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POLICY NOTE

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Opportunity Knocks for Public Health Departments: Increasing the Use of Clinical Preventive Services by Older Adults

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SUMMARY: This policy note examines the role that state, local and tribal public health departments can play to increase the use of clinical preventive services by adults age 50 and older. Recommended strategies include the use of technology tools, community partnerships, clear leadership roles, monitoring and evaluation, and patient navigation. This note includes real world examples and links to resources that can help public health providers initiate similar efforts in their own communities. Related opportunities to provide clinical preventive services for aging services providers, community health centers and nonclinical community organizations are the focus of other policy notes in this "Opportunity Knocks for Preventive Health" series[1] which highlights the promise of community collaboration to improve the health of older Americans.

By 2015, one in five Americans will be between the ages of 50 and 64. Over the next few decades, the population of those age 65 and older is projected to more than double – from 40 million in 2010 to more than 88 million by 2050.[2] Meeting the health needs of this growing population is increasingly critical from both a public health and health care cost containment perspective. The use of clinical preventive services (CPS) – health care services that prevent disease or detect it at a very early stage when it is most treatable – can play an important role in meeting this goal.[3]

Adults age 50 and older are at increased risk for a number of diseases that can be prevented or treated early through CPS, such as influenza and pneumococcal vaccinations, colorectal cancer screening, and for women, breast and cervical cancer screening. The U.S. Preventive Services Task Force (USPSTF) publishes a list of all recommended services.[4] These services vary with age, gender and risk factors.

Despite the effectiveness of potentially life-saving CPS, only 25% of adults ages 50 to 64,[5] and fewer than 40% of adults age 65 and older,[6,7] are up to date on a core set of recommended services. This is true despite the fact that these services are paid for by nearly all insurance plans, including Medicare and Medicaid. The Affordable Care Act eliminates most remaining financial barriers,[8] but additional efforts are needed to increase CPS use.

Public health departments are ideally positioned to lead prevention efforts and facilitate needed linkages to medical care provider systems that tend to be more focused on acute care, treatment and cure. Linking CPS to places where people routinely live, work, pray and play can reduce the effort and inconvenience incurred by seeking CPS, and can increase awareness and interest in obtaining the set of recommended services.

Benefits of Clinical Preventive Services

Given the potential to improve overall population health outcomes and decrease long-term health care expenditures, increasing the uptake of CPS by older adults corresponds with the mission of most health departments.

Providing CPS to the older adult population also offers an opportunity for public health departments to increase revenues. Those equipped to provide CPS may submit reimbursable claims for CPS delivered to the Medicare-eligible population (i.e., mostly adults over 65). Furthermore, as additional provisions of the Affordable Care Act are implemented, more opportunities for reimbursement for CPS provided to adults ages 50-64 are expected.[8]

Additional benefits for CPS engagement, delivery and follow-up include the potential for partnerships with universities and research institutions engaged in CPS research, and with local and tribal health systems, physician groups and other health care professionals who are on the front lines of CPS delivery. The provision of CPS offers an opportunity to strengthen community trust and advance the reputation of public health departments as strong leaders in community health prevention and promotion efforts.

Building on the Strengths of Public Health Departments

State and local health departments have a population-based perspective and many have the ability to measure and track CPS information through epidemiology and evaluation units. As such, they are an important and efficient community resource that can assist local aging services, community health and other community-based providers with CPS data needs.

Given their ability to collect and monitor population data, public health departments are also uniquely positioned to rigorously assess the impact of local, regional and statewide initiatives launched to increase CPS uptake. By coordinating these efforts, public health departments can help prevent duplication while leveraging opportunities to bring successful efforts to scale. CPS monitoring and evaluation efforts can be institutionalized by including them as part of the standards for national accreditation as a public health program (Public Health Accreditation Board),[9] further advancing quality and performance.

Public health departments often provide a convenient delivery platform, especially in rural and other medically underserved areas where limited health care resources are available. In rural areas, community members often view the public health department as the main source of health information, referrals and/or service delivery. According to a representative from one rural local health department, *"Our community knows the county public health departments have always done [CPS]. They rely on it and expect it. What's new?"*

In addition to existing relationships with members of the local community, public health departments often have productive partnerships with other community-based organizations and providers of aging services that can be leveraged to form local coalitions around CPS engagement, delivery and follow-up and related health conditions experienced by adults 50+.

Different Roles for Public Health Departments

Public health departments are present in nearly every local community and therefore are well positioned to take the lead or play a significant role in the provision of CPS. Yet each public health jurisdiction has a unique infrastructure and, consequently, the scope and breadth of CPS efforts will vary based on population needs and resources available.

Public health departments are most familiar and successful with implementing the engagement component of CPS delivery. Engagement efforts include activities such as advertising CPS in local and online newspapers, distributing posters in senior centers and other community sites, presenting information about CPS at community meetings, and offering information and online options to schedule appointments. Successful activities specifically used to reach older adults include providing written information about CPS, or in some cases directly providing CPS at local senior centers and other settings. In addition, some health departments host radio shows that target an older adult audience and are focused on preventive health and wellness topics, including CPS. For adults in the 50 – 64 year old category, different outreach tactics may be called for, especially for those who are still actively employed, raising children and/or dealing with their own aging parents.

Although many state, local and tribal health departments do not directly deliver individual or bundled CPS (i.e., offering more than one CPS or combining CPS offered at a similar site), they often contract with and refer to a local health system or community clinics, including federally qualified health centers (FQHCs), to provide these direct services. They can function as a partner in CPS engagement activities and play an important connector role in CPS delivery and follow-up. They may also develop partnering strategies and long-range solutions to increase demand for CPS and shape the policies that guide their implementation. Most CPS activities administered through state, tribal and local health departments are funded by the Centers for Disease Control and Prevention and by the Centers for Medicare and Medicaid Services.

Clinical Preventive Service Provision Strategies

CPS providers – whether large public health departments or small county and tribal entities – have been successful using a variety of strategies. This note specifically looks at five: 1) Technology Tools; 2) Community Partnerships; 3) Clear Leadership Roles; 4) Monitoring and Evaluation; and 5) Patient Navigation.

Technology Tools

Many opportunities exist for public health departments, both small and large, to expand their role in providing CPS. Technologies such as electronic health records, immunization registries, on-line appointment scheduling and electronic population health data present opportunities to improve the delivery of CPS through increased information, access and efficiency. Web-based services, such as online health assessments and educational events that require fewer staff resources also hold promise.

Technology tools also facilitate the monitoring of service delivery effectiveness. While the start-up costs of some of these technologies can be significant, collaborative arrangements with other community organizations can include agreements for cost-sharing. Partnerships with aging services providers, community health

centers, local businesses, employers and other community-based organizations can be leveraged to share the costs and benefits associated with implementing electronic health records (EHRs), monitoring systems and other technologies. The initial investment can save money in the long run as more consistent standards of documentation and communication lead to better quality of care and increased efficiency.

Community Partnerships

For public health departments to successfully expand the provision of CPS, to increase uptake among adults 50+, and to ensure sustainability, partnerships are critical. Strategic partners with access to long-term funding mechanisms are ideal. These partnerships can be organized around a variety of activities including, for example, outreach through public health detailing. This strategy involves health department staff visiting physician offices and medical centers to deliver brief targeted public health messages to health care providers; it also offers a natural venue from which to build collaborative arrangements and encourage CPS provision.

Appropriate messengers may vary with the setting and target population. A number of large health departments, including the New York Department of Health and Mental Hygiene (NY DOHMH),[10] have successfully used public health detailing to extend reach and actively promote CPS to aging services providers, community health centers, and other community-based providers.[11] These partnerships are especially important when the delivery of CPS leads to the detection of disease and requires follow up treatment.

Advancing CPS uptake benefits consistent funding and/or partners who are willing to provide direct support. This concern has been successfully addressed by a number of local county health departments, who have partnered with local community groups and private entities in order to fund a limited number of direct service clinics. In addition to easing financial constraints, a collaborative approach allows providers to dismantle disease-specific *silos* that preclude a more holistic vision of wellness and illness prevention. As noted by one county public health stakeholder, *"A major structural barrier is the disease-specific funding model utilized in the U.S., described as 'silos'...People experience a constellation of health outcomes but we still fund health care in [disease specific] silos."*

Real world example:

The Hunterdon County Health Department in New Jersey provides comprehensive and recommended CPS through its Senior Health and Fitness Program.[12] This program offers a wide variety of services to older adults, including health screenings, brunch and learn programs, chronic disease management workshops, and fitness classes. Specifically, 13 different screenings, including blood pressure and colon cancer, are provided as part of a no-cost, one-on-one encounter with uninsured or under-insured Hunterdon County residents who are 50 - 64 years of age. Ingredients for success include the following:

- A collaborative model that leverages outside funding from partners, including the pharmaceutical corporation Merck & Co., the Italian American Club of Hunterdon County, and other private and municipal donors.
- Additional in-kind support from volunteer physicians, nurses and an advisory council.
- Online appointment scheduling and screenings offered at the county senior center.
- Referrals accepted and low-cost care provided by local Hunterdon hospitals and health centers.

Clear Leadership Roles

Collaborative arrangements with clearly defined leadership roles can help to ensure accountability in CPS engagement (identifying need, making referrals), delivery (administering, counseling and supporting adoption) and follow-up (documenting and referring to additional services or treatment).

Real world example:

The New Mexico Clinical Prevention Initiative[13] brought together more than 30 organizations and 175 individual members to participate in activities intended to promote a wide range of clinical preventive services, including vaccinations, mammography screening and colorectal cancer screening.[14] The joint chairs of The New Mexico Medical Society and The New Mexico Department of Health agreed upon an accountable entity at each phase of a CPS provision program so as to ensure successful engagement, delivery and follow-up. The development of this public-private partnership aimed to strengthen the infrastructure for CPS provision and led to an increase in colorectal screening among older adults as well as a modest decrease in adult smoking rates. While this effort extended beyond CPS provision for older adults, the model reveals several important ingredients for success:

- Administrative support funded through general chronic disease dollars (i.e., limited start-up funds that gradually increase as the project moves forward).
- Use of state assignees who are federal employees assigned to work at a state's public health agency. State assignees are well-suited for leadership roles, such as a collaborative co-chair, because they offer a broader perspective that is more closely aligned with federal initiatives and resources.
- A plan for evaluation that includes pre-established performance measures, such as Healthcare Effectiveness Data and Information Set (HEDIS), to set a baseline and then regularly tracks changes over time.
- Leveraging existing funds for breast and colorectal cancer screenings to support a broader collaborative effort.

Real world example:

Similarly, the national SPARC (Sickness Prevention Achieved through Regional Collaboration)[15] model provides an important example of the clear delineation of leadership roles and responsibilities when implementing collaborative strategies to increase the uptake of CPS in the community.[16] This model, which has been effective in increasing rates of several types of CPS, is specifically focused upon community collaboration and the facilitation of convenient delivery mechanisms. As observed by the President of SPARC, Dr. Doug Shenson, "Increasing CPS is a team sport!" A SPARC Action Guide[17] has been developed to support the implementation of SPARC, with critical steps outlined.

Monitoring and Evaluation

Monitoring and evaluating activities specifically focused on CPS represent a largely untapped opportunity. Health departments can collect and aggregate meaningful and comparative data that can be used to inform program planning and a more targeted approach to CPS provision. The Behavioral Risk Factor Surveillance System (BRFSS) can be used as a baseline measure in states, but may be insufficient to describe geographic (community-level) and most racial or ethnic disparities. Public health departments can lead efforts to develop uniform measures for tracking and comparing CPS data at the local level.

Patient Navigation

So-called *patient navigator programs* can advance the delivery of CPS. Patient navigators are health care workers trained to provide culturally and linguistically appropriate support services and guidance to patients to help them overcome challenges, such as a lack of food, medicine or transportation. Patient navigation services have much in common with traditional public health home visiting programs. As such, public health departments are uniquely positioned to provide expertise and technical assistance that supports patient navigator outreach, delivery and follow-up activities.

Real world example:

One such example is the New York City Department of Health and Mental Hygiene (DOHMH),[18] which over the last eight years has conducted a multi-faceted campaign to increase rates of colorectal screening using broad coalitions and patient navigator programs. The NYC DOHMH partnered with the Citywide Colon Cancer Control Coalition (C5)[19] to create a targeted campaign using private and New York City funds to increase colonoscopy rates among New Yorkers age 50 and older. Together, the DOHMH and C5 worked to address disparities in colorectal screening by designing local patient navigator programs and convening discussions and summits with experts to carefully define screening guidelines and identify strategies for reducing disparities. As a result of these efforts, colonoscopy rates among older adults increased from 41.7% in 2003 to 67.5% in 2010. Furthermore, all racial and ethnic disparities in screening colonoscopy utilization rates that were present at the initiation of the program were eliminated by 2010 and these improvements were sustained through 2011.[19, 20]

Between 2003 and 2009, DOHMH provided each site with seed money to fund the first year salary for two qualified and bilingual lay navigators with the understanding that participating hospitals would continue funding the navigators' salaries and program costs in future years. From 2010 forward, DOHMH is providing seed money for a single lay navigator at each new site. With the participation of several local hospitals, DOHMH has launched 22 new patient navigator programs and continues to provide a network of support to staff and physicians at 17 locations of the Navigator Program Network (NPN). Furthermore, they plan to launch programs at three more hospitals in 2012.

Ingredients for the success and growth of this initiative include:

- Funding provided by the New York Community Trust and Fund for Public Health of New York.
- Partnership with numerous city hospitals.
- Comprehensive five-day trainings, including educational materials, navigator tool kits, and tools for tracking data to measure program success.
- Continued professional development for patient navigators and technical support beyond the funding year.

Following the initial success of this campaign, it continues to increase awareness and service delivery through annual citywide colon cancer control summits and the consistent operation of successful patient navigator programs.

Conclusion

There are a number of provisions in the Affordable Care Act[21] that support the collaborations detailed in this brief and offer points of entry for CPS along the continuum of primary, secondary and tertiary prevention. These provisions include the creation of Accountable Care Organizations,[22] Patient-Centered Medical Homes,[23] Medicaid Health Homes,[24] and the Community-based Care Transitions Program.[25] The Chronic Care Model[26] informed a number of these ACA provisions and also holds great promise to support CPS engagement, delivery and follow-up in the community while functioning as a driver of cost savings. Finally, a systems approach will be needed to achieve the national goals and standards put forth by the U.S. Department of Health and Human Services' *Healthy People 2020,*[27] *Action Plan to Reduce Racial and Ethnic Health Disparities,*[28] and *National Prevention Strategy*.[29] Partnerships with other community providers will be critical for leveraging the financial and human capital needed to initiate and sustain these efforts to improve the health of older Americans.

Methodology

Researchers from the UCLA Center for Health Policy Research conducted a literature review and 43 telephone interviews with a diverse group of community-based stakeholders representing public health, aging services, community health centers, and other community organizations and retailers (such as the YMCA and pharmacies) in 2011. A stakeholder meeting was then convened to identify opportunities to advance the provision of clinical preventive services to older adults in the community. Krist and colleagues (2012) presented a landscape paper that conceptualizes the provision of CPS in three stages: engagement (identifying need, making referrals), delivery (administering, counseling and supporting adoption), and/or follow-up (documenting and referring to additional services or treatment).[30] Stakeholders then formed small groups to discuss implications for their involvement in the provision of CPS to older adults. This policy note draws upon the Krist et al. paper, the literature review, the telephone interview data and the stakeholder discussions to identify specific opportunities for state, local and tribal public health departments to provide CPS and to illustrate how they may benefit from expanding their role and increasing CPS uptake among adults 50+.

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Endnotes

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