Arizona Public Health Summit 2014 - Agenda

8:00-8:30  Registration Continental Breakfast - Meet and Greet

8:30-9:00  The Framework of the Affordable Care Act – Page 26
Bonnie Preston, MSPH, US Dept of Health and Human Services, Region IX

❖ 9:00  Medicaid Expansion and The Exchange – Page 46
Monica Coury, AHCCCS
❖ 9:15  Safety Net and the Medical Home Partnership
Kim Van Pelt, St. Luke’s Health Initiatives
❖ 9:30  Patient Centered Coordinated Care in Practice-
How Does Health Care Look at the Clinic Level?
Avein Tafoya, Adelante Health Care

10 minute Q&A – Will we still need a safety net?
5 minute break

❖ 10:00  Intent of ACA and Prevention Services – Page 61
Bonnie Preston, MSPH, US Dept of Health and Human Services, Region IX
❖ 10:15  Health Plan Implementation of ACA – Page 72
Charlton Wilson, MD, Mercy Care Plan/Aetna
❖ 10:30  Accountable Care Organizations and Prevention Model – Page 83
Debbie Johnston, Arizona Hospital and Healthcare Association

10 minute Q&A - What support systems do payers need?
5 minute break

❖ 11:00  Public Health Return on Investment/Assessments –
Public Health Implementation of ACA – Page 100
Bob England, MD, Maricopa County Department of Public Health
❖ 11:30  Public Health Community Assessment – Page 136
Cara Christ, MD, ADHS
❖ 11:45  Family Planning Funding, Data and Changes – Page 154
Brenda Thomas, Arizona Family Health Partnership
❖ 12:00  Health Plans Prevention and Population Requirements
Erin Klug, Arizona Department of Insurance

10 minute Q&A - Working Lunch
How do we protect Public Health?

❖ 12:30  Lunch with small group discussion: How do the pieces fit together?
Where are the gaps? Where are the strengths and natural partnerships?
❖ 1:15  Report from groups
❖ 1:40  Group Discussion – What do we know? What’s missing?
What are the top 3 costliest conditions? How can public health help?
What are the obstacles? Action items?
❖ 2:45  Closing remarks
ACA Growing Pains
Redefine Health Care

Prevention vs Illness Care

For Health Care Providers
Health care delivery organizations must adapt and innovate to understand options, plan around obstacles, and seek new solutions that create value for patients and providers. Improving outcomes requires new models of care structured around the needs of identified groups of patients.

For Health Plans
Health plans no longer insure illness care; rather, they must increasingly ensure the health of their members. Enabling health is the path to future profitability. This C-level mission change requires leaders to think differently about health and health care. It requires a redefinition.
✓ Plans must provide first dollar coverage for preventative services
✓ More people with no copays or deductibles for prevention
✓ Pressure to decrease Federal spending so the funding can shift to new coverage
✓ Billing programs in public health
15 Covered Preventive Services for Adults

1. **Abdominal Aortic Aneurysm** screening for men 50 and older
2. **Alcohol Misuse** screening and counseling
3. **Aspirin use for men and women of certain ages**
4. **Blood Pressure screening for all adults**
5. **Cholesterol screening for adults of certain ages or at higher risk**
6. **Colorectal Cancer screening for adults over 50**
7. **Depression** screening for adults
8. **Type 2 Diabetes** screening for adults with high blood pressure
9. **Diabetes counseling for adults at higher risk for chronic disease**
10. **HIV** screening for all adults at higher risk

11. **Immunization** vaccines for adults—doses, recommended as:
   - Hepatitis A
   - Hepatitis B
   - Herpes Zoster
   - Human Papillomavirus
   - Influenza (Flu) Shot
   - Measles, Mumps, Rubella
   - Meningococcal
   - Pneumococcal
   - Tetanus, Diphtheria, Pertussis
   - Varicella

12. **Obesity** screening and counseling for all adults
13. **Sexually Transmitted Infection (STI)** prevention counseling
14. **Tobacco Use** screening for all adults and cessation intervention
15. **Syphilis** screening for all adults at higher risk

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22 Covered Preventive Services for Women, Including Pregnant Women

The eight core prevention-related health services marked with an asterisk (*) must be covered with no cost-sharing in plans starting on or after August 1, 2012.

1. **Anemia** screening on a routine basis for pregnant women
2. **Bacteriuria** urinary tract or other infection screening for pregnant women
3. **BRCA** counseling about genetic testing for women at higher risk
4. **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
5. **Breast Cancer Chemoprevention** counseling for women at higher risk
6. **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women*
7. **Cervical Cancer** screening for sexually active women
8. **Chlamydia Infection** screening for younger women and other women at higher risk
9. **Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abstinence methods***
10. **Domestic and Intimate Partner Violence** screening and counseling for all women*
11. **Folic Acid** supplements for women who may become pregnant
12. **Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes*
13. **Gonorrhea** screening for all women at higher risk
14. **Hepatitis B** screening for pregnant women at their first prenatal visit
15. **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women*
16. **Human Papillomavirus (HPV) DNA Test:** high-risk HPV DNA testing every three years for women with normal cytology results who are 30 or older*
17. **Osteoporosis** screening for women over age 60 depending on risk factors
18. **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
19. **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
20. **Sexually Transmitted Infections (STI) counseling for sexually active women***
21. **Syphilis** screening for all pregnant women or other women at increased risk
22. **Well-woman visits to obtain recommended preventive services***

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26 Covered Preventive Services for Children

1. **Alcohol and Drug Use** assessments for adolescents
2. **Autism** screening for children at 18 and 24 months
3. **Behavioral assessments for children of all ages**
   - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
4. **Blood Pressure screening for children**
   - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
5. **Cervical Dysplasia** screening for sexually active females
6. **Congenital Hypothyroidism** screening for newborns
7. **Depression screening for adolescents**
8. **Developmental screening for children under age 3, and surveillance throughout childhood**
9. **Dyslipidemia screening for children at higher risk of lipid disorders**
   - Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
10. **Fluoride Chemoprophylaxis** supplements for children without fluoride in their water source
11. **Gonorrhea** preventive medication for the eyes of all newborns
12. **Hearing** screening for all newborns
13. **Height, Weight and Body Mass Index measurements for children**
   - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
14. **Hematocrit or Hemoglobin** screening for children
15. **Hemoglobinopathies or sickle cell screening for newborns
16. **HIV** screening for adolescents at higher risk
17. **Immunization** vaccines for children from birth to age 18—doses, recommended ages, and recommended populations vary.
18. **Iron supplements for children ages 6 to 12 months at risk for anemia**
19. **Lead** screening for children at risk of exposure
20. **Medical History** for all children throughout development
   - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
21. **Obesity screening and counseling**
22. **Oral Health risk assessment for young children**
   - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
23. **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
24. **Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk**
25. **Tuberculin testing for children at higher risk of tuberculosis**
   - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
26. **Vision** screening for all children
You know you are a public health nerd if you...

✔ Like data and statistics.
✔ Wondered why just one CDC scientist was deployed in Contagion.
✔ Care about saving lives and protecting people 24/7.

#PHNerd
Developed Billing Program

- 325,000 immunizations given to insured patients
- No insured patients turned away despite loss of federal funding
- Over $5 million billed for immunizations in 5 years
TAPI’s Objectives

- Audit top services provided by public health
- Survey physicians/patients to determine most frequently referred services
- Review all state statutes related to public health billing. Affordable Care Act requirements and health plan needs
TAPI’s objectives

- Understand public reaction to billing and percent of Medicaid patients and privately insured in public health

- Develop policies to refer patients back to medical home

- Public health services becoming classified as a “Community Health Urgent Care” working with the medical home?
WE HAD TO INSTALL THE SAFETY NET FOR INSURANCE PURPOSES.
Physicians Refer Patients to Public Health

- Childhood immunization
- Adult immunization
- Lead poisoning
- TB screening or treatment
- Breastfeeding peer counseling
- Children with Special Health Care Needs
- Healthy Start (South Phoenix)
- Hepatitis screening and/or education
- Diabetes screening and education
- Tobacco cessation
- Communicable disease
- Newborn Intensive Care Program
- Dental sealants
- Dental varnishes
- Refugee Health
- STD testing, treatment and education
- HIV testing and education
- Well Woman Health Check
- WIC
- Reproductive health care and education (Family Planning)
- Chronic Disease (obesity, nutrition, asthma, Hep C, blood pressure)
- Nurse Family Partnership (consultation to families at risk to ensure healthy pregnancy, babies and children)

Services Most Often Referred to Public Health

- WIC
- STD testing, treatment and education
- Communicable disease
- Tobacco cessation
- TB screening or treatment
- Adult Immunization
- Childhood immunization

Yes - 85% of Physicians refer to public health
Number of surveys completed by program

<table>
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<tr>
<th>Service Type</th>
<th>Refusals</th>
<th>Completed</th>
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<tbody>
<tr>
<td>STD clinic services</td>
<td>156</td>
<td>1007</td>
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<tr>
<td>STD outreach services</td>
<td>0</td>
<td>66</td>
</tr>
<tr>
<td>Tuberculosis (TB)</td>
<td>0</td>
<td>35</td>
</tr>
<tr>
<td>Nurse Family Practice (NFP) services</td>
<td>0</td>
<td>127</td>
</tr>
<tr>
<td>Healthy Start</td>
<td>0</td>
<td>54</td>
</tr>
</tbody>
</table>

- Completed surveys: 1289
- Refusals: 156

Bar chart showing the number of completed surveys and refusals for each program category.
Question 1: Would you allow us to bill your insurance for your visit? Yes answers (this does include 156 refusals to complete survey for STD clinic)

Question 2: Do you have health insurance? Yes answers (does not include refusals.)

<table>
<thead>
<tr>
<th></th>
<th>NFP</th>
<th>TB</th>
<th>STD Clinic</th>
<th>STD outreach</th>
<th>Healthy Start</th>
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<tr>
<td><strong>Q1</strong></td>
<td>89%</td>
<td>54%</td>
<td>38%</td>
<td>44%</td>
<td>46%</td>
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<tr>
<td><strong>Q2</strong></td>
<td>79%</td>
<td>49%</td>
<td>40%</td>
<td>45%</td>
<td>0.74</td>
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Percent of Insurance Coverage by Program

<table>
<thead>
<tr>
<th>Program</th>
<th>Private Insurance</th>
<th>Medicaid</th>
<th>Medicare</th>
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<tr>
<td>NFP = 127</td>
<td>11</td>
<td>89</td>
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<tr>
<td>TB = 25</td>
<td>47</td>
<td>33</td>
<td>20</td>
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<tr>
<td>STD Outreach = 66</td>
<td>60</td>
<td>40</td>
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<tr>
<td>STD Clinic = 1007</td>
<td>68</td>
<td>26</td>
<td>4</td>
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<tr>
<td>Healthy Start = 54</td>
<td>8</td>
<td>92</td>
<td>0</td>
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</table>

Key:
- Blue: Private Insurance
- Orange: Medicaid
- Gray: Medicare
Does the person receiving services today currently have health insurance?

- 39% have insurance
- 46% Do not have insurance
- 15% are not sure or not willing to share

Type of Insurance:
- 69% Private Health Insurance
- 26% Medicaid

* 65% did not specify. Not included
If we were to start billing insurance for the services we provide, would you allow us to bill your insurance for your visit?

- Yes: 38%
- No: 48%
- Refused: 13%
Private Insurances used by clients

<table>
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<tr>
<th></th>
<th>Aetna</th>
<th>Assurant</th>
<th>BC/BS</th>
<th>Cigna</th>
<th>HealthNet</th>
<th>Humana</th>
<th>United Health Care</th>
<th>United Health One</th>
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<td>11</td>
<td>0</td>
<td>67</td>
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<tr>
<td>TB</td>
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<td>0</td>
<td>18</td>
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<td>0</td>
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<td>0</td>
<td>31</td>
<td>6</td>
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<td>0</td>
<td>39</td>
<td>14</td>
<td>5</td>
<td>3</td>
<td>21</td>
<td>1</td>
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<tr>
<td>Healthy Start</td>
<td>33</td>
<td>0</td>
<td>0</td>
<td>33</td>
<td>0</td>
<td>0</td>
<td>33</td>
<td>0</td>
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</table>
Medicaid Insurances used by clients

<table>
<thead>
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<th>Column1</th>
<th>Column2</th>
<th>Column3</th>
<th>Column4</th>
<th>Column5</th>
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</thead>
<tbody>
<tr>
<td>Care 1st Arizona</td>
<td>CRS Fully Integrated</td>
<td>DES</td>
<td>FES</td>
<td>Health Choice AZ</td>
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<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
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<td>22</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>9</td>
<td>18</td>
<td>11</td>
<td>29</td>
<td>17</td>
</tr>
</tbody>
</table>
When Ideas have Sex
Matt Ridley, Ted Talks 07/19/2010
When Ideas have Sex
Matt Ridley, Ted Talks 07/19/2010

30,000 generations

Obsolete in 5 years
Private

YOU GOT PUBLIC CLOUD IN MY PRIVATE CLOUD!

Public

YOU GOT PRIVATE CLOUD IN MY PUBLIC CLOUD!

HYBRID CLOUD
Logistics of the Day...

Speed dating
Whisper sweet nothings
Idea toys
Match making
15 Covered Preventive Services for Adults

1. Abdominal Aortic Aneurysm screening for men of specified ages who have ever smoked
2. Alcohol Misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood Pressure screening for all adults
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal Cancer screening for adults over 50
7. Depression screening for adults
8. Type 2 Diabetes screening for adults with high blood pressure
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   • Pneumococcal
   • Tetanus, Diphtheria, Pertussis
   • Varicella
   Learn more about immunizations and see the latest vaccine schedules.
12. Obesity screening and counseling for all adults
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
14. Tobacco Use screening for all adults and cessation interventions for tobacco users
15. Syphilis screening for all adults at higher risk

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18. Rhesus Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
19. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
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The Affordable Care Act

A Framework and Resources for Transforming Health Care

Arizona Public Health Summit
Phoenix, Arizona
June 24, 2014
HEALTH & HUMAN SERVICES (HHS) HAS TEN REGIONS
Office of the HHS Regional Director

- Our office serves as the public interface with federal health programs
- Present Regional Issues to Officials to Influence Operation of Federal Programs
- Share Best Practices Across Region
Three Aims Of the Affordable Care Act

Better Care
- Patient-Centered Care Coordination
- Quality

Better Insurance
- Accessibility
- Affordability

Staying Healthy
- Prevention
- Public Health
Individual Requirement

- January 1, 2014

- Exemptions include:
  - Financial hardship;
  - Religious objections;
  - Native Americans
  - Without coverage for less than 3 months;
  - Incarcerated individuals; and
  - Cost exceeds 8% of individual’s income.
New Coverage Options for Millions of Americans

0%FPL
Medicaid
$15,000/Indiv.;
$31,000/Family

133%FPL
Marketplace with Tax Credits
$45,000/Indiv.;
$92,000/Family

400%FPL
Marketplace or Private Plan
The Marketplace

- Place for individuals and small employers to directly compare private health insurance options
  - Known as Qualified Health Plans (QHPs)

- Can directly compare on the basis of price, benefits, quality, and other factors
All Qualified Health Plans Cover These Essential Health Benefits

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care
Who is eligible?
- Young adults under 30 years of age
- Those who cannot afford coverage and obtain a hardship waiver

What is catastrophic coverage?
- Plans with high-deductibles and lower premiums
- Includes coverage of 3 primary care visits and preventive services with no out-of-pocket costs
- Protects consumers from high out-of-pocket costs
Strengthens Other Public Programs

- Increases Medicaid Primary Care Reimbursement
- Medicare – Improves Care and Lowers Costs
  - Preventive care with no copays,
  - Improves drug coverage,
  - Strict anti-fraud measures and
  - Better care coordination
Affordable Care Act Accomplishments – Expanding Coverage

- Nationally, more than 8 million people have enrolled in private insurance through the Marketplace

- An additional 6 million additional people enrolled Medicaid

- 3 million young adults were able to stay on their parents’ plans
Affordable Care Act Accomplishments—Improving Coverage

- 71 million privately insured people gained improved coverage for preventive services
- 105 million Americans have had lifetime limits removed from their insurance
- 7.1 million people with Medicare saved over $8.3 billion on drugs since law’s enactment
- 37.2 million people with Medicare received a free preventive service
Affordable Care Act Accomplishments – Expanding Coverage in Arizona

- 120,071 individuals selected a Marketplace plan during 2014 Open Enrollment
- 145,805 Arizonans enrolled in AHCCCS
- 69,000 young adults have gained insurance through their parents’ plans
Affordable Care Act Accomplishments—Improving Coverage in Arizona

- Over 1.4 million privately insured people gained improved coverage for preventive services
- Over 2 million Arizona residents have had lifetime limits removed from their insurance
- More than 76,000 people with Medicare in 2013 received over $63 million in prescription drug discounts
- Almost 730,000 people with Medicare received a free preventive service in 2013
Affordable Care Act Accomplishments—Quality and Cost

- Slowest sustained national health spending growth in 50 years
  - Low growth continued in 2013 for Medicare and Medicaid
  - Resulting in No Increase in 2014 Medicare Part B Premium

- $500 million returned to consumers in 2012
  - 423,981 Arizonans with private insurance coverage benefited from $18,711,067 in refunds from insurance companies in 2012
  - Plans must spend 80% of premium on healthcare

- Over $19.2 billion recovered from anti-fraud efforts – a record level which added years to Medicare Trust Fund
Affordable Care Act Accomplishments—Quality, Cost and Access

- Medicare Payment reform led to 8% decrease in readmit rate between 1/2012 and 12/2013
- 360 Medicare ACOs developed
- Strengthening Primary Care Workforce
  - Primary Care providers in NHSC doubled since 2008
- 1,200 Community Health Centers are providing primary care to >21 million annually
- Small business tax credit provided >$1 billion to small employers
What’s Next?

- **Coverage to Care**
  - Department of Education report showed 1 in 10 Americans have proficient level of “health literacy”
  - Language and cultural barriers add to confusion
  - IOM found that people with low health literacy are more likely to be hospitalized and have more ER visits

  - to help those with new health care coverage make the most of their coverage, and raise awareness about the importance of getting routine primary care and regular preventive care
Outcome Accountable Care

Acute Care System 1.0

- Episodic Health Care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly Coordinate Chronic Care Management

Coordinated Seamless Healthcare System 2.0

- Patient/Person Centered
- Transparent Cost and Quality Performance
- Accountable Provider Networks Designed Around the patient
- Shared Financial Risk
- HIT integrated
- Focus on care management and preventive care

Community Integrated Healthcare System 3.0

- Healthy Population Centered
- Population Health Focused Strategies
- Integrated networks linked to community resources capable of addressing psycho social/economic needs
- Population based reimbursement
- Learning Organization: capable of rapid deployment of best practices
- Community Health Integrated
- E-health and telehealth capable

Neal Halfon, UCLA Center for Healthier Children, Families & Communities
National Prevention Strategy
Strategic Directions and Priorities

Increase the number of Americans who are healthy at every stage of life.
Bonnie Preston
Regional Outreach & Policy Specialist
415-437-8503 – Direct Number
Bonnie.Preston@hhs.gov

Thank you!
Arizona Medicaid
Moving Forward

June 2014
Medicaid and ACA Populations

Reaching across Arizona to provide comprehensive quality health care for those in need

*Enrollment frozen July 2011 – December 2013
# Medicaid Restoration

<table>
<thead>
<tr>
<th>Description</th>
<th>12-1-13</th>
<th>6-1-14</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prop 204 Restoration</td>
<td>67,770</td>
<td>215,742</td>
<td>147,972</td>
</tr>
<tr>
<td>Adult Expansion</td>
<td>-</td>
<td>19,789</td>
<td>19,789</td>
</tr>
<tr>
<td>KidsCare</td>
<td>46,761</td>
<td>2,008</td>
<td>(44,753)</td>
</tr>
<tr>
<td>AHCCCS for Families &amp; Children (1931)</td>
<td>672,135</td>
<td>710,268</td>
<td>38,133</td>
</tr>
<tr>
<td>All Other</td>
<td>505,379</td>
<td>560,782</td>
<td>55,403</td>
</tr>
<tr>
<td><strong>Total Enrollment</strong></td>
<td>1,297,150</td>
<td>1,508,689</td>
<td>211,539</td>
</tr>
</tbody>
</table>
KidsCare Update – changes for 2-1

• KidsCare I (covers 133% - 200% FPL)
  o 7,000 Kids
    ▪ roughly 4,500 to Medicaid
    ▪ 2,300 stay in KidsCare

• KidsCare II (expired 2-1-14)
  o 37,000 Kids
    ▪ 23,000 Medicaid
    ▪ 14,000 to FFM - Marketplace
Essential Health Benefits

- EHBs required for Marketplace Coverage
- In Medicaid EHBs apply to New Adult Group Only.
- Medicaid rules allow Aligning to Medicaid package – Arizona’s path (See 42 CFR 440.347)
  - Added HPV vaccine for adults (21-26) – 1/1/14
  - Restored well visits – 10/1/13
  - Allowing separate 15 visit PT limit for acquiring or maintaining a skill or function
  - 25-day IP limit going away 10/1/14
Calculating Income

• Changing the way states calculate income
• Modified Adjusted Gross Income (See 42 USC 1396a(e)(14) and 42 CFR 435.603)
• Sounds simple on paper...but in practice?
New Application and Eligibility System

AHCCCS’ ACE

DES’ AZTECS

Health-e-Arizona

Health-e-Arizona Plus

Reaching across Arizona to provide comprehensive quality health care for those in need
Expanding the Public/Private Partnership

- AHCCCS partners with over 100 organizations and providers to offer local application assistance to consumers.
- AHCCCS has trained nearly 2,000 subscriber employees known as “community assistors” to assist applicants.
- Many new organizations are signing up to become subscribers to HEAplus.
- Making Eligibility Local. Provide personalized support to your customers in their own community.
Moving Forward

Medicaid vs. Marketplace
Federal Marketplace
- Premium Tax Credits
- Cost Sharing Reductions
- Qualified Health Plan enrollment
- Navigators/Certified Application Counselors

Arizona
- AHCCCS (Medicaid)
- KidsCare (CHIP)
- Health-e-Arizona Plus

Reaching across Arizona to provide comprehensive quality health care for those in need
Medicaid vs. Marketplace

What if a HEAplus applicant is over income for AHCCCS?

- HEAplus will tell you if you are over income for AHCCCS and that your information is being transferred to the Marketplace.
- For people not AHCCCS eligible, HEAplus will automatically transfer the application to the Marketplace for review.
- AHCCCS has transferred approximately 146,000 accounts to FFM (as of April 1, 2014).
- Applicants will need to go to www.healthcare.gov to open an account in the Marketplace.
Medicaid vs. Marketplace

- **What happens if an applicant applies for coverage through the Marketplace but is screened as AHCCCS eligible?**
  - FFM will *not* make AHCCCS eligibility determinations.
  - Marketplace will eventually be able to send the application to AHCCCS without the person having to do anything.
  - AHCCCS will then complete your eligibility determination.
  - FFM transferred 88,000+ accounts; multiple errors.
  - AHCCCS is still working through FFM account transfers – identifying duplicates, already eligible/denied, known to system/unknown.
  - So if you think you or your customer may be AHCCCS eligible, start the application in [www.healehtearizonaplus.gov](http://www.healehtearizonaplus.gov).
Medicaid vs. Marketplace

- Are any of the federal Marketplace website issues impacting HEAplus?
  - HEAplus relies on a federal data hub to access certain information.
  - That system is sometimes taken down for maintenance.
  - This means that HEAplus will not be able to verify certain information like citizenship during those off hours.
  - Any unscheduled problems with the federal data hub will also cause delays for HEAplus.
Questions?

Reaching across Arizona to provide comprehensive quality health care for those in need
Thank You.

Reaching across Arizona to provide comprehensive quality health care for those in need
The Affordable Care Act & Prevention Services

Arizona Public Health Summit
Phoenix, Arizona
June 24, 2014
Prevention Coverage

• Preventive Services Covered at no cost
  • QHPs
  • Catastrophic Plans
  • Medicare

• EHB Category: Preventive and wellness services and chronic disease management
Quality Rating System & Enrollee Satisfaction Survey System

Purpose: To inform consumer choice of a QHP, informing QHP certification and monitoring QHP performance
Quality Rating System

• All 2014 issuers (with >500 enrolled) required to report as part of 2015 beta test
• Final QRS measure set for 2016
• Detailed specifications released Fall 2014
• Public Reporting during 2016 Open Enrollment for 2017 coverage year
Quality Rating System Cont.

- Contains 43 measures
  - 12 are collected from QHP Enrollee Survey
  - All are required by at least one other Federal, State or private health plan reporting system
- Enrollee Satisfaction Survey to assess consumer experience
QRS 8 Domains

1. Clinical Effectiveness
2. Patient Safety
3. Care Coordination
4. Prevention
5. Access
6. Doctor and Care
7. Efficiency and Affordability
8. Plan Services
QHP Enrollee Survey

• Survey adult enrollees in QHPs
• National implementation by CMS in 2016
• Topics include: Access to care, access to information, care coordination, cost, cultural competence, doctor communication, health promotion, plan administration, prevention, shared decision-making and specialized services
Purpose
This issue brief provides background information about two new consumer experience surveys authorized by the Patient Protection and Affordable Care Act (ACA). The surveys measure consumer experience with the Health Insurance Marketplaces (Marketplaces) and Qualified Health Plans (QHPs). Both were developed by the Centers for Medicare & Medicaid Services (CMS) with support from American Institutes for Research (AIR).

Background
Health Insurance Marketplaces are available in every state to help qualified consumers shop for, select, and enroll in high-quality, affordable QHPs. One way to understand how well the Marketplaces and QHPs are meeting health care consumers’ needs is to ask consumers directly about their experiences with the Marketplaces and QHPs in which they have enrolled.

To that end, the ACA authorized the development and administration of two consumer surveys:

1. **Health Insurance Marketplace Survey (Marketplace Survey)**—A survey of individuals who use the Marketplaces to shop for health insurance.

2. **Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey)**—A survey of adult enrollees in QHPs.

Both surveys are scheduled for national implementation by CMS in 2016. Each will play an important role in monitoring the quality of consumers’ experiences and encouraging efforts to make improvements. CMS also plans to develop longitudinal databases to support future research on consumers’ experiences with the Marketplaces and QHPs.

Overview of the Two Surveys

<table>
<thead>
<tr>
<th></th>
<th><strong>Marketplace Survey</strong></th>
<th><strong>QHP Enrollee Survey</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>To obtain consumers’ perspectives on the services provided by Marketplaces</td>
<td>To obtain enrollees’ perspectives on the services provided by QHPs</td>
</tr>
</tbody>
</table>
| **Anticipated users and uses** | Marketplaces: To identify and improve their performance  
CMS and state regulators: To oversee the Marketplaces | Consumers: To inform their choice of a QHP through the Marketplaces  
Marketplaces and QHPs: To identify and address performance issues  
Regulatory and accrediting organizations: To strengthen their ability to monitor QHPs |
| **Preliminary findings available to the Marketplaces and QHPs** | Field test: Fall 2014 (national Federally-Facilitated Marketplace (FFM) and State Partnership Marketplace (SPM) results only)  
Beta test: Summer/fall 2015 | Field test: Spring 2015 (national FFM and SPM results only)  
Beta test: Summer/fall 2015 |
| **Legislative authority** | Sections 1313 and 1321(A) of the ACA | Section 1311(c)(4) of the ACA  |
The Marketplace Survey

**Purpose of the Survey.** The Marketplace Survey will evaluate consumers’ experiences with the Web site, telephone call centers, and in-person support.

**Survey Topics.** Marketplace Survey topics include:
- Application process
- Cultural competence
- Health plan enrollment process
- Information seeking (Web, phone, and in person)
- Premium tax credit eligibility
- Specialized services

**Anticipated uses and users.** The survey results will provide actionable information that Marketplaces can use to improve performance. CMS and state regulatory organizations can also use the survey results for oversight.

The QHP Enrollee Survey

**Purpose of the Survey.** The QHP Enrollee Survey will assess enrollees’ experience with QHPs.

**Survey Topics.** The QHP Enrollee Survey expands on the CAHPS Health Plan Survey 5.0 by incorporating existing CAHPS supplemental items as well as new survey items. QHP Enrollee Survey topics include:
- Access to care
- Access to information
- Care coordination
- Cost
- Cultural competence
- Doctor communication
- Health promotion
- Plan administration
- Prevention
- Shared decision-making
- Specialized services

**Anticipated uses and users.** The results of this survey will be publicly reported as part of the quality rating system beginning with open enrollment in 2016 for 2017 coverage. Consumers will be able to use the published results when comparing and choosing among competing QHPs. Survey results will also enable Marketplaces and QHPs to identify strengths and weaknesses and improve the services available from QHPs. CMS, state regulators, and other organizations may also use the results for regulatory oversight.

Survey Development

CMS is working with AIR to develop the consumer experience surveys in a manner that ensures the soundness and usefulness of the results. The surveys build on the Agency for Healthcare Research and Quality’s Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys and principles, which are the national standard for assessing patient and consumer experience.

The surveys are being developed and tested in three languages: English, Spanish, and Chinese. The development process for these surveys ensures that they are scientifically valid and that they address the information needs and concerns of consumers and key stakeholders. The process involves a comprehensive review of the literature and related surveys; focus groups with consumers; stakeholder interviews; cognitive testing of new survey questions in all three languages; input from a technical expert panel that included representatives from the State-Based Marketplaces, consumers, plans, state regulators, and providers; psychometric testing in 2014; and beta testing in 2015.

Anticipated uses and users. The results of this survey will be publicly reported as part of the quality rating system beginning with open enrollment in 2016 for 2017 coverage. Consumers will be able to use the published results when comparing and choosing among competing QHPs. Survey results will also enable Marketplaces and QHPs to identify strengths and weaknesses and improve the services available from QHPs. CMS, state regulators, and other organizations may also use the results for regulatory oversight.

Technical Assistance Regarding Preliminary Survey Findings

Through CMS funding, AIR is providing technical assistance to support Marketplaces in understanding, interpreting, and using the results of the surveys. This assistance includes:
- Reports containing results for each Marketplace and comparative benchmarks *(starting in 2015).*
- Identifying best practices to help Marketplaces further improve consumers’ experiences.
Health Insurance Marketplace Quality Initiatives

Update: CMS posts final 2015 QRS Beta Test Measure Set, versions of the Marketplace Survey that will be used in the 2014 psychometric testing, and an issue brief about the Marketplace and QHP Enrollee Experience Surveys.

The Affordable Care Act (ACA) authorizes the creation of Health Insurance Marketplaces to help individuals and small employers shop for, select, and enroll in high quality, affordable private health plans beginning October 2013. Only qualified health plans (QHPs) may be offered within the Marketplaces. The ACA requires HHS to develop quality data collection and reporting tools such as a Quality Rating System (QRS), a Quality Improvement Strategy (QIS) and an enrollee satisfaction survey system (ESS). The purposes of these tools include informing consumer choice of a QHP, informing QHP certification and monitoring QHP performance. HHS intends a phased approach to QHP specific quality reporting, beginning in 2016.

CMS published a Notice of Proposed Rule Making in the Federal Register on March 21, 2014 describing Exchange and Insurance Market Standards for 2015 and Beyond, including QRS and ESS standards. The public comment period for this proposed rule closed on April 21, 2014. These proposed standards can be found here:


The public comment period for the information collection requirements associated with the above, proposed Marketplace quality standards is open until May 21, 2014. The PRA package can be found here, under CMS Form 10520: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html

Quality Rating System

Section 1311(c)(3) of the Affordable Care Act directs the Secretary to develop a system that rates QHPs based on relative quality and price. It also requires Marketplaces to display QHP quality ratings on Marketplace websites to assist in consumer selection of QHPs. On November 19th CMS published a Federal Register Notice (FRN) to solicit comments on a proposed QRS measure set that QHP issuers would be required to collect and report, the hierarchical structure of the measures and the elements of the QRS rating methodology. A copy of this FRN is included in the download section below for your convenience. The comment period for this notice ended on January 21st, 2014. The final 2015 QRS Beta Test Measure Set is available in the Downloads section below.
CMS posted draft QRS Scoring Specifications on March 28th, for public comment. The draft QRS Scoring Specifications provide a high-level summary of the proposed steps involved in assigning quality ratings to QHPs operating in the Marketplaces. The comment period on these draft scoring specifications ended on April 28, 2014.

**Enrollee Satisfaction Survey**

The Affordable Care Act Section 1311(c)(4) requires the Secretary to develop an enrollee satisfaction survey system that assesses consumer experience with QHPs offered through a Marketplace. It also requires public display of information by each Marketplace to allow individuals to assess enrollee experience among comparable plans. CMS is developing a QHP Enrollee survey that assesses consumer experience with qualified health plans (QHPs) offered through the Marketplaces. Sections 1313 and 1321(a) of the Affordable Care Act provide the Secretary with general authority to establish standards and regulations related to Marketplaces and QHPs. In addition to the QHP Enrollee Survey, CMS is developing a Marketplace survey to assess consumer experience with the Marketplace.

A FRN was published on November 1, 2013, seeking public comment on CMS' intention to collect information using the QHP Enrollee survey and the Marketplace survey. Copies of the draft surveys as well as an issue brief on the surveys have been included in the download section below for your convenience. The comment period for this notice ended on December 2, 2013.

**Downloads**

- [2015 QRS Beta Test Measure Set](#) [PDF, 114KB]
- [Marketplace and QHP Survey Issue Brief](#) [PDF, 99KB]
- [QRS Scoring Specification](#) [PDF, 701KB]
- [Marketplace Survey (English)](#) [PDF, 586KB]
- [Marketplace Survey (Spanish)](#) [PDF, 297KB]
- [Marketplace Survey (Chinese)](#) [PDF, 541KB]
- [QHP Enrollee Survey (English)](#) [PDF, 208KB]
- [QHP Enrollee Survey (Spanish)](#) [PDF, 222KB]
- [QHP Enrollee Survey (Chinese)](#) [PDF, 576KB]
- [QHP Enrollee Survey Vendor Participation Notice](#) [PDF, 248KB]
Health Plan Implementation of the Affordable Care Act’s (ACA) Preventive Care Provisions

Charlton Wilson, MD, FACP, FACHE
Chief Medical Officer
Terminology used in today’s presentation

**Health Plan**
An program that pays for medical and surgical expenses that are incurred by an insured person

Group, individual, Federal marketplace, Medicare, Medicaid

**Cost-sharing**
Additional payment by the insured at the time of service
Co-insurance, co-pays, deductibles

**Preventive Services**
Services to prevent or delay disease
Examinations, testing, counselling, immunizations, etc.
Attainment of Preventive Services by a Person’s Health Insurance and Cost-sharing Status

(Illustration only)
ACA and Preventive Care

All non-grandfathered Group Health Plans and Individual Policies must cover preventive services without cost share.

https://www.healthcare.gov/what-are-my-preventive-care-benefits/
ACA Defined Preventive Services

Items or services recommended with an A or B rating by the U.S. Preventive Services Task Force

Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC

Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration

Preventive care and screenings for women supported by the Health Resources and Services Administration per the August 1, 2011 guidance
ACA and Preventive Care

Medicare defined preventive services without cost sharing
Similar to ACA, but includes additional services and “Welcome to Medicare” and “Yearly Wellness” visits
http://www.medicare.gov/coverage/preventive-and-screening-services.html

Medicaid
Required coverage overlaps with ACA requirements in many ways, but preventive services as a category are optional
ACA provides States a slightly enhanced FMAP to implement all ACA-defined preventive services
Preventive Care Coverage and Cost-sharing: Issues

Health Plans
May require use of contracted providers, aka “in-network”
May impose utilization criteria, for example may apply criteria on frequency of repeat testing
Network development activities must address accessibility in the setting of potentially pent up demand and address the local workforce
Payment reform initiatives and value based insurance design seek to increase high value healthcare delivery
Preventive Care Coverage and Cost-sharing: Issues

Depending on complicated billing procedures, if the preventive service occurs at the same time as medical care, or results in additional medical intervention, cost-sharing may apply.

Healthcare provider education
Health literacy and health financial literacy

Costs
Affordability
Price transparency initiatives
Attainment of Preventive Services by a Person’s Health Insurance and Cost-sharing Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Attainment of Preventive Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideal</td>
<td>Ideal attainment of services</td>
</tr>
<tr>
<td>Uninsured</td>
<td>Lower attainment of services</td>
</tr>
<tr>
<td>Insured with cost sharing</td>
<td>Intermediate attainment of services</td>
</tr>
<tr>
<td>Insured without cost sharing</td>
<td>Higher attainment of services</td>
</tr>
</tbody>
</table>
Health Plan Engagement with Broader Public Health Activities

Mercy Care Plan is engaging with other stakeholders Community Coalition addressing childhood obesity Member education incentives focusing on healthy eating, direct mailing of coupons and materials Tobacco-use screening and ASHline referral process
Thank you
What is an ACO?

Conceptually

- A partnership among health care providers who accept responsibility to care for the health needs of a defined population while meeting predetermined quality benchmarks. Three goals:
  - Improve outcomes/quality of care
  - Improve experience of care
  - Lower costs

The PPACA Section 3022 definition

- Organization of health care providers that agrees to be accountable for quality, cost and overall care of Medicare beneficiaries who are enrolled in traditional fee-for-service program and who are assigned to it
- For each 12-month period, participating ACOs that meet specified quality performance standards eligible to receive share of any savings if actual per capita expenditures for assigned Medicare beneficiaries are sufficient percentage below specified benchmark amount
The ACO Concept Pre-Dates the ACA

“ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth. Our definition emphasizes that these cost and quality improvements must achieve overall, per capita improvements in quality and cost, and that ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients.”

Elliot Fisher, MD, Dartmouth Medical Center, 2006
Shared Savings Model

![Graph showing expenditure trends with labels for ACO Launched, Projected Spending, Target Spending, Shared Savings, and Actual Spending. The graph illustrates cost savings over years post-ACO launch.]
Distinguishing Between ACOs and Earlier Initiatives: HMOs and PCMHs

<table>
<thead>
<tr>
<th></th>
<th>HMO</th>
<th>PCMH</th>
<th>ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment Structure</strong></td>
<td>Capitation</td>
<td>FFS</td>
<td>Varies</td>
</tr>
<tr>
<td><strong>Quality Benchmarks</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Incentive Payments</strong></td>
<td>No</td>
<td>Varies</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Administration</strong></td>
<td>Health Plan</td>
<td>Primary Care</td>
<td>Varies</td>
</tr>
</tbody>
</table>

ACOs allow for flexible payment structures, such as FFS with shared savings; negotiated bundled payments; and capitation. The type of payment is closely tied to the level of financial risk providers are expected to assume.
How Care is Traditionally Provided... In Silos

- Primary Care
- Specialty Care
- Ambulatory
- Hospital and ED
- Post Acute Care
Accountable Care as the Clinical Integrator

Primary Care

Specialty Care

Hospital and ED

Post Acute Care

Patients
Alternative Schematic
ACOs Across the Country

Access to ACOs varies widely by geography, but in more than half of states, a majority of the population could receive care from an ACO
Coverage by Referral Regions

ACOs by Hospital Referral Region

ACOs
- 10+
- 6-9
- 4-5
- 3
- 2
- 1
- 0
ACOs in Arizona

Arizona Care Network, LLC
GPIPA ACO
Yavapai Accountable Care
Yuma Connected Community
AzPCP-ACO, A Medial Corporation, PC
John C. Lincoln Accountable Care Organization, LLC
Banner Health Network
Arizona Connected Care, LLC
ACO Performance Measures

Before an ACO can share in any savings generated, it must demonstrate that it met 33 quality performance standards for that year.

There are also interactions between ACO quality reporting and other CMS initiatives, particularly the Physician Quality Reporting System (PQRS) and meaningful use.

The sections below provide resources related to the program’s 33 quality measures, which span four quality domains: Patient / Caregiver Experience, Care Coordination / Patient Safety, Preventive Health, and At-Risk Population.

Of the 33 measures, 7 measures of patient / caregiver experience are collected via the CAHPS survey, 3 are calculated via claims, 1 is calculated from Medicare and Medicaid Electronic Health Record (EHR) Incentive Program data, and 22 are collected via the ACO Group Practice Reporting Option (GPRO) Web Interface.
# AIM: Better Care for Individuals

<table>
<thead>
<tr>
<th>#</th>
<th>Category</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Patient/Caregiver Experience</td>
<td>Getting timely care, appointments and information</td>
</tr>
<tr>
<td>#2</td>
<td>Patient/Caregiver Experience</td>
<td>How well your doctors communicate</td>
</tr>
<tr>
<td>#3</td>
<td>Patient/Caregiver Experience</td>
<td>Patients’ rating of doctor</td>
</tr>
<tr>
<td>#4</td>
<td>Patient/Caregiver Experience</td>
<td>Access to specialists</td>
</tr>
<tr>
<td>#5</td>
<td>Patient/Caregiver Experience</td>
<td>Health promotion and education</td>
</tr>
<tr>
<td>#6</td>
<td>Patient/Caregiver Experience</td>
<td>Shared decision making</td>
</tr>
<tr>
<td>#7</td>
<td>Patient/Caregiver Experience</td>
<td>Health status/Functional status</td>
</tr>
<tr>
<td>#8</td>
<td>Care Coordination/Patient Safety</td>
<td>Risk-standardized, All condition readmission</td>
</tr>
<tr>
<td>#9</td>
<td>Care Coordination/Patient Safety</td>
<td>Ambulatory sensitive condition admissions: COPD</td>
</tr>
<tr>
<td>#10</td>
<td>Care Coordination/Patient Safety</td>
<td>Ambulatory sensitive condition admissions: CHF</td>
</tr>
<tr>
<td>#11</td>
<td>Care Coordination/Patient Safety</td>
<td>Percent of Primary Care Physicians who successfully qualify for an EHR Incentive Program Payment</td>
</tr>
<tr>
<td>#12</td>
<td>Care Coordination/Patient Safety</td>
<td>Medication Reconciliation after discharge from IP facility</td>
</tr>
<tr>
<td>#13</td>
<td>Care Coordination/Patient Safety</td>
<td>Falls: Screening for fall risk</td>
</tr>
</tbody>
</table>
# AIM: Better Health for Populations

<table>
<thead>
<tr>
<th>#14</th>
<th>Preventive Health</th>
<th>Influenza immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td>#15</td>
<td>Preventive Health</td>
<td>Pneumococcal vaccination</td>
</tr>
<tr>
<td>#16</td>
<td>Preventive Health</td>
<td>Adult weight screening and follow-up</td>
</tr>
<tr>
<td>#17</td>
<td>Preventive Health</td>
<td>Tobacco use assessment and tobacco cessation intervention</td>
</tr>
<tr>
<td>#18</td>
<td>Preventive Health</td>
<td>Depression screening</td>
</tr>
<tr>
<td>#19</td>
<td>Preventive Health</td>
<td>Colorectal cancer screening</td>
</tr>
<tr>
<td>#20</td>
<td>Preventive Health</td>
<td>Mammography screening</td>
</tr>
<tr>
<td>#21</td>
<td>Preventive Health</td>
<td>Proportion of adults 18+ who had their blood pressure</td>
</tr>
</tbody>
</table>
### AIM: Better Health for Populations

<table>
<thead>
<tr>
<th>#</th>
<th>At Risk Population: Diabetes</th>
<th>Diabetes Composite (all or nothing scoring):</th>
</tr>
</thead>
<tbody>
<tr>
<td>#22</td>
<td></td>
<td>Hemoglobin A1c Control (&lt;8 percent)</td>
</tr>
<tr>
<td>#23</td>
<td>At Risk Population: Diabetes</td>
<td>Diabetes Composite (All or nothing scoring):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low Density Lipoprotein (&lt;100)</td>
</tr>
<tr>
<td>#24</td>
<td>At Risk Population: Diabetes</td>
<td>Diabetes Composite (All or nothing scoring):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blood Pressure &lt;140/90</td>
</tr>
<tr>
<td>#25</td>
<td>At Risk Population: Diabetes</td>
<td>Diabetes Composite (All or nothing scoring):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tobacco non use</td>
</tr>
<tr>
<td>#26</td>
<td>At Risk Population: Diabetes</td>
<td>Diabetes Composite (All or nothing scoring):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aspiring use</td>
</tr>
<tr>
<td>#27</td>
<td>At Risk Population: Diabetes</td>
<td>Diabetes Composite (All or nothing scoring):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hemoglobin A1c poor control (&gt;9 percent)</td>
</tr>
</tbody>
</table>
# AIM: Better Health for Populations

<table>
<thead>
<tr>
<th>#</th>
<th>At Risk Population:</th>
<th>Hypertension (HTN): Blood pressure control</th>
</tr>
</thead>
<tbody>
<tr>
<td>#28</td>
<td>At Risk Population: Hypertension</td>
<td></td>
</tr>
<tr>
<td>#29</td>
<td>At Risk Population: Ischemic Vascular Disease</td>
<td>Ischemic Vascular Disease (IVD): Complete lipid profile and LDL control &lt;100mg/dl</td>
</tr>
<tr>
<td>#30</td>
<td>At Risk Population: Ischemic Vascular Disease</td>
<td>Ischemic Vascular Disease (IVD): Use of aspirin or another antithrombotic</td>
</tr>
<tr>
<td>#31</td>
<td>At Risk Population: Heart Failure</td>
<td>Heart Failure: Beta-blocker therapy for Left Ventricular Systolic Dysfunction (VSD)</td>
</tr>
<tr>
<td>#32</td>
<td>At Risk Population: Coronary Artery Disease</td>
<td>Coronary Artery Disease (CAD) All or nothing scoring: Drug therapy for lowering LDL Cholesterol</td>
</tr>
<tr>
<td>#33</td>
<td>At Risk Population: Coronary Artery Disease</td>
<td>Coronary Artery Disease (CAD) All or nothing scoring: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) therapy for patients with and/or Left Ventricular Systolic Dysfunction (LVSD)</td>
</tr>
</tbody>
</table>
Medicaid ACO Activity
“Top ten” reportable diseases Maricopa County - 2010

1. 15,579 Chlamydia
2. 9,456 Coccidioidomycosis (valley fever)
3. 2,283 Gonorrhea
4. 1,718 Respiratory Syncytial Virus (RSV)
5. 1,124 Genital Herpes
6. 798 Methicillin-resistant Staph aureus**
7. 642 Viral / Aseptic Meningitis
8. 636 Influenza (lab confirmed only)
9. 626 Syphilis*
10. 546 Campylobacteriosis

* Includes non-acute infections  **Invasive disease only
“Building walls” around disease
Ways to build walls

- Literally “build walls” (isolate)
- Treat cases to render noninfectious
- Treat contacts to cut off incubating disease
- Immunizations
- Behavior change
- Render environment less facilitating of transmission (e.g., sanitary conditions)
- Policy decisions that are less facilitating of transmission (e.g., access to health care)
Herd immunity...
Measles – United States, 1950-2001
# Impact of Vaccines in the 20th & 21st Centuries

## Comparison of 20th Century Annual Morbidity & Current Morbidity

<table>
<thead>
<tr>
<th>Disease</th>
<th>20th Century Annual Morbidity*</th>
<th>2010 Reported Cases†</th>
<th>% Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smallpox</td>
<td>29,005</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>21,053</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Pertussis</td>
<td>200,752</td>
<td>21,291</td>
<td>89%</td>
</tr>
<tr>
<td>Tetanus</td>
<td>580</td>
<td>8</td>
<td>99%</td>
</tr>
<tr>
<td>Polio (paralytic)</td>
<td>16,316</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Measles</td>
<td>530,217</td>
<td>61</td>
<td>&gt;99%</td>
</tr>
<tr>
<td>Mumps</td>
<td>162,344</td>
<td>2,528</td>
<td>98%</td>
</tr>
<tr>
<td>Rubella</td>
<td>47,745</td>
<td>6</td>
<td>&gt;99%</td>
</tr>
<tr>
<td>CRS</td>
<td>152</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Haemophilus influenzae (&lt;5 years of age)</td>
<td>20,000 (est.)</td>
<td>270 (16 serotype b and 254 unknown serotype)</td>
<td>99%</td>
</tr>
</tbody>
</table>

**Sources:**
- JAMA. 2007;298(18):2155-2163
- CDC. MMWR January 7, 2011;59(52):1704-1716. (Provisional MMWR week 52 data)
Immunizations

- 325,000 immunizations given to insured kids since TAPI began billing project

- MCDPH ~50,000 / year

- No insured patients turned away, despite lack of payment
The Toll of Flu

- Cases: 25 – 50+ million cases
- Infection rate: 7% to 20% of general pop
- Days of illness: 100 – 200 million days
- Work loss: ~75 million days
- Hospitalizations: >200,000 (57% < 65y.o.)
- Deaths: ~1k-50k (~24k avg)
- Costs: ~$3-5 billion
Mass Flu Vaccine in School Kids in Japan

Excess Deaths Attributed to Pneumonia and Influenza (per 100,000)

1962
School children flu vaccination program begins

1977
Flu vaccination becomes mandatory

1987
Parents allowed to refuse vaccination

1994
Program is discontinued

Mathematical Modeling...

80% of school kids vaccinated $\rightarrow$ >90% decrease in flu for everyone else!
80% of school kids vaccinated $\rightarrow$ >90% decrease in flu for everyone else!

Cost: $7-8$ million

Cost of health care prevented: ~$140$ million
Syphilis

• >1/10 American Adults ~1900
  (would be ~300,000 in M.C. today)

• 666 in Maricopa County in 2013
  (includes all forms – only 357 early)
Early Syphilis Cases
By Sexual Preference
2004-2013

<table>
<thead>
<tr>
<th>Year</th>
<th>MSM</th>
<th>Heterosexual</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>81</td>
<td>180</td>
</tr>
<tr>
<td>2005</td>
<td>112</td>
<td>117</td>
</tr>
<tr>
<td>2006</td>
<td>175</td>
<td>142</td>
</tr>
<tr>
<td>2007</td>
<td>215</td>
<td>148</td>
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<tr>
<td>2008</td>
<td>258</td>
<td>133</td>
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<tr>
<td>2009</td>
<td>207</td>
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<td>2010</td>
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<td>74</td>
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<td>2011</td>
<td>275</td>
<td>78</td>
</tr>
<tr>
<td>2012</td>
<td>182</td>
<td>76</td>
</tr>
<tr>
<td>2013</td>
<td>249</td>
<td>108</td>
</tr>
</tbody>
</table>
DUAL INFECTION
MSM Early Syphilis and HIV
2002-2010

Lifetime cost of HIV treatment: $380,000
(676 cases = $257 million)
Chlamydia and Gonorrhea Cases
2004-2013

Chlamydia

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>11644</td>
</tr>
<tr>
<td>2005</td>
<td>12155</td>
</tr>
<tr>
<td>2006</td>
<td>13887</td>
</tr>
<tr>
<td>2007</td>
<td>14583</td>
</tr>
<tr>
<td>2008</td>
<td>15285</td>
</tr>
<tr>
<td>2009</td>
<td>16048</td>
</tr>
<tr>
<td>2010</td>
<td>16732</td>
</tr>
<tr>
<td>2011</td>
<td>18069</td>
</tr>
<tr>
<td>2012</td>
<td>19149</td>
</tr>
<tr>
<td>2013</td>
<td>19157</td>
</tr>
</tbody>
</table>

Gonorrhea

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>2997</td>
</tr>
<tr>
<td>2005</td>
<td>3207</td>
</tr>
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<td>2006</td>
<td>3783</td>
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<td>2007</td>
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<td>2008</td>
<td>2466</td>
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<tr>
<td>2010</td>
<td>2442</td>
</tr>
<tr>
<td>2011</td>
<td>3468</td>
</tr>
<tr>
<td>2012</td>
<td>4369</td>
</tr>
<tr>
<td>2013</td>
<td>4724</td>
</tr>
</tbody>
</table>
Chlamydia

• 75% asymptomatic in women
• 10-40% of untreated cases result in pelvic inflammatory disease (PID)
• 14% of PID cases are hospitalized
• 15% of PID cases will experience infertility
• 2012 average cost of a hospitalized PID case in Arizona: $19,853
we could prevent...

- 500-1,900 cases of PID
- 70-270 hospitalizations
- 75-285 cases of infertility
- 90 ectopic pregnancies
- plus ?? chronic pelvic pain
and we could save...

- Over $5 million in hospital costs for PID alone
- Plus costs for chronic pain, ectopic pregnancies, and infertility treatment
Trends in Infectious Disease Mortality in the United States During the 20th Century

Nurse-Family Partnership

- 79% reduction in child abuse and neglect
- 56% reduction in emergency room visits
- 83% increase in labor force participation
- 30-month reduction in welfare use
- 81% reduction in convictions of 15 year old adolescents
- ~$4 Return on Investment per dollar spent
- (~$17,000 saved per child)
Obesity is associated with...

- Hypertension
- High blood cholesterol
- Metabolic disorder
- Diabetes
- Coronary heart disease
- Congestive heart failure
- Stroke
- Gallstones
- Cholecystitis and cholelithiasis
- Gout
- Osteoarthritis
- Obstructive sleep apnea and respiratory problems

- Some types of cancer (e.g., endometrial, breast, prostate, and colon)
- Complications of pregnancy (DM, HTN, preeclampsia, c-sections)
- Menstrual irregularities, infertility, irregular ovulation
- Bladder control problems (such as stress incontinence)
- Uric acid nephrolithiasis
- Psychological disorders (e.g., depression, eating disorders, distorted body image, and low self-esteem)
Number and % of US Population with Diagnosed Diabetes, 1958-2009
Other Prevention Programs

- Chronic Disease Self Management for Diabetes
  - 30% decrease in complications ($13,700 average)
  - ROI = $2.42
  - At current funding, saving ~$2.4 million
- WIC ROI = $4.21 in healthcare (AHCCCS)
- Oral Health (sealants and varnish) ROI = $4
- And then there’s policy...
Local Public Health System

- Home Health
- MCOs
- Health Dept
- Churches
- Laboratory Facilities
- Mass Transit
- Parks
- Urban Planners
- Police
- EMS
- Doctors
- Hospitals
- Community Centers
- Schools
- Philanthropist
- Civic Groups
- Mental Health
- Tribal Health
- Employers
- Economic Development
- Drug Treatment
- Corrections
- Environmental Health
- Nursing Homes
- Elected Officials

Tribal Health

Elected Officials

Philanthropist
MCCCD & ASU Tobacco-Free

- MCDPH instrumental, ~$400K over 5 yrs
- Prior studies/experience: ~20% decrease in smoking
- At current smoking rates, ~9,800 will quit
- ~$100K lifetime health care cost each
- ~$980 million in health care savings
- ROI = $2,450 payback
- Repeat every 2-4 yrs with each new cohort
Tobacco Free Multi-unit Housing

39 properties so far

10 more in process

82 more considering

246 more educated
Other Policy Work

- Healthcare
  - Breastfeeding friendly birthing facilities, etc.

- Workplaces
  - HAWP

- Schools
  - Nutrition, Physical Activity, Joint Use, etc.

- Built Environment
  - Cities’ General Plans, HIAs, etc.
Per capita funding, all sources

2010 mean for LHDs serving > 2 million persons = $55
(non clinical revenues, excluding fees)
2010 mean for LHDs serving > 2 million persons = $55
(non clinical revenues, excluding fees)

FY 2009-10 budget for MCDPH = $11
2010 mean for LHDs serving > 2 million persons = $55
(non clinical revenues, excluding fees)

FY 2009-10 budget for MCDPH = $11

2010 mean for large pop LHDs from local & state revenue = $34
Per capita funding, all sources

2010 mean for LHDs serving > 2 million persons = $55
(non clinical revenues, excluding fees)

FY 2009-10 budget for MCDPH = $11

2010 mean for large pop LHDs from local & state revenue = $34

FY 2009-10 actual budget for MCDPH = ~ $3.50
Dr Bob expresses his feelings
So....now what?

What can Public Health do to support the system?

What can the system do to support Public Health?
Webinar: Better Health Outcomes through Population Health Interventions

Thursday, July 17, 2014, 03:00pm - 04:15pm EDT

(12:00 - 1:15 pm MST)

Please join us for this free webinar, tailored for those working to improve population health. The training will provide insight into the value of community clinical partnerships.

Register

Target audiences:
Community Benefit Managers, Health Care Quality Improvement Managers, Health Sector, Payers, Community Partners, and others.

Learning Objectives:
Upon completion, participants in the webinar will be able to

1. Discuss successful clinical-community interventions that focus on priority population health goals.
2. Define the role of a health department in supporting the health of the population and strategy.
3. Describe two practical stories illustrating clinical and community partnerships.

Trainers:
Gretchen Musinac, MPH
Commissioner
Minneapolis Health Department

Gayle Hoxter, MPH, RD
Program Chief, County of Riverside Department of Public Health
Nutrition & Health Promotion Branch.

Laurie Haessly, MA, RD, IBCLC
Director, Lactation Services, WIC Program
County of Riverside Department of Public Health

This free webinar is brought to you by Maricopa County Public Health and HRHA’s Community Health Training Institute
Arizona State Health Assessment

- Cara Christ, MD, MS
  Chief Medical Officer
  Deputy Director
  Public Health Services
  Arizona Department of Health Services
Presentation Overview

• State Health Assessment (SHA)
• Methodology
• Leading Public Health Issues
• County Health Profiles
• Summary
• State Health Improvement Plan & Next Steps
Why Engage in State Health Improvement Planning?

• Collaboratively sets priorities specific to needs within the state

• Provides leadership and direction on how to improve health in next five years

• Aligns partnerships and resources to work collectively on shared goals and strategies

• Meets national standards for accreditation of state health departments
Health Indicators
Demographics
Access to Health Care
Chronic Conditions
Environmental Health
Health Behaviors
Infectious & Sexually Transmitted Diseases
Injury & Violence
Maternal & Child Health
Mental Health
Mortality/Morbidity
Nutrition
Overall Health Status & Quality of Care

Community Health Assessments
15 counties completed a CHA
– Various models were utilized and engaged partners, tribes and non-profit hospitals

10,000 people statewide participated through;
– Focus groups
– Surveys
– Meetings and Community forums

Counties identified the top 10 county priority health issues
15 Leading Public Health Issues

County Level Analysis

1. Obesity
2. Behavioral Health Services
3. Diabetes
4. Heart Disease
5. Insurance Coverage
6. Teen Pregnancy
7. Substance Abuse
8. Access to Well-Care
9. Creating Healthy Communities & Lifestyles
10. Management of Other Chronic Diseases
    (Asthma, Cancer, Respiratory Disease)
11. Tobacco

12. Suicide

13. Healthcare Associated Infections (HAI)

14. Unintentional Injury

15. Oral Health
Leading Public Health Issues

Addressed in the SHA report under 3 subcategories:

- Risk Factors and Co-Occurring Conditions
- Morbidity and Mortality
- Systems of Care

<table>
<thead>
<tr>
<th>Risk Factors &amp; Co-occurring Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
</tr>
<tr>
<td>Tobacco Use</td>
</tr>
<tr>
<td>Substance Abuse</td>
</tr>
<tr>
<td>Teen Pregnancy</td>
</tr>
<tr>
<td>Creating Healthy Communities and Lifestyles</td>
</tr>
<tr>
<td>Healthcare Associated Infections (HAI)</td>
</tr>
<tr>
<td>Suicide</td>
</tr>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Heart Disease</td>
</tr>
<tr>
<td>Other Chronic Disease (Cancer, Respiratory Disease &amp; Asthma)</td>
</tr>
<tr>
<td>Oral Health</td>
</tr>
<tr>
<td>Unintentional Injury</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Morbidity &amp; Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Health Insurance Coverage</td>
</tr>
<tr>
<td>Access to Well Care</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Systems of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Wellness for all Arizonans</td>
</tr>
</tbody>
</table>
Leading Public Health Issues

The SHA contains a section for each of the 15 Public Health Issues.

How is Arizona Doing?
- Trends

How does Arizona Compare?
- Ability to Make a Difference

Capacity
- Evidence-Based and Best Practices

Opportunities to Expand Current Efforts
County Community Health Profiles

For each of the 15 counties:

- Vision
- Major Public Health Successes
- Community’s Health Priorities
- Community Involvement
- Community Comments

Gila County

Vision
To continually assess the needs of the community while providing the highest level of quality services with integrity, respect, and support for community, partners, and our state and federal partners. The Division will strive to achieve excellence and improve the public health and safety in Gila County.

Major Public Health Successes
1. From 2012 to 2013, staff at the Health and Emergency Services Department led the country participating in the Healthy and WellBean Program.
2. The Gila County Health Department was recognized by the Arizona Partnership for Immunization (API) and received an award for the submittal of data to the Arizona State Immunization Information System (ASIIIS).
3. Gila County received Dr. David T. Cloud awards for outstanding practice in the Year Award category.
4. Women’s Infants and Children’s Department received the 2013 PHBCI Challenge Award for the Most Improved Agency.
5. In 2015, the Gila County Health and Emergency Services Tobacco Free Environments Program was instrumental in implementing a policy making our Gila County Health Care Complex a Tobacco-Free Campus.

Community’s Health Priorities
- Access to Care—Continue to improve access to and improve the health of diverse communities in Gila County.
- Chronic Disease—Promote healthy lifestyles, including prevention, physical activities, and healthy eating, to reduce chronic disease rates.
- Mental and Substance Use—Have access to and improve access to mental health and substance abuse services.

Community Involvement
1. Held 17 focus groups with a total of 67 community members for planning.
2. Conducted a community survey with 397 respondents.

Community Comments
"We have one small clinic in town, one with six doctors. I need to go to Yuma for dental care, etc. I have to travel 100 miles—many days a week—to go to Yuma. Sometimes we are co-op packed—limited travel. Even the DA can’t always make it in to provide the needy clinics."
"It would be nice if the insurance would work with us to be part ofCONTENT out and help support the care."

Information for this profile was provided by Gila County. For more information about the Gila County Public Health Assessment, please visit Gila County’s website.
At Risk Communities

- Community Health Analysis Areas (CHAAs)
- Each CHAA was ranked on 27 indicators to produce an overall risk score
- Higher scores indicate higher risk
- Displayed as a statistical map to show geographical variations

**Figure 5.1: Overall Health Risk by Community Health Analysis Area (CHAA), 2008–2010**
Appendices

A. Arizona: Our People and Our Geography
B. Economic and Social Characteristics Impacting the Health of Arizonans
C. Community Health Analysis Area Profiles (CHAA)
D. Data Book
E. Evidence-Based and Best Practices
F. State and Local Program Assets
Summary

Overarching Themes:

A. Improving access and coordination of care

B. Advocating an environmental shift for individuals and families to live healthier lifestyles, where the healthy choice becomes the easy choice

C. Achieving healthier communities that are empowered to impact systems and policy level change
Next Steps

• Prioritize the leading public health issues

• Develop the Arizona State Health Improvement Plan
The State Health Improvement Plan

• Provides an overarching five year game plan for partners to work together towards achieving a healthier Arizona

• Begins the process of:
  – Prioritizing the leading public health issues
  – Defining objectives for each priority
  – Assessing Arizona’s capacity to address the issue
Where Are We Now?
Engagement of Stakeholders

- Establish Steering Committee
- Create mechanisms to gather community input
- Determine criteria to prioritize the leading health issues
- Prioritize the leading health issues
- Assemble Workgroups
- Identify activities addressing the priority health issues
- Implement activities
- Monitor health impacts
Steering Committee

- Arizona Department of Health Services
- St. Luke’s Health Initiatives
- Arizona Local Health Officers Association
- Arizona Alliance of Community Health Centers
- Arizona Hospital & Healthcare Association
- AHCCCS
- Veteran’s Administration
- Chicanos Por La Causa

- Arizona Council of Human Service Providers
- Arizona State University College of Nursing & Healthcare Innovation
- Arizona Public Health Association
- Governor’s Health Policy Advisor
- Native American Connections
- Livable Communities Coalition
- Indian Health Services
- University of Arizona College of Public Health
The full Arizona State Health Assessment report is available on the ADHS Managing for Excellence Website:

http://www.azdhs.gov/diro/excellence
AFHP is a catalyst for lifelong reproductive healthcare as an essential component of each person's overall health.

www.arizonafamilyhealth.org
Family planning is one of the 10 greatest public health achievements of the 20th century.

- Centers for Disease Control and Prevention (1999)

Source: http://www.cdc.gov/about/history/tengpha.htm
“Other” revenue category includes other federal grants, other public and private third parties, block grants, agency contributions, client donations, and minor grants.
“Other” revenue category includes other federal grants, other public and private third parties, block grants, agency contributions, client donations, and minor grants.
## Clients Served
### 2013 AFHP vs 2012 FPAR

<table>
<thead>
<tr>
<th></th>
<th>2013 AFHP</th>
<th>2012 FPAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clinics</td>
<td>31</td>
<td>4,189</td>
</tr>
<tr>
<td>Number of clients</td>
<td>35,504</td>
<td>4,763,797</td>
</tr>
</tbody>
</table>
Only federal program dedicated to family planning

Medicaid pays for clinical care

Title X along with other grant programs fill in the gaps in services and coverage

Every $1 spent saves $5.68 in Medicaid expenditures

- Net government savings $10.5 billion in 2010
The 2008 US rate for unintended pregnancy was 54 per 1,000

Source: http://www.guttmacher.org/pubs/family-planning-and-health-reform.pdf. (Figure 1.4 p.9)
Examples include services such as

- Services such as intensive counseling and outreach;
- And to support and improve health centers’ infrastructure
Six in 10 women who obtain care at a center consider it their usual source of medical care, and Four in 10, that center is their only source of care.
Essential Community Provider
Well trained network of providers
Clients that tend to be younger and healthier
Cost effective
The principles include:

- Voluntary
- Confidential
- Regardless of income
- Informed consent through neutral, factual counseling
- Accountability through data collection
Provider to choice - retention

Diversification of funding

New Program Guidelines:

- Title X Program Requirements
- Providing Quality Family Planning Services (QFP)
The Quality Family Planning (QFP) Recommendations Integrate and Fill Gaps in Other Guidelines for the Family Planning Setting

The QFP is the gold standard or ‘ceiling’ that family planning programs should strive towards.
Examples include services such as

- Services such as intensive counseling and outreach;
- And to support and improve health centers’ infrastructure
- Safety net provider for those who remain uninsured
Importance of Family Planning

- Health Outcomes
- Reproductive Health
- Education
- Socio Economic Status

Family Planning