ASTHO**Report**
In-depth coverage of leading state and territorial public health issues.

March 2019

ASTHO/CDC Heart Disease and Stroke Prevention Learning Collaborative:

Lessons Learned from the Payers Cohort

ASTHO and the CDC's Division for Heart Disease and Stroke Prevention collaborated to support the ASTHO/CDC Heart Disease and Stroke Prevention Learning Collaborative, where 31 state and territorial health agencies (S/THAs) from 2013 to 2018 were engaged to test, implement, and scale up approaches to address hypertension. Through this learning collaborative, a six-state cohort (Arkansas, Florida, Nevada, Utah, Virginia, and Wisconsin), herein referenced as the "payers cohort," collaborated with public health departments and private payers to improve population-level blood pressure control through innovative, data-driven healthcare delivery, and payment models. The six states convened cross-sector teams which included payer partners, local health agency staff, academic institutions, community health workers, and other state- or local-level stakeholders. Participating states and their partners shared efforts to improve cardiovascular health outcomes, focusing on blood pressure control and reduce healthcare costs. The lessons outlined below represent proven approaches to crafting collaborative practice solutions.

Partnerships between payers and public health present many opportunities and should be approached thoughtfully. Strong, collaborative partnerships between payers and public health agencies can be powerful catalysts to create robust systems of care that respond to the needs of the patients who are the least adherent to care plans and challenging to engage as well as the costliest to the healthcare system. Identifying common goals allows partners to coordinate existing initiatives or develop new joint initiatives that align with organizational missions. At a policy level, decreasing the risk for chronic disease and hypertension has become a priority for healthcare providers, payers, governments, and insurers. By examining payer partner data, population-based zip codes, or data from all-payer claims databases, the learning collaborative states have identified high- or at-risk patients to target interventions to monitor medication adherence, prevent unnecessary emergency department visits, reduce hospital admissions, and reduce frequency of provider interactions—all of which reduces costs for payers. Additionally, the shift towards value-based care along with greater reporting and implementation of quality improvement initiatives is supportive of these targeted interventions.

These considerations presented an opportunity for these six state public health agencies to partner with private payers to:

- Identify high-risk, high-cost, underserved, and hard to engage populations.
- Develop and test innovative, scalable payment mechanisms, or healthcare delivery models.
- Strengthen statewide capacity to collect, access, share, and use data.
- Quantify the return on investment (ROI) for the intervention.

The states in the learning collaborative found this structured, purposeful partnership around shared specific outcomes (increasing hypertension identification and control) supports long-term engagement.

They also found that this intentional partnership requires an investment of time and a responsiveness to promptly address partners' needs or questions. Additionally, they discovered the importance of overcoming the different terminology used by each sector. Staff from the Virginia Department of Health found that cultivating a relationship with the payer required flexibility and negotiation around a shared vision to ensure reciprocal benefit around outcomes. Several states (Florida, Virginia, and Wisconsin) learned that establishing bi-weekly or monthly standing calls with partners was a useful way to build strong team relationships, support peer-to-peer learning, and ensure implementation was staying on track. This is especially important when working with multiple payers, as was the case in Nevada.

Payers and public health play unique roles in improving hypertension identification and control. Public health agencies and payers each bring unique strengths and resources to the partnership. Public health agency staff are trained to identify high-risk populations, develop interventions, and provide tools and resources to understand the root causes of disparities and implement evidence-based interventions to address them. They are also well-positioned to convene cross-sector stakeholder teams and leverage state and local resources to build connections between public health, clinical, and community resources.

Private payers have strong data analytics teams and can look within their enrollment data in real time to identify individuals with undiagnosed or uncontrolled hypertension with ICD-10 codes, use payer medication claims data to calculate medication adherence, and develop predictive algorithms for hypertension surveillance and prevention. The Virginia Department of Health team developed the algorithm to identify how data is documented, then analyzed and reported in the healthcare practice's eClinicalWorks software. Through this effort, their team was revised and tailored the methods and algorithm in order to achieve optimal results, remove duplicate data, and minimize error. Payers on every state team used member data to identify geographic areas in which populations had higher prevalence of hypertension or to identify individual members with uncontrolled hypertension. Providers within each state team then engaged these areas in interventions through the support of community health workers (CHWs), community pharmacists, or public health nurses. Several payers leveraged their staff and expertise to develop predictive models for identifying individuals at-risk for hypertension. Payers can also build in-house care coordination capacity by employing CHWs to connect high-risk or high-cost beneficiaries to resources and support, as well as sustain an intervention by using incentive payments or specific reimbursement for services that have a demonstrated ROI.

Collaboration with specific payer partner staff is essential. Public health leaders identified that having the "right" payer staff as part of the collaborative mattered. The "right" payer staff is someone who champions the intervention, translates strategy and ideas into execution, has open and honest communication, understands care is local, values collaboration, and has the influence to bring the needed resources including additional staff to achieve the shared vision and goals. In Wisconsin, United Health Care engaged its internal Business Intelligence Team to take advantage of their strong in-house data analytics capacity and familiarity with using claims data to explore healthcare cost and utilization. In Florida, partners learned that it is important to engage health plan staff at all levels of the organization, from top-level leadership at Molina (who committed resources to the initiative) to front-line staff such as CHWs and their supervisors, who used their experiences and observations of their patients and members to help shape the protocols that were tested.

Each state in the learning collaborative created a cross-sector team that included representatives from the state and local health agencies, payers, academic institutions, performance measurement and quality improvement experts, health information technology and health informatics experts, risk analysis and actuarial staff, clinical providers, pharmacists, and community-based healthcare professionals, such as CHWs.

Co-management of efforts between public health and payers is challenging but possible. Success in co-management begins with a commitment toward shared goals. Without proper coordination and communication, it is challenging to move forward or to pivot in a learning collaborative. Regular meetings between learning collaborative team members were an effective tool to ensure coordination between payers and public health. It is important to share ownership of the goal(s) but divide roles and responsibilities based on each party's strengths and expertise.

Accessing, sharing, and using data presents both opportunities and challenges. Data can help healthcare providers and patients discover—with far more precision—what treatments work best given multiple medical, biological, environmental, and even socio-economic criteria. Despite these benefits, payers and public health agencies may encounter challenges and barriers to sharing data. Some of these challenges relate to data security and data governance, access to timely and real time data, cost of sharing, and the technical ability to share.

For example, Florida found that using ICD-10 codes to analyze Molina member claims data to identify members to engage is a helpful first screening step. However, this may yield false positives (members who may have had hypertension in the past but whose blood pressure is now normal). In addition, through the analysis of member claims data, staff may miss members who have elevated blood pressure but have not yet received a hypertension diagnosis. Further exploration to test additional screening steps is needed. Both Utah and Wisconsin found that payer claims data revealed that the members they identified to engage did not necessarily go to the same pharmacies, which presented challenges to recruiting pharmacy sites to participate in the pilot initiative. Wisconsin also learned that using claims data to identify "high volume" clinics would have allowed a more efficient use of resources and higher numbers of members reached through the pilot initiative. Additionally, the state health agency in Virginia identified that Anthem was not using the same method for determining medication adherence in their commercial and public plans and developed a model to address this issue.

Understanding the cost savings of a model is necessary to achieve buy-in and sustainability. The states identified a strong need to translate the outcomes of a prevention program into dollar values to evaluate the "bottom-line" impact of an intervention. To do this, partners must agree on a shared vision of the intervention's benefits and associated costs as well as address questions such as whether to include "non-avoidable costs," costs that would not disappear if the intervention went away, or which indirect benefits should be included. An important early step is to identify the stakeholders to develop or validate the ROI over a given timeframe, such as staff from health plans, community organizations, or academia with expertise in evaluation, risk analysis, analytics, research, or actuarial science. Additionally, it is important to find project partners with forecasting competencies to accurately adjust future costs and benefits.

In Arkansas, the public health department and Humana analyzed healthcare utilization and cost data for Humana members that received care coordination and counseling from a Jefferson County Local Health Unit nurse care manager to understand the model's effects on member healthcare service utilization and healthcare costs. They determined that, among 12 Humana members referred to the nurse care manager, the average monthly expense per patient decreased from $1,347 in April 2017 to $907 in April 2018 (a 32.7% reduction). As a result, Arkansas is working with Humana to identify a reimbursement model and the appropriate codes for public health team-based care. In Nevada, this work has strengthened the understanding and value of integrating the CHWs in each payer's case management work so much that the Medicaid agency is looking to pilot reimbursement for the services of CHWs.

Community-based healthcare extenders are key to successful patient engagement. Patients, pharmacists, and CHWs are key team members to improve quality of care. Through these pilots, state health agencies coordinated with payers to leverage the skills of CHWs and pharmacists who act as more than providers of care—they are system catalysts. While they have the clinical skills to monitor blood pressure and medication adherence, they also have skills to care for the health of populations and create the needed bridge between public health and health systems. In this way, they add value to both payers and public health agencies by improving health outcomes and connecting patients to the necessary supports to manage their health conditions. In Virginia, the CHW applied community context when describing the role of the CHW to residents, serving as an effective bridge between clinical and community settings.

Several states learned that the specific framing used to recruit individuals to participate in pilot initiatives made a difference in how interested they were to participate. For example, in Utah, pharmacists learned that framing participation as taking advantage of a service, rather than enrolling in a formal program, increased interest among targeted individuals. CHWs in Virginia found that patients prefer face-to-face interaction with CHWs rather than phone calls or email communication. In Florida, the training for CHWs incorporated elements on health equity and cultural sensitivity. Equipping CHWs with these skills as representatives of the community they serve allowed for increased trust between the health insurer and the patient. The nuance of community context is important to convey to payers when working with them to involve CHWs in case management.

State and payer teams that involved pharmacists in the care team found regular meetings in which participating pharmacists shared patient recruitment approaches and counseling practices proved to be effective for peer-to-peer learning. Participating teams practiced Plan Do Study Act (PDSA) quality improvement cycles throughout their time in the learning collaborative to assess their progress toward their aims and then adjusted their action plans accordingly. The PDSA cycles helped clarify: (1) patients' preference for interacting with CHWs in a community setting rather than in a clinic, (2) the selling points of the program to stakeholders, (3) the challenges of sharing data and getting access to the right data at the right time, and (4) the need for ROI calculation in promoting sustainability.

Conclusion

Just as the clinical management of hypertension requires buy-in and consistent engagement from both patient and physician, population management requires constant communication and cooperation from private and public stakeholders. States in the payers cohort of the ASTHO/CDC Heart Disease and Stroke Prevention Learning Collaborative identified the above promising lessons, but this work needs to be scaled in order to have a meaningful impact on hypertension in the United States. Both payers and state health agencies can play a range of important roles in identifying, implementing, spreading, and sustaining these strategies and this work over time. As a result of this work, all the states in this cohort plan to continue engaging with their payer partners to address hypertension and other chronic diseases.

This publication was supported by grant number 6NU38OT000161-05-03, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the U.S. Department of Health and Human Services.

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.