticipated judgment and blame. Stand-alone STD clinics provided their own challenges, with many located in run-down areas or requiring long waits before patients could see a provider. To decrease stigma, researchers recommended (but did not provide evidence for) increasing sensitivity training for healthcare providers and redesigning the way STD services are provided. Suggestions included enhancing the physical characteristics of STD clinics and incorporating STD services into broader clinics to normalize testing and treatment and facilitate referrals for other healthcare needs.

In terms of disparities, African Americans have the highest prevalence of three reportable STDs—chlamydia, gonorrhea and syphilis—and both African Americans and Hispanics are significantly more likely to be diagnosed with these STDs than whites (Figure 4). Discrimination is cited as one of many social determinants of health that cause this disparity.<sup>18</sup>

**FIGURE 4. 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 areas such as maternal and child health and immunization, with few if any publications highlighting concrete examples of the process of moving toward integrated STD services.

Thus, the present work aims to consider the current status of STD programs and services and 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. Stakeholder insights will be used to inform future planning and policy considerations and 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 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.

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 STD services they provide. One objective was to determine what collaboration already exists between the two sectors.

A wide range of public health services are provided to address and prevent STDs. These include:

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

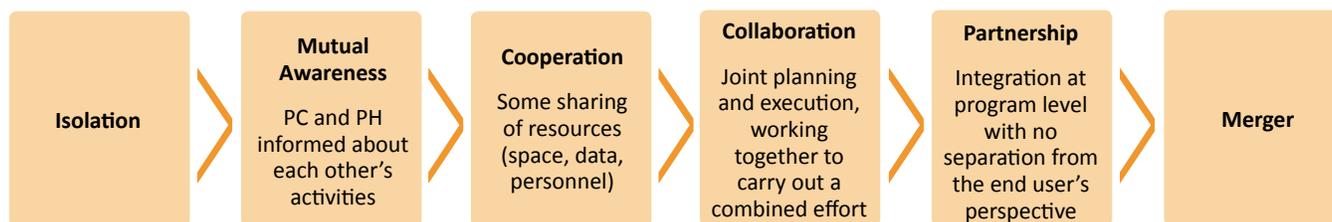
All health departments provide some level of education and outreach, epidemiology, and disease intervention and partner notification. All but two of the health departments provided some form of direct clinical services for STDs (see Figure 6). Public health agencies noted their ability to provide care that was free or low cost, confidential, and targeted to vulnerable and hard-to-reach populations.

Community health centers 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 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 speakers, and the poor.

With regard to “integration,” there were examples across the spectrum (see Figure 5, below).



**FIGURE 5. MODEL OF INTEGRATION, ADAPTED FROM THE IOM REPORT**



The interviews showed that the integration of STD services into primary care settings is limited and uneven. There were some instances of a collaborative approach to clinical services with a shared understanding and support of the current system.

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

- Public health uses epidemiology and disease intervention services to assist primary care providers.
- Primary care (community health centers specifically) screens and treats patients for STDs.
- In limited instances, public health departments operate their own FQHCs that provide a wide range of clinical services, including for STDs.
- In some states or counties, there were discussions about opportunities to develop pilots to test integration approaches.
- 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 6. HEALTH DEPARTMENTS AND PUBLIC-HEALTH-RUN STD CLINICS**

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 and King County	Yes

## ■ Funding, Reimbursement, and Budgets

### WHY THIS MATTERS

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

*“It would be really helpful to learn about billing and potential opportunities for generating revenue, and learn from experiences of other states.”*

State Health Official

Furthermore, federal, state, or health insurer rules can limit public health’s ability to get reimbursement. 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 STD services.

### 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.).

*“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 Official

## ■ Stability of Public Health

### 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

- There needs to be greater awareness of the interdependency of these services, only some of which have the potential to be integrated into primary care.
- Thoughtful discussion is needed about how roles can be transformed, recognizing that it can't happen overnight.



## ■ Confidentiality and Stigma

### 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 hometown. Examples were given of how this plays out in the healthcare system:

- **Financial:** Some patients would rather pay the out-of-pocket expenses 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.

*"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 healthcare provider to know."*

Community Health Center

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

### 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 Explanations of Benefits.

### ■ 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 are not comfortable with taking a sexual health history or 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 to allow for sophisticated care for complicated or co-occurring conditions and disseminate current research and education to the primary care community.

*“Our clinicians wanted more education about leading questions—they realized they were missing opportunities to identify cases and to get the patient navigator to work with those patients.”*

Primary Care Association

### WHAT COULD HELP

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

### ■ Impact of ACA and Access to Insurance

#### 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 ACA implementation. At the time interviews were conducted (July 2013), six of the 12 states with interviewees were planning to expand Medicaid eligibility (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.

*“It is too early to know what to expect as the ACA is rolled out. We need to remain open to the idea that health departments will need to continue to provide STD services.”*

State Health Department



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 healthcare reform was fully implemented. Furthermore, public health departments regularly expressed uncertainty about their roles in ACA and accountable care organizations (ACOs).

The implementation of healthcare 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, 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 health record (EHR) can hinder that collaboration. Good electronic health records are necessary for implementing improvements in all care, including STD care. Many health centers regularly use data from their EHRs to conduct quality assurance, check screening rates, and implement reminder systems for providers—all areas that would benefit the delivery of care for STD patients.

*“Our CHCs [community health centers] 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

But the issue of whether or not public health will have access to health information exchanges (HIEs) 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 EHR/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 existing barriers to information sharing.

### ■ Expedited Partner Therapy

## 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, 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 a change would be difficult and time-consuming to implement.

## WHAT COULD HELP

- States could learn from other states that have successfully advocated for EPT.
- Well-written documents explaining the benefits of EPT, including cost savings and health outcomes, would be valuable resources.
- Toolkits containing sample language, fact sheets, and talking points would also be helpful.

### ■ Access to Primary Care

## WHY THIS MATTERS

In small and rural states (and even in some urban areas), 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, duplication of services is reduced; 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 Official



## 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 healthcare 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 in areas such as STD, TB, and HIV by partnering with an FQHC, 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?”
- To be a true patient-centered medical home, most health center representatives indicated that they need to “treat the whole person” and be a one-stop shop for their patients.
- Co-location has been successful for a few public health/primary care systems. Close proximity allows for better partnership, regular meetings, and regular opportunities for integration.
- Using a variety of funding sources, a state health department developed a new continuing medical education opportunity for physicians, advance practice registered nurses, and registered nurses. By partnering with a statewide medical association, the health department educated more clinicians on STDs than they could before.

## Spotlight: County Health Department

### *Benton County 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 despite this, services were not always coordinated. “Even though we were in the same building, we had big barriers,” says the director of Benton County 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 STD care, and began a process that allowed them to really focus on this issue of organizational culture.

The agency stuck to five basic principles:

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 healthcare services. The key eventually turned out to be navigators—staff who serve as connectors to social services and supports and 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 on the delivery of STD care. The agency admits it 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 individuals to the PCPs 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 in to 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 10 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 to evaluate the meeting’s initial impact on integration efforts. Over the course of two weeks, 28 individuals participated in the survey, a response rate of 65 percent. Of the 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 10 jurisdictions participated.

The survey consisted of seven questions designed to address the post-meeting integration efforts among the jurisdictions that attended the meeting. (The survey is included as Appendix 8.)

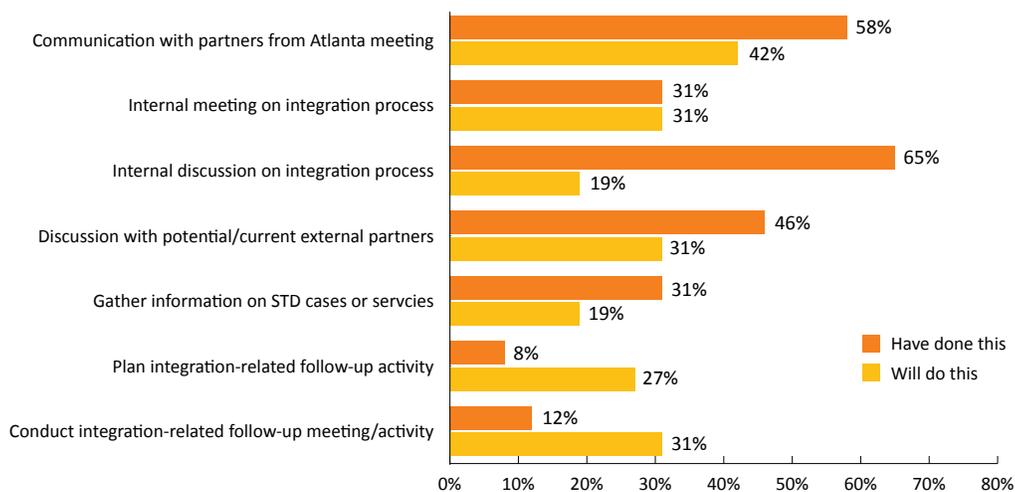
In the weeks following the meeting, most participants engaged in some kind of follow-up activity. More than half of the participants reported engaging in specific activities such as having informal initial internal discussions about ways to begin or continue the integration process (65%) and having follow-up 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 7).

**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 7. OVERVIEW OF CURRENT AND PLANNED ACTIVITIES**

**Survey Results: Planned or completed activities to integrate STD and primary care services**



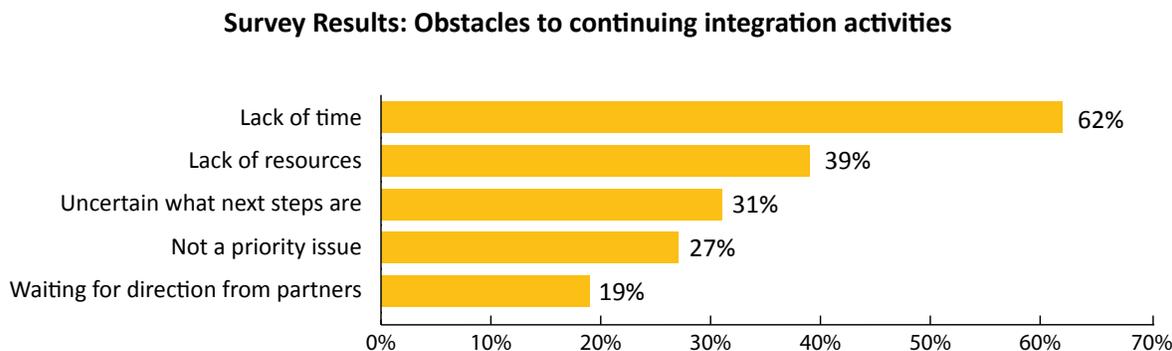
When asked about future integration-related activities, less than half of participants reported plans to engage in activities such as follow-up communication with local/state partners who were at the national meeting (42%),



holding informal, initial internal discussions focused on ways to begin or continue the integration process (31%), speaking to potential or current external partners about possible ways to begin or continue the integration process (31%), and conducting an integration-related follow-up meeting/activity (31%) (Figure 7).

As shown in Figure 8, meeting participants are experiencing various obstacles to working on this issue. More than half of participants (62%) reported a lack of time, followed by a lack of resources (39%).

**FIGURE 8. OBSTACLES TO INTEGRATION**



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

The three most helpful means of support (see Figure 9) 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.
2. Compilation of a “how to” with regard to integration, with best practices, models, and policies on integration.
3. A small grant (\$5,000) to help plan and convene a meeting.

**FIGURE 9. 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 EPT 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 slides, 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 original and specific ideas on pilot programs, funding, and worthwhile activities for the federal partners.

**Possible Pilot Projects**

Twenty 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 **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). Pilots concerning **accountable care organizations, workforce development, and messaging to policymakers** were each suggested once.

**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 community health center staff, including the physician or other healthcare 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 community health center, which already has the means for billing, could charge for the medical evaluation services.”

– SANDRA PARKER, TARRANT COUNTY HEALTH DEPARTMENT

### 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 communities (8 out of 13). Other responses included meeting facilitation (2), continued or increased communication from federal agencies (2), and funding (1).

## 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 changing 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, or 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. healthcare reform, patient centered medical home) led you to change or think about changing 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 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

	<b>PUBLIC HEALTH REPRESENTATIVES</b>	<b>PRIMARY CARE REPRESENTATIVES</b>
	Twelve interviews were held with public health jurisdictions from across the country. Many interviews included both the state health official and the director of infectious disease. Twenty-two people in total participated. See detail below.	Nine interviews were held with primary care representatives. Interviewees held a wide range of job titles, with the most common being director of the agency or director of clinical services. Twelve people in total participated.
<b>CALIFORNIA</b>	<b>California Department of Public Health</b> Ron Chapman, Director	
<b>IDAHO</b> North Central District	<b>Public Health Idaho North Central District</b> Carol Moehrle, District Director	<b>Terry Reilly Health Services</b> Heidi Hart, Executive Director
<b>MASSACHUSETTS</b> Boston	<b>Boston Public Health Commission</b> Anita Barry, Director, Infectious Disease Bureau	<b>East Boston Neighborhood Health Center</b> Mari Bentley, Clinical Compliance Officer
<b>MISSISSIPPI</b>	<b>Mississippi State Department of Health</b> Mary Currier, State Health Officer Joy Sennett, Director, Office of Communicable Diseases Mary Jane Coleman, Retired Director, Office of Communicable Diseases	<b>Mississippi Primary Health Care Association</b> Robert Pugh, Executive Director Joyce Smith, Director of Clinical Quality
<b>NEW YORK</b>	<b>New York State Department of Health</b> Dan O'Connell, Acting Director, AIDS Institute	
<b>NORTH CAROLINA</b>	<b>North Carolina Department of Health &amp; Human Services</b> Evelyn Foust, Director, Communicable Disease Branch Laura Gerald, State Health Director	<b>Piedmont Health Center</b> Evette Patterson, Director of Clinical Services <b>North Carolina Community Health Center Association</b> Marti Wolf, Clinical Programs Director
<b>NORTH DAKOTA</b>	<b>North Dakota Department of Health</b> Terry Dwelle, State Health Officer Kirby Kruger, Director of Disease Control	<b>Community HealthCare Association of the Dakotas</b> Mary Hoffman, Clinical Services Specialist Linda Ross, Chief Executive Director Cheryl Underhill, Director of Training and Technical Assistance
<b>OKLAHOMA</b> Tulsa	<b>Tulsa Health Department</b> Bruce Dart, Health Director Priscilla Haynes, Division Chief, Community Health	<b>Morton Comprehensive Health Services</b> Cassie Clayton, Chief Nursing Officer
<b>OREGON</b>	<b>Oregon Health Authority</b> Thomas Eversole, Administrator, Center for Public Health Practice Melvin Kohn, Director, Public Health Division Veda Latin, HIV, STD, and TB Section Manager	<b>Oregon Primary Care Association</b> Jennifer Pratt, Director of Systems Innovation
<b>TENNESSEE</b> Shelby County	<b>Shelby County Health Department</b> Yvonne Madlock, Director	
<b>TEXAS</b>	<b>Texas Department of State Health Services</b> 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	<b>Texas Association of Community Health Centers</b> Davelyn Hood, Director of Clinical Affairs
<b>WASHINGTON</b> Seattle & King County	<b>Seattle &amp; King County Department of Health</b> David Fleming, Director and Health Officer Matthew Golden, Director, HIV/STD Program	

## Appendix 4: National Meeting Agenda

ASTHO	NACCHO	NACHC	NCSD
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### 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 healthcare 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 “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 15**

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

**Agenda: August 16**

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

## Appendix 5: National Meeting Presentation—Findings from the Field



### Perspectives from the Field

**John Auerbach**  
Institute on Urban Health Research and Practice  
Northeastern University

CDC/DSTDP National Partners Collaborative on the Integration of Public Health and Primary Care to Improve STD Prevention  
August 15-16, 2013

### Purpose of Research



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

### Methodology



- Interviews conducted with the following:
  - 5 local health directors (often with ID or STD directors)
  - 7 state health commissioners (often with ID or STD directors)
  - 5 state Primary Care Association leaders
  - 4 Community Health Center leaders
- Municipalities selected to reflect diversity of the nation geographically, demographic composition, density of population, Medicaid expansion policy

### Clarifying some terms/concepts

**Primary care** = Often refers to Community Health Centers and FQHCs. Sometimes may refer to others (private practice, hospital outpatient settings).



**Funded STD services** = Focus is on services provided with PH funding or by PH; uneven awareness of STD services in private sector paid for most often by insurance.



### Profile of PH Services Provided



- Public health likely to offer:
  - Limited primary prevention
  - Epidemiology
  - Disease Intervention Services
  - Outbreak response
  - Laboratory services
  - Assurance of access to services – direct/indirect

### Where public health-funded clinical services offered

- Generally not within comprehensive primary care site
- Sometimes clustered with HIV, Hep, TB, WIC, family planning
- Billing is the exception not the rule



Pride in offering services that are:

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

"Walk-in only - No appointments are taken. Patients are seen on a first come, first serve basis. We have a limited number of openings each days for patients. We suggest you arrive early. All STD testing and treatment is free and confidential. Anyone 12 years of age and older can utilize the STD clinic."

**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

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



NOTES: 1 - Exploring an approach to Medicaid expansion likely to require waiver approval. 2 - Discussion of a special session being called on the Medicaid expansion. SOURCES: Based on KCMU analysis of recent news reports, executive activity and legislative activity in states. Data reported here are as of July 1. It is important to note that per CMS guidance, there is not deadline for states to implement the Medicaid expansion. Requirements for legislation to implement the Medicaid expansion vary across states.

### 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

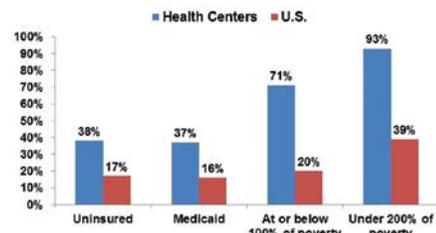


### Differences Are Striking

- |  |  |
|--|--|
| <p><b>North Carolina</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> <li>• 83% with insurance</li> <li>• No Medicaid expansion</li> </ul>   | <p><b>Oregon</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> <li>• 85% with insurance</li> <li>• Will expand Medicaid by 240,000</li> </ul>                         |
| <p><b>Texas</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> <li>• 75% with insurance coverage</li> <li>• No Medicaid expansion</li> </ul>   | <p><b>North Dakota</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> <li>• 89% have insurance</li> <li>• Will expand Medicaid by 20,000 (1/3 of uninsured)</li> </ul> |
| <p><b>Washington State</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> <li>• 86% with insurance coverage</li> <li>• Will expand Medicaid</li> <li>• 800,000 may be newly insured</li> </ul> | <p><b>Oklahoma</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <ul style="list-style-type: none"> <li>• 78% have insurance</li> <li>• No Medicaid expansion</li> </ul>                                 |

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

Health Center Patients Are Disproportionately Poor, Uninsured and Public-Insured vs. the U.S. Population, 2009



Source: National Association of Community Health Centers, Access Endangered: Profiles of the Medicaid Disenfranchised, August 2011

### 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

24 Local Health Jurisdictions Reduced or Eliminated Vital Public Health Programs in 2009



Source: EPA and SHAPED survey of health jurisdictions BUDGET & POLICY CENTER

## 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

*Healthcare Financing, vol. 20, 2012*  
 Anyone who wants to understand the alarming rise in sexually transmitted disease in Sacramento County need only look at the numbers. Five years ago, Sacramento County had half a dozen public health clinics to serve the poor. Today, only one still operates. Five years ago, Sacramento had 150 communicable disease investigators who tracked STD cases and contacted sex partners of infected patients to make sure they got treatment.

## 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

FORT WORTH — When the Legislature slashed two-thirds of the state family planning budget in 2011, clinics sold their equipment, laid off staff or closed their doors. Now that money is trickling back in, some are cautiously rebuilding. Janice Collins, the owner of Collins Family Planning Clinic in Fort Worth, saw her state funding dwindle from about \$400,000 for the 2011 fiscal year to \$150,000 for the first three months of 2012 before the state siphoned off the money completely. "I'm a planner; I planned out everything in my life. Last year, the plan kind of got a little fuzzy," said Collins, 49, a longtime nurse.

## Other circumstances matter



### In North Dakota Small Towns Find Fracking Brings Boom, Booming Headaches

*By Alan Iyengar - Mar 27, 2013*  
 Fracking's secondary effects will increasingly challenge small towns and cities grappling with job gains and environmental costs, according to a study by Oklahoma State University researchers. Towns that have already experienced the U.S. boom in natural-gas exploration using hydraulic fracturing, or fracking, hold lessons for dealing with mineral-rights disputes, pollution concerns and increased strains on roads, schools and police forces, said Shannon Ferrell, agricultural law professor at the Stillwater, Oklahoma-based school. "A lot of the issues revolve around who benefits from natural gas development," Ferrell said in a phone interview. "The stakeholders are very diverse, as are the regions where it's taking place." The Oklahoma State study wasn't meant to make policy recommendations, he said.



### The Washington Post

#### How Mississippi could end up killing Medicaid

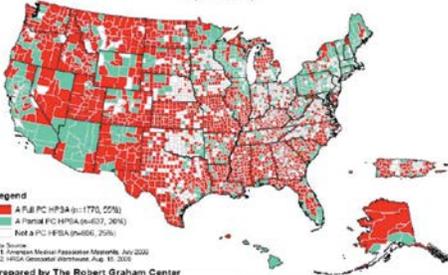
*By Sandhya Somashankar, Updated: June 13, 2013*  
 The fight over expanding Medicaid has gotten ugly, and the latest state to grab the spotlight is Mississippi, where a standoff in the legislature is pushing the state toward a cliff. Without a last-minute agreement, Medicaid may cease altogether there on July 1. Most people think it won't come to that, but given the unpredictable nature of the fight over Obamacare, advocates and hospitals there are growing understandably concerned. Some 700,000 people are on the Medicaid rolls in Mississippi, and the program represents about 16 percent of the state's hospital revenue.

## 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

2008 Primary Care Health Professional Shortage Areas By County



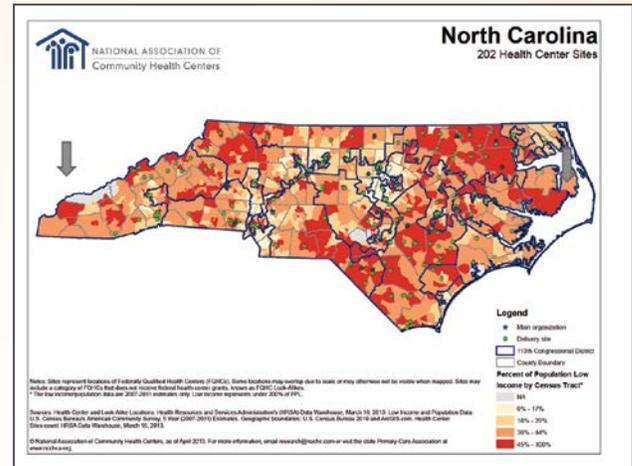
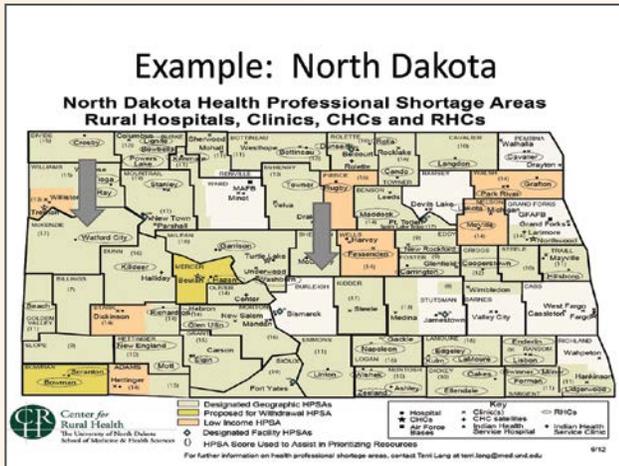
## CHCs and STDs

### STD Distribution



### FQHC Distribution





### 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

**STDs HAPPEN—MOST ARE CURABLE**

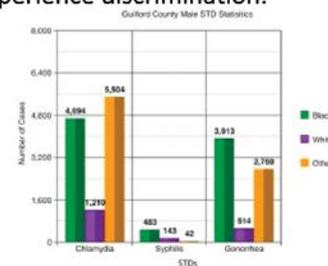


FIND OUT WHAT'S RECOMMENDED FOR YOU → START RECOMMENDATION



### Discrimination against certain people/ populations

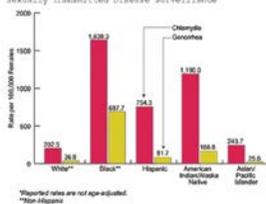
STD clinics may be the only clinical providers for some who have experienced or fear they will experience discrimination.



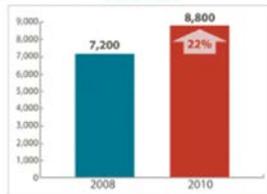
### Elevated Risk Among Those Who Face Discrimination

STDs\* Among Females Aged 10 and Older, by Race/Ethnicity, 2002

Source: (1,15) Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance



Estimated Number of New HIV Infections among MSM aged 13-24, 2008-2010



### 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

For more resources, visit [ahealthcare.org](http://ahealthcare.org) free/low-cost • confidential • quality • many languages

Make us your first call. Get the information you need from someone you can trust—the health department. Call 1-888-604-4636, Mon-Fri 8:30am-5:00pm

Need a free pregnancy test?

### 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



## 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




Join us for a  
**Sexually Transmitted Infection (STI) Education Workshop**

- Learn about STIs!
- Get treatment and referrals for care!
- Free refreshments!
- Metro card giveaways!

CHN Bronx Health Center  
975 Westchester Avenue  
Bronx, NY 10459  
718.320.4466

Date: April 29, 2013  
Time: 10am-12pm

[in](#) [t](#) [f](#)

## 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

### 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 following 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 min.)

The groups should identify, and be prepared to share with the larger group, two 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 on 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 five years. But it was located near a newly rebuilt FQHC that had room to expand the number of patients it served.

The Springfield Community Health Center was eager to help the county public health department and provide care for the STD patients as part of its efforts to be a patient-centered medical home. But 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

### 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 healthcare 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 following 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 min.)

The groups should identify, and be prepared to share with the larger group, two 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:

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 opening of the new wing came at a good time because the state was anticipating that a million more residents 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 1.5 million, 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, a dozen community health centers (half of which were FQHCs), and numerous group private practices. The large, rural southern region was comprised of small towns and large rural areas and accounted for half the geographic area of the state. It had only two health centers and two medium-sized community hospitals. At the hospitals 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 six 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 African-American 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 United States for less than five 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 the 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-needed service, but what they did was often in isolation from 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, while sharing 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 10 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.
- Have follow-up communication with my local/state partners who were at the Atlanta meeting.
  - Hold an internal meeting in my organization focused on ways to begin or continue the integration process.
  - Have informal initial internal discussions in my organization about possible ways to begin or continue the integration process.
  - Speak to potential or current external partners about possible ways to begin or continue the integration process.
  - Gather additional information about STD cases or services to better understand the potential for integration.
  - Plan an integration-related follow-up activity.
  - Conduct an integration-related follow-up meeting/activity.
  - 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.
- Lack of time.
  - Lack of resources.
  - Uncertain about what the next steps are.
  - Not a priority issue for my organization.
  - Waiting for direction from the CDC, other federal partners/funders, and/or the national partner organizations.
  - 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 important) 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 PowerPoints, 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 follow-up work would be most helpful? (Please describe).

---

**THANK YOU FOR YOUR PARTICIPATION!**

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## Additional Resources

### Issue Briefs, Guides, and Resource Collections

#### **Advancing the Reintegration of Public Health and Healthcare**

*ASTHO*

This collection of more than 45 state stories, collected as part of the 2013 ASTHO President's Challenge, provides examples of state public health programs and initiatives that integrate public health and healthcare.

<http://www.astho.org/Presidents-Challenge-2013/>

#### **Billing for Clinical Services: Health Department Strategies for Overcoming Barriers**

*NACCHO*

NACCHO prepared this issue brief to help public health officials, state and local leaders, and policymakers understand the opportunities and challenges local health departments face when billing third-party payers for clinical services. The brief includes information about the public health billing landscape, barriers to third-party reimbursement, and strategies local health departments have used to overcome these challenges. (Free registration is required for download.)

[http://eweb.naccho.org/eweb/DynamicPage.aspx?WebCode=proddetailadd&ivd\\_qty=1&ivd\\_prc\\_prd\\_key=cd163a96-cef0-4a39-a665-f7d4a51ccb93&Action=Add&site=naccho&ObjectKeyFrom=1A83491A-9853-4C87-86A4-F7D95601C2E2&DoNotSave=yes&ParentObject=CentralizedOrderEntry&ParentDataObject=Invoice%20Detail](http://eweb.naccho.org/eweb/DynamicPage.aspx?WebCode=proddetailadd&ivd_qty=1&ivd_prc_prd_key=cd163a96-cef0-4a39-a665-f7d4a51ccb93&Action=Add&site=naccho&ObjectKeyFrom=1A83491A-9853-4C87-86A4-F7D95601C2E2&DoNotSave=yes&ParentObject=CentralizedOrderEntry&ParentDataObject=Invoice%20Detail)

#### **Community Benefit**

*NACCHO*

This web page collects resources to help local health departments and nonprofit hospitals conduct collaborative community health assessment and improvement processes.

<http://www.naccho.org/topics/infrastructure/mapp/cha-healthreform.cfm>

#### **How to Work with Schools to Conduct STD Screening**

*NCSD*

Schools, community health centers, health departments, and community-based programs across the nation are joining forces to provide adolescents with needed access to STD and HIV testing and treatment where youth spend

a large portion of their day—at school. This fact sheet contains information on adolescents and sexual activity, how to work with schools, and next steps.

<http://www.ncsddc.org/publications/how-work-schools-conduct-std-screening>

#### **Partnerships Between Federally Qualified Health Centers and Local Health Departments for Engaging in the Development of a Community-Based System of Care**

*NACHC/NACCHO*

This guide describes how health centers and local health departments can work together toward developing a high performing delivery system model. It highlights the importance of strategic alliances between health centers and local health departments to strengthen the bonds between public health and primary care in the context of a medical home, meaningful use of health information technology, and health reform.

[http://iweb.nachc.com/Purchase/ProductDetail.aspx?Product\\_code=ST\\_PART\\_10](http://iweb.nachc.com/Purchase/ProductDetail.aspx?Product_code=ST_PART_10)

#### **Primary Care and Public Health Strategic Map**

*ASTHO*

Created in July 2012 with the support of the Institute of Medicine, United Health Foundation, CDC, and the Health Resources and Services Administration, this strategic map outlines the central challenge that we face in integrating primary care and public health integration in 2012-2014 and the strategic priorities and objectives that will help meet that challenge. Each strategic objective in the map links to resources in support of that objective.

<http://www.astho.org/pcph-strategic-map/>

#### **Shifting to Third-Party Billing Practices for Public Health STD Services: Policy Context and Case Studies**

*NCSD*

NCSD has collaborated with key partners to develop this resource to support the sustained delivery of STD services in the face of a changing funding and policy landscape. This guide introduces what providers need to consider as they approach the decisions surrounding third-party billing.

<http://www.ncsddc.org/publications/shifting-third-party-billing-practices-public-health-std-services-policy-context-and-ca>

### State Health Department Framework: Preventing Infectious Diseases Through Healthcare

*ASTHO*

ASTHO is working with its members and partners to examine how the healthcare system, evolving under health reform implementation, will influence the role of state health department infectious disease programs. This document represents a summary of collective thinking, a roadmap for moving forward, and an effort to complement work being done by CDC to develop a framework at the federal level.

<http://www.astho.org/Programs/Infectious-Disease/Integration/Preventing-Infectious-Diseases-through-Healthcare/>

## Meeting Reports

### Infectious Disease Integration of Public Health and Primary Care

*ASTHO*

The ASTHO Infectious Disease Policy Committee hosted a meeting on the impact of public health and primary care integration on infectious disease programs. This paper summarizes the in-person meeting and captures state examples of infectious disease integration.

<http://www.astho.org/Programs/Infectious-Disease/Integration/Infectious-Disease-Integration-of-Public-Health-and-Primary-Care/>

### Infectious Disease Strategic Thinking Summit Report

*ASTHO*

ASTHO convened state health agency leadership to discuss policy issues related to HIV/AIDS, viral hepatitis, STDs, and TB and to identify strategies for ASTHO and state health officials to effectively address these infectious diseases. This report captures the findings of that meeting and outlines a comprehensive system to integrate efforts to prevent and treat HIV, HCV, STDs and TB.

<http://www.astho.org/Programs/Infectious-Disease/Integration/Infectious-Disease-Strategic-Thinking-Summit-Report/>

### STD Prevention in a Changing Environment: Opportunities for Public Health Leadership Engagement

*ASTHO*

ASTHO and CDC convened a meeting of local, state, and federal public health experts and partners to discuss how public health leadership can assist STD programs as they adapt to ACA implementation. This report summarizes the findings of the meeting and captures state-specific integration stories.

<http://www.astho.org/Programs/Infectious-Disease/Hepatitis-HIV-STD-TB/Sexually-Transmitted-Diseases/STD-Prevention-in-a-Changing-Environment/>

## Policy Statements

### Statement of Policy: Provision of Clinical Services by Local Health Departments

*NACCHO*

Nearly half of local health departments directly provide clinical care services to address the needs of underserved populations. This NACCHO policy statement discusses issues local health departments need to consider in light of the changing healthcare system.

<http://www.naccho.org/advocacy/positions/upload/12-17-Provision-of-Clinical-Services.pdf>

### Statement of Policy: Support for Collaboration Between Medicine and Public Health

*NACCHO*

This policy statement lays out NACCHO's support for collaboration between public health and medicine to fulfill the core functions of public health. At press time, NACCHO was in the process of updating the statement.

<http://www.naccho.org/advocacy/positions/upload/04-12revMedicineandPublicHealth.pdf>





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