



**What's Preventing Prevention?
AARP Public Policy Institute
Alliance for Health Reform
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ED HOWARD: Good afternoon, my name is Ed Howard, I am with the Alliance for Health Reform on behalf of Senator Rockefeller, Senator Blunt, our Board of Directors want to welcome you to today's program on the efforts to make prevention services more accessible to all Americans including a close look at the factors that hinders that access. You know, there is an old saying that an ounce of prevention is worth a pound of cure – you don't really hear that expression as much as you used to. I think it's because there are a bunch of economists who have questioned that 16 to 1 ROI and so we have talked about different aspects of prevention. But quite apart from the cost benefit analysis, we value prevention. Yes, sometimes it saves money. Even if it doesn't, many prevention interventions return value in the form of better health per dollar spent. Now, the Affordable Care Act reflected the favorable view of prevention that is held across the political spectrum. It required that a set of preventative services in private insurance be available to consumers with no cost sharing. And it expanded Medicare coverage of prevention services as well.

So today, we are going to look at how Americans are faring at getting the preventative services they could benefit from and where they are not, why they are not. We are very pleased to have as a partner in today's program, the Public Policy Institute at AARP, which carries out in commissions, research and analysis on issues affecting older people and younger people at the state, national, international levels. So we are very pleased to have them involved in today's program. And we are also very pleased to have as a co-moderator, Susan Reinhard who is the Vice President of AARP and the Director of the Public Policy Institute. Susan, welcome back to the co-moderator role.

SUSAN REINHARD: Thank you. Good thing I lifted a few weights this morning. Thanks Ed. So on behalf of the AARP Public Policy Institute, we are really delighted to sponsor this and not just this time, in the past and in the future, work with Ed and his team in sharing the work that we are really passionate about and this one in particular is Lynda Flowers, who is sitting here on the very end. She is a member of our Public Policy Institute Team, on the health team and I just want to acknowledge the entire – almost entire health team sitting before me. The ones taking pictures that are doing the social media, that would be them. We hope others are doing social media too. So we are very committed to the issue of prevention and clearly the AARP's focus is on people 50 plus, but of course all – you know, what we do, we do for all, is the motto of our sponsor, our founder of AARP. And we really are delighted and played a role actually in advocating for prevention in the ACA. And so that is the really good news. We think that that opens up the door, literally for many, many people to get the services that we think are important. But we know that there are still barriers to overcome. Some of them are in people's control, like tomorrow I actually am going for some preventive services because of this – like, I have to tell Lynda, I'm going to get all my tests and things that I should be doing. So part of it is us, but – and we don't know all the reasons, but we do know that three out of four people who are between the ages of 50 to 64, a very important period of your life, where you really need to make sure you are keeping your health. Everybody –

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all ages, but clearly at the period of time, it is so important to maintain your health, keep promoting and preventing things that could be coming down the road. But three out of four are not doing all of the things they should be doing in prevention. And it's just unacceptable, as we would say, just not acceptable to us. So what are we going to do about that?

Lynda will be presenting more data on the use of preventative services among this age group. These data compliment a PPI report that is in your packet. Its clinical preventive services among adults age 50 to 60. And in particular, Lynda has been a great leader in the area of colorectal cancer and screening that can be done to prevent that. And one of the biggest reasons of course is that this really is entirely preventable. So it seems like a no-brainer. This is preventable, it's really serious if you get it and we now – there is no cross barriers, we would hope, to getting the test. So just a little teaser to get her going – a recent report, also in your packet, on colorectal screening in Medicare. So we are very pleased to present this and I will turn it back to Ed.

ED HOWARD: Great, thanks very much, Susan. Just a couple of housekeeping items. There is a lot of important information in your packets and I really commend to you the materials that are assembled there, because I think you will find them even more illuminating than usual in our briefing series. There are also hard copies of the Power Point slides that the speakers will be using so that you can take notes in a relevant and efficient fashion. There is a list of additional materials that you can also find online and click on so you don't have to copy down the URL to get to it. That is at the Alliance website at allhealth.org. There is going to be a transcript available in a few days, posted on that same website, along with the speaker slides. There are, in your packets, first of all, a green question card that you can use once we get to the Q&A section of the program and a blue evaluation form, if you would fill out. Plan now on filling it out then, because we really want your feedback on how we can make these programs better. What kind of topics you want to hear, who are the speakers that you want to hear them talk about? So we would really appreciate your cooperation.

Let's get to the program. We have, as Susan as alluded to in part, just a terrific lineup of experts and analysts for today's program. They are going to give their presentations and then we will get to a very extensive question and answer period where you can get in on the conversation. And we are going to start on my immediate right with Dr. Judy Monroe, who is a deputy director of the Centers for Disease Control and Prevention. She directs the Office for State Tribal, Local and Territorial Support at CDC. She is a family doc, she served as a health commissioner in Indiana. She has held leadership roles in several national public health organizations and we are very pleased to have you with us today. Judy?

JUDY MONROE: Okay, thank you, Ed and let me just say what a privilege it is to be with you today and to represent CDC. We are an agency that works 24/7 to help save lives and protect people and prevention is nothing new for CDC. We added prevention to

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our name back in the '90s, very appropriately. And we get our work done through multiple mechanisms, but about 70% of the funding that comes to CDC, goes out the door to state and local health departments and other partners along with the technical assistance.

But to get us started, I wanted to go back to my early days in my career, because as Ed told you, I'm a family physician. That is what I thought I would be doing in my career, would be practicing. I had a vision to practice in an underserved community and I took a National Service Corps commitment and found myself in Appalachia practicing medicine. And about two weeks into my practice, I could not believe what I was seeing. I had women coming into my office with end stage breast cancer. They had not accessed care, they had not seen anyone. I had women coming in with abnormal bleeding and they had cervical cancer that I could diagnose without a biopsy. Pap smears were almost unheard of in terms of being done. And I really struggled those first few weeks. It was like, this is not why I went into medicine, to see end stage disease. How do we move upstream? And I found myself partnering in this small community with the local health department – that was my first partner. And I started partnering with the media because I realized with the women, they needed education, they needed an understanding of what was available, some needed health insurance. They needed to access Medicaid or other insurance, but this was well outside – to make an impact was outside the walls of my office. I had to extend myself, so it was kind of a foreshadowing, I guess, of a career in public health later. Also, had to build trust because a lot of these – and I had men as well coming in with – I don't have time to go through all of the things that I saw in the Mountains of Tennessee, but to kind of focus on the women's health, there was a lot of distrust. I had to build the trust. I had to build the trust with partners and do the education. To fast forward what we did in partnership was four years later. We had brought in mobile mammography, we had done thousands of Pap smears by that time and happy to say that all of the breast cancer diagnosed in the fourth year was done by mammography, it was early detection. So I had a chance in my career to actually see how – pulling all this together in a small community can make a difference.

So going to CDC, for those of you not as familiar with our agency, we are an evidence based agency, we use that approach for all that we do. These are our strategic directions right now to improve health security at home and around the world. Better prevent the leading causes of illness, injury, disability and death, which is a huge cost driver, is our chronic disease. And a third priority here for strengthening public health and healthcare collaboration, which I think is very, very important. So what do we bring to the table? What does public health bring to the table? Long history of monitoring the use of clinical preventive services in the context of today's discussion and that data provides health departments as well as healthcare providers and other partners information that they need to plan and implement evidence based programs and to use their dollars wisely.

Here is a long list of things that we bring – I just want to draw your attention to number one especially, the data for decision making. CDC has the National Center for Health

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Statistics, that is where a lot of our data is housed, used again by Public Health officials; it's used for policy makers to make sound decisions in policy. Community organization and healthcare are using our data more every day in multiple sectors. So that is a huge piece of what we bring. We also are beginning to change the questions to look at the impact of health reform. So we have got new questions in many of our surveys, adding questions such as health insurance coverage or meaningful use with electronic health records as an example. But you can see the list there. There is a lot that we bring to the table.

I wanted to mention the National Prevention Strategy and mainly highlight the public health vision here, which is working together to improve the health and quality of life for individuals, families and communities by moving the nation from a focus on sickness – and I will tell you, many of the communities I visit, if you talk about diabetes as an example and the renal failure – kidney failure, we are not building dialysis units fast enough in this country. That is very costly and that is way downstream. We want to move upstream because if a child never develops diabetes, they don't ever have to have the dialysis or lose a leg. And so this really speaks to me, especially with my clinical experiences, moving from sickness and disease to one of – based on prevention and wellness. So happy to see so many of you here today, interested in this. As part of the National Prevention Strategy, one focus of that is the clinical and community preventative services pieces of this. And this is a nice intersection with medicine and public health because the clinical preventative services really need to be supported in the community. Just tie like that part there.

So this is something we say a lot at CDC, that prevention is a best buy for healthier communities. And just to give you a little data on that, first off we prevent disease, we do prevent money being spent on unnecessary and costly issues and we save lives. Seven out of ten deaths in this country are from preventable causes and that gets down to when we look at obesity, diabetes, hypertension, heart disease and cancer. There is a lot of root cause there that can be prevented. And if we fail to prevent, it costs us money. So for every one – every obese individual, it's \$1400 more per year for their healthcare cost. If someone smokes, it's \$2000 more per year for healthcare costs. And for diabetics, \$7900 more per year because of the devastation of diabetes. So this slide kind of speaks to all of it, I think. If you look at those chronic diseases that I mentioned, 70% of the root cause are behaviors and in our environment. But as a nation, we spend 3% of our dollars on preventing those causes.

So we do have some studies and we have more detail for you, but there are studies coming out showing savings through prevention. A recent study coming in a CDC publication is that 2.9 billion dollar investment in community based disease prevention programs was estimated to save 16.5 billion dollars annually within five years. And I would point out – I'm not going to go through each of these, you can see those on the slide, but the Milken Institute and our businesses are taking a hard look at this, the Milken Institute recently did a study suggesting that a modest reduction in avoidable risk

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factors could lead to a gain of more than one trillion – that is with a T – trillion dollars in labor, supplies and effectiveness by 2023. So we have got a lot to do. Here is another way to think about it and studies have shown that if we invested ten dollars per person every year in proven – and again, proven, evidence based community public health efforts, the national savings could be greater than 16 billion in less than five years.

I wanted to – on this slide, just to quickly mention the 317 funding for vaccines and the importance of the infrastructure. Vaccines save lives and they really are a primary prevention. Once you have the vaccine, you don't get polio; you don't get small pox or the measles. So the 317 funding has been crucial for infrastructure and it goes beyond just the provision of vaccines. This includes looking – doing assessments of provider quality, educating our providers, registries are quite important to making a difference here. School based and community based vaccine delivery and I think my time is running out. So I'm going to – I expected a big hug, actually. So yeah, I had a lot of material here, I thought they were going to give me an hour, but – let me just call out, the million hearts initiative – this is an initiative that is CMS and CDC that are working together to lead a charge to save a million hearts in five years. These are the initiatives that would be done, but you can see nicely, the community prevention – we have to make a difference in tobacco and sodium reduction and trans fats. On the other side is what the clinicians can be doing, focusing on the ABC's, which is aspirin, blood pressure, cholesterol and smoking. Health information technology and clinical innovations. Very nice – and then colon cancer, just to show you what CDC does when we have funding for these types of initiatives, we are able right now to fund 25 states and four tribes with a goal in those green states that are funded, a goal of having the colorectal screening at 80%. And we are far below that now for a preventable disease. Of that funding, two thirds of the funding is going to evidence based screening, so again it's not the actual testing – it's getting out into the screening and that means we have to drive people to these tests. So that is media, there providers – we have client and provider reminders. Patient navigation is a new area and provider assessment. Then a third of the funding goes for diagnostic screening. The actual diagnostics for folks that can't afford that or don't have insurance.

Quick shout out to the community preventative services. If you are not familiar with this, it's a guide that CDC has had now for a number of years. We have been adding to it. these are the lists of diseases and issues that if you go to the community guide, you will see the evidence – very strong evidence for what you can do in the community to make a difference. And then this is another – just to point out, the IOM has an integrative framework for assessing the value of community based prevention. I would invite you to take a look at this, but it does give us a valuable step toward really what has been an elusive goal of really thinking about the community preventative services in a way that we really see the value of those.

So let me just end with – wrap up on CDC. Again, we put our funding out to state and local communities – over 70% of our funding does go out. We have had budget challenges. Our budget of 40 is the lowest right now since 2003 and yet the burden of

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chronic disease and the burden of the diseases that we can prevent has grown in our country and is costing us a lot in lives and money. So I will wrap up there.

ED HOWARD: Terrific, thank you, Judy. Your reference to the community based prevention efforts of course echoes the CDC director's record in New York City where you can see the very sharp declines in smoking and other health threatening behaviors when the steps that he steered through the city's bureaucracy took effect. So it's good to note that that is also happening at the national level.

Susan referred to our next panelist, Lynda Flowers, who is a senior policy advisor with AARP's Public Policy Institute. Lynda has a very distinguished and long career, focusing on issues like dual eligible and disparities and public health. She is the co-author, by the way, of the issue brief on colonoscopy screening that you will find in your materials and I commend that to you and I should note at this point that her co-author in that is Diana Okrant who is the senior policy associate at the Alliance who has been doing the heavy lifting on this briefing. So we are very pleased to have both co-authors and we have managed to get one of them onto the panel. Lynda?

LYNDA FLOWERS: Great, thank you Ed and thank you Susan and it's delightful to be here today to talk about such an important issue. But before I continue, I do want to also recognize another one of my co-authors, Claire Noel Miller, who is also one of the authors on the colorectal cancer screening brief and also Megan Multack who has been very helpful in helping to put together this briefing and also has a very important report that you will find in your packets.

With that – learning right from left up here. So I'm going to present to you, on disparities and the use of the preventive services. And at the end of my presentation, we will talk briefly about some other barriers to the use of preventive services.

So first of all, we have discovered through our research that there are disparities in the use of preventive services across four domains, those being income, race, educational level and also insurance status. So I wanted to start with some Healthy People 2020 goals. Healthy People as you might know is a set of goals and objectives for the nation to achieve and reported out every ten years by the Department of Health and Human Services. And particularly – we particularly in this slide focus on the 50-64 population. And as you can see, we are not likely – looking at where we are now, we are not likely to meet our 2020 targets. So you can see for mammography, only 11 states have currently met that goal. For colorectal cancer, it's two states. And these are not the laundry list of preventive services, they are selected preventive services that are highly recommended for this age cohort, with the exception of cholesterol screening, which we didn't include in this slide because that is one area where states are doing exceptionally well.

So lets talk about income disparities. As you can see from this slide, the lowest income mid life adults are half as likely to be up to date with their selected preventive services

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than the higher income mid life adults. And my mid life, throughout this slide deck, we will be talking about people ages 50-64. But as you can also see from this slide, even though there is a huge disparity across all income levels, we have a long way to go.

Now in terms of racial disparities, Hispanics are fairing much worse than most of the other populations. Being 40% less likely to be up to date with select clinical preventative services during mid life Asians. I would also like to point out to you that the definition of select clinical services, you will find at the back of your packet in an appendix.

In terms of educational level, high school drop outs are half as likely to be up to date with their clinical preventive services for this age group. But again, as you see on all slides, all groups across the education spectrum have a long way to go.

And then insurance status. Uninsured mid life adults are two thirds less likely to be up to date with select preventive services. Again, even with those with insurance status, insurance is not the be all and end all, because those who are insured are still underutilizing preventive services.

So I put this slide up just to show, in terms of insurance status, one of the things that helps people get into preventive services is to have access to healthcare. Right now, we only have 27 states including DC who have expanded their Medicaid programs. So we hope that with further expansion of Medicaid, we are creating more access to the use of preventive service – at least eliminating a cost barrier – we hope. So getting people covered many help reduce disparities in the use of preventive services. One way to do that is to expand Medicaid to create opportunities for low income people to get these services. We can identify those who are currently eligible in those states that have expanded coverage and get them enrolled in that program as well. We can also identify and enroll uninsured people in private coverage for which they may be eligible through the marketplaces, through employer coverage and through the private market. And then we can help those who are eligible for exchange coverage in the marketplace, to get qualified for subsidies if they have low income. This will also support their access in affordability to preventive services. But we know that coverage is necessary, but not sufficient. So even though these disparities exist in the use of preventive services, we know they are under utilized across all income levels, races, educational levels and health insurance status. So we need to get the word out among people that the ACA as alluded to, does eliminate cost sharing for prevention both in private sector and in Medicare, but we also need to eliminate some of the loop holes to using that service and Kevin Lucia will highlight that in his talk. Thankfully. We also need to get people into health insurance coverage, but then we also need to couple those efforts with consumer outreach and education. Hence the need for sustained federal and state and local funding. As you can see from Dr. Monroe's discussion, that funding really makes a difference. And so when we think about that, we think about the prevention fund and how that is being slowly eroded and if we can maintain that fund, it's a special fund that was created in the ACA. It's 18.7 million dollars over I think 12 years that would support community based

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preventive service outreach and the delivery of services. So it's an important part of money that supports some important national goals and we hope to see that it can be preserved.

And then finally, we need a variety of stakeholders to join together to help ensure that people get into preventive services. Finally, I just wanted to highlight some of the other barriers that Susan alluded to. There are barriers that are consumer focused and there are barriers that are provider focused. A lot of them are not subject to policy solutions on the consumer side – we have a lack of awareness of need, fears about preventive services, lack of trust in the healthcare system. On the provider side, we have lack of awareness of age based prevention services recommendations, failure to recommend their preventive services to their patients. The underestimation of the safety and efficacy of their preventive services and then failure to institute standing orders in automated reminder systems that can support practices as they need to deliver these services to consumers. So these are important barriers. Hopefully we can become creative about how we can come up with developed solutions to overcome those as well. And with that, I will end my presentation and happy to take questions at the end.

ED HOWARD: Terrific, thank you Lynda. We are going to turn now to Kevin Lucia who is senior research fellow at the Center for Health Insurance Reform at Georgetown's Health Policy Institute. He actually was the co-founder of that center a few years ago. He has held a senior post within CMS's insurance oversight operation. He serves on the board of the DC Insurance Exchange, which has just gone through an intense period of activity. And he too has co-authored a study that is relevant. It's in your materials. I commend it to you. I commend him to you, Kevin thanks for joining.

KEVIN LUCIA: Thanks for that nice introduction. I'm really happy about being here. So let's just start out – at Georgetown University, our Center is really focused on watching how the ACA is being implemented both inside and outside the exchange and the regulatory changes that states are making. But we are really interested in how consumers kind of navigate the private health insurance markets and how they are faring in this new kind of setting that we have set up. I know today we are going to be talking about preventive services and so I just want to do a quick overview of what is required of private carriers. So under the ACA, private health insurers are required to cover certain recommended preventative services without cost sharing. So no deductibles, co-insurance or co-pays. Among others, insurance must cover evidence based screening and counseling services with A or B recommendations, that is like the effectiveness level, from the United States Preventive Service Task Force along with routine immunizations, preventive services for children and youth and preventive services for women. Extraordinary large number of people have been helped already by this requirement, in 2011 alone, it was estimated that 54 million Americans were – used this service – this extended services under the Preventive Service Requirement. Surprisingly, premiums didn't go up too much. It was estimated that premiums in the private market went up

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probably between one and one point five percent. Some of our regulatory discussions with states, the estimate was even lower.

So in 2011, after completing my – I call it my Tour of Duty at Socio the implementing agency for the ACA, I came back to Georgetown and I spent the first two months really reaching out to state regulators to find out how the early market reforms are being implemented including the preventive service benefit. The two takeaways from those interviews – and I talked to almost every state, was it was clear that states were encouraging insurance companies to come into compliance with the reforms and that issuers were really stepping up to the plate to do what they are supposed to do. At least on paper. And already in early 2011, state regulators were getting lots of calls about colonoscopies and basically consumers were going in to get their colonoscopy – their free colonoscopy without cost sharing. A polyp would be found and they would get basically nailed with the cost sharing. And so this quickly was being heard by consumer advocates, by state regulators, we were starting to hear about it and it bubbled up in the media and so we thought it was a good idea to start to figure out what was happening on the ground. We teamed up with Kaiser Family Foundation, the American Cancer Society and the National Colorectal Round Table to really dig a little bit deeper into this issue.

So it was the right thing to do. Colorectal cancer is one of the most common cancers and cause of death from cancer in men and women in the United States. It's estimated that approximately 50 thousand people die a year of this. And so screening for this cancer is really critical. Especially the removal of these polyps. And so it's important – really important – to make sure that people have access to these colonoscopies and to avoid premature death. And the thing – the problem is that colorectal screenings are really expensive and so between \$1,000 and \$2,000. We heard reports going up to \$5,000 - \$7,000, even higher if you look around online. You hear stories of people going in and really getting high cost. And so our thought was, if people are nervous about going in to get a colonoscopy, because they are afraid that they are going to get hit with the cost sharing, they won't go. And so it was really important that this protection be applied in a uniform way nationally. So we studied how insurers were approaching cost sharing for this screening in three different clinical circumstances. One, just when someone goes in for a colonoscopy and has the polyp removed, so they go in for the screening, but they do have a polyp removed. How are insurers paying on that? And then often people will go in for a blood test and if it's positive it will kind of prompt them to go – they will be required to go and get a colonoscopy, a screening colonoscopy. So how are insurance companies paying in that respect? And then of course lots of people have family members who have had colorectal cancer or maybe they have had a polyp removed earlier in their life and they are just required, as a high risk person, to go in and continue to get their screening. So we were interested to see how insurance companies were paying in these different situations.

So drawing from interviews with state regulators, consumer assistance programs, medical directors of major insurance companies in seven states, medical providers, we

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talked to billing experts in those offices. And then of course we talked to patients and we really found variation on how the cost sharing was applied. It was amazing. It varied from state to state, from insurance company to insurance company, to provider to provider and regardless of the scenario. So two people could look exactly the same in different states and experience this protection totally different. I'm pretty sure that is not what we thought the ACA was going to do on this benefit. And so we also found that there was a high, high level of complaints coming into state regulators. It was their number one issue on the early market reforms. And they had already turned to the federal government to seek advice on how to counsel insurance companies and providers on proper coding techniques or universal coding techniques and payments on these different scenarios.

So when we finished the study, the real take home for me was the USPSTF review process. It distinguishes those preventive services that are evidence based and a good buy for Americans, right? They are going to be helpful. However, the recommendation doesn't address the nuances of the services and not how they would be applied to these different kind of clinical scenarios. And really that organization is not charged with development recommendations on technical issues and insurance coverage and claims processing. Their job is really to look at the clinical expertise and yet, regulators, who are trying to regulate insurance companies, are really – they need guidance on insurance coverage and claims processing, so they can pass that on to the payers.

So I walked away at the end of the study that we really need a way to kind of transition the recommendation to something that is useful for regulators on the ground to make sure that the preventive service is actually being applied universally. So these were all general suggestions after the study and basically we were asking the federal government to offer more guidance on cost – you know, when cost sharing would be waived in those three scenarios and guidance on – for providers on coding so that it was more universal across the states. And then of course we were asking Socio and HHS to really reach out and listen to state regulators so that they could hear these complaints that were coming in. Although the federal government – it's a federal law – I mean, this thing is being implemented at the state level. I know the feds are running a lot of marketplaces, but the states, except in five states, are directly enforcing the market rules, including the preventive service regs. So in order for the feds to be able to give out good guidance, they have to have some mechanism to be collecting data, especially complaint data from state regulators.

So you figure, they started probably hearing complaints in 2010 and it took almost two or three years later before they put out guidance on this issue. And basically the Socio came out with guidance that said that issuers can no longer apply cost sharing when a polyp is removed during a screening colonoscopy, but they didn't address the two other scenarios. And those are the fuzzy issues. So they partially solved it for one scenario, but I do want to point out, although they took care of it on the private side, they didn't apply it to Medicare. So if you are a Medicare beneficiary and you go in for a screening

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colonoscopy, they find a polyp and its removed, you are going to face cautionary and so this lack of parity between private and public doesn't make sense in this kind of new world that we are living in. Its really – it's unfortunate.

So general suggestions that I have is really, we need to think about figuring out a way to take the recommendations for these preventive services and make sure that there is some type of entity that can provide federal and state regulators with really good understanding of how these – the claims are going to be processed and coded at the provider level. I think that will help. And then, I gotta tell you, I think that this issue for Medicaid has to be resolved. It just doesn't make sense, especially when the federal government – I mean, Medicare – especially when Socio was already taking care of it on the private side. And with that, I will finish up with 20 seconds to go.

ED HOWARD: And Julie says she can make good use of that 20 seconds. Our final panelist – thanks very much, Kevin, that was very helpful. And our final panelist is Julie Eckstein who is the head of the Department of Community Health and Environment in St. Charles County, Missouri.

[Discussion on pronouncing “Missouri”]

ED HOWARD: Well, that post, however you pronounce the state, is the latest one in Julie's quarter century of experience in public and community health. She formally ran the state Department of Health and Senior Services, so she really understands the challenges of actually delivering preventive services to a population and I want to extend a special thanks to Senator Roy Blunt who is the Alliance Honorary Co-Chair who helped us identify and recruit Julie for our panels, so we are very happy to have you join us.

JULIE ECKSTEIN: Thank you very much, Ed. It's a pleasure to be here. I had worked for the Senator's son, Governor Blunt, when I was State Director, so it's all in the family.

So really found it important, more important than ever over the last couple of years to first explain, what is public health? In Missouri we have term limits now, so our state legislature has all turned over since I was Health Director and it is such a challenge for them to take on the big issue of health, healthcare, health insurance anything related to it and specific what is public health. So I wanted to start with the definition, the activities that ensure conditions in which people can be healthy. These activities include community wide efforts to identify, prevent and combat threats to the health of the public. So when you are talking about healthcare delivery, it's usually a one on one interaction between the physician or other provider and the client or the patient. But when you are talking about public health, it's the entire community that is our population health. So we are talking about big. But one of the other things that is important to realize is that every health department is different and I will get to that in a little bit more detail in a minute. But there are some that provide services even the medical services. But many times that is confused with public health and this definition versus “public health care” being free medical services to the public. That is what many of our legislators told me

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they thought public health was. They thought it was the delivery of free medical services. So we have a lot of challenges. All over the country, actually with understanding what public health is all about. But the three P's are what we live by – prevent, promote and protect.

So when you have seen one health department, you have really only seen one health department. You can't say when you have seen one you have seen them all. In the United States there are over 2500 local health departments or local public health agencies, whatever you want to call them. And they are all very, very unique. So a few things about some of the data about them. 70% of them have a local Board of Health, which is usually an elected body. 96% employ nurses and 60% do provide maternal and child health home visits, but there are so many models of how Health Departments are run. So basically three models of governance. One is that they are purely a part of state government and there are, I think, only three states that have that model. Then there are a few that have a shared model, but the majority are independent agencies like mine that are either city or county Health Departments and so for us, it's a relationship with our state Health Department that is usually based on contracts for services or contracts for funding that usually then comes from the CDC or other parts of HHS. So you can see the challenge even in what number of Health Departments are you talking about in a state? In Missouri, we have 115 local Health Departments compared to somebody like Idaho and Alaska that only have 7. So think of it as, each of these individual bodies talking about the population within their specific jurisdiction. Do they work with their neighbors or not? How is that happening? How does the state fund all of these 115 versus funding six? It really can be a challenge. And as I said, when you have seen one, you have seen one – not only for that governance structure, but because of what they do. So this provides the list of the top ten programs and services that are likely to provide, but I put at the bottom I think what is most important for this conversation, that only 50% of local Health Departments provide chronic disease programs. And that can be preventive programs or some kind of services to assist once they have that. Like Diabetes Education Programs once they are diagnosed. Or cardiovascular disease programs. Again, once they are diagnosed with an issue. So it's very problematic that not all of us are even engaged in chronic disease and preventive services. But we do partner. One of the things that is important about public health is the word "assurance" and if we are not going to be the ones to provide that, we want to assure that our population has access to that. So assurance can mean working very closely with an FQHC, a federally qualified health center. Or a volunteer clinic or the providers in the community at whatever they are, to make sure that our population does have access to services.

But let's get a little closer to home with Missouri. So how bad is our funding there for public health? Well, we are now the worst in the nation, thanks to DC! Because the District of Columbia used to be number 51, but now we are. So we used to be at least 50. It's really gotten bad. And it's gotten so bad that if you talk about from 2007 when I left as State Health Director, the funds that we gave to local public health agencies across the state were a little over nine million dollars. It stayed that way, lucky to say, during the

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Blunt Administration. The current administration has gone from a little over the nine million to two million dollars, being distributed to 115 local public health agencies. Split that up, it's a pittance. We are hardly getting anything. And so that means that most of the funding is really coming from local sources. So what do we do in St. Charles County? It's a population of about 380,000. We are a suburb of St. Louis. We are actually the healthiest county in the state by all the county health rankings, which is always a great thing. A pretty affluent well educated entrepreneurial part of the state, which is a good thing, but our challenge is really, how do we maintain that? And with poor funding, it gets harder and harder and harder. In fact, just last week the county executive was talking to me about the challenges of truancy in our schools. How much of that is related to health issues versus all the socio economic issues that we know are determinants not only in health, but in education as well. So we are now going to get into some discussions about, what are we going to do about that? Because in the older parts of our county, we are starting to see some issues there and needing to make sure that we don't have a slide in that – stop it while we can.

So we have three divisions in our department there in St. Charles County. The Division Public Health, which provides vital records – the birth and death certificates. Communicable disease investigations, we have had way too many of those recently. Some norovirus outbreaks. A little bit of TB thrown in there as well. STD clinic that we provide – sexually transmitted disease clinic. An immunization clinic, our WIC program there and then one health educator for the population of 380,000 and then of course Emergency Preparedness falls under that division as well. So a lot of that. Environmental Health and Protection is where we do all of the regulatory parts of the food establishment inspections, day care inspections, lodging inspections, all of those kinds of things. We also have two recycling facilities in our community that we run and vector control. Luckily in our county, we don't have rats. So really, the only thing in vector control is mosquitoes and trying to avoid West Nile Virus.

And then Humane Services is a kind of unique one that falls under my department as well. So we had a pet adoption center, which is phenomenally successful, has some of the best outcomes in the entire country, related to the number of pets that we are able to adopt into the community. Return them to their owners and things like that. But Animal Control is a part of that and is very much important to public health to make sure if you are talking about attacks or bites or things like that, there is very responsible pet ownership. We just had an issue within the last week where there was a dog fight attack at one of the dog parks and we ended up having to do the investigation on all of that and making sure everything went well.

So I put up our budget, just so you can see our revenues and our expenses and where dollars are coming and going. Because close to 50% is the general revenue that is appropriate by our county council and our county executive. What you will see there in grants and contracts, 18%, that is the money that comes from the state government, comes from the federal government, so it's not a lot that's funding us. And then of course

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fees. Anything that we can recover from the cost of licenses for food establishments to what we can collect, the reimbursement from immunizations and things like that.

So what could we do if we had additional resources? Oh my gosh, that is where my mind just goes crazy. So many things we could be doing. One of the things I think public health really could be and should be doing is be on the front end of the continuum when you talk about the accountable care organizations. Population health needs to be at the front end of that. As Dr. Monroe said, the upstream, so we are not talking about illness all the time, but we are not there. We are not really even close to being there in public health, because we don't have the skill set for contracting, making sure that all of our outcomes are really good. But many, many agencies see that opportunity to be a partner with those ACOs and are developing more of those competencies. The population health management, case management for the challenging population that we know about in our community. They might come into our doors as a WIC client. They might come into our doors seeking counsel on an STD issue or coming in with their family for immunizations. And just wanted to mention on the immunization front, that we are seeing more and more people coming from private practices, where their physicians are no longer providing immunizations. They are no longer carrying the vaccines in their office. They don't want to deal with that. So it's sometimes people – more than ever that have insurance, that are coming to us to get the immunization. So we are able, thanks to the CDC and some of the funding that has come down through the state, for very innovative programs for order vaccinations, the vaccine and being able to track it and do the billing. Because that sometimes can be very challenging for local public health agencies. We could always be more efficient though, there is not a lot of funding usually in any government to do lean six sigma kind of work and I have some background in that. We could definitely do more of that. Where is there waste in programs? One of the things that is very frustrating to my staff and our WIC program is that we, through the current administration now have to ask each of our clients about, are they registered to vote? And it's the law, so we are glad to do it. But the challenge is that it's every time they come in for certification or recertification, that can be twice in two weeks, depending on how many kids they are and what that looks like. It's a form that has to be filled out, blah, blah, blah, blah. So there are ways that I think federally we could identify what are ways to make our lives easier at the local health department so that we can take more time with our clients rather than time with signing people up to vote and asking them 12 times in one year. And you can imagine, our customers aren't very happy when we do that. But it's the law, so we do that.

I wanted to also talk a little bit about the prevention – the federal and state funding that is available that is so, so critical for us. Much of it comes through the state Health Department and so its unique being able to talk from also being a state health officer, you know, I always heard from those locals, that damn state! And so now I'm at the local saying, that damn state! So it's all about, what is the balance between the money that the state government and the Health Department keeps to provide the environment and the policy and the infrastructure for us at the local department to be able to do our jobs. It's a

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game, we are continually playing. Our national organization is the National Association of County and City Health Officials, which is working very closely right now with the CDC to make sure that we can get funding appropriately that the state is not being a barrier on that.

The Prevention Public Health Fund, such an important opportunity for us. Jumping down to the bottom though, a big portion of that was used for implementation of the ACA. We really are hopeful and encouraging anybody in the audience who is a staffer of anybody in Congress to please make sure that that money continues to go through the states to the locals for us to do our job. Without the additional funding, we are really handcuffed. As you can see, my agency really doesn't even get involved enough in the preventive services that we would like to, because we can't it's a matter of trying to prioritize what will have the biggest impact today in the people in our community. So for example, the communicable disease investigations, avoiding the norovirus and TB and things like that, from spreading throughout the community, but where we want to be, we should be, and can be is more preventive services. More of the screenings. Investing today so that we can be a healthier population in the future. And the one last slide just about investing in your local community and again, this is all in your packet, so I'm not reading it to you. I just want to say, it's important at the local level that we create those very effective partnerships and that is my passion, is community coalition work. Because when we do that, we not only start with data, identify the priorities, put in place the action plan based on best practices. What does the data say works throughout the country? But we can leverage funding from other local organizations. The private sector is willing to come to the table because they know a healthy population means a healthy work force and so any dollars that we can invest locally, usually have ROI four, five, six, ten times or more, depending on the issue and the funders, because we are using local dollars, local investment, local resources that everybody cares about. I'm just going to wrap it up by saying thanks for your time and thanks to the Alliance for the invitation. The reason I was so excited is because their name is the Alliance for Health Reform, not healthcare reform and I'm always very touchy about that. So I'm thrilled about that. And it is all about health. But when it's not all about health for me, it's all about Cardinals baseball and the Cardinals are playing the Nationals tonight, so sorry, we are going to beat up on you. And it's a Blues hockey season and uh, it's post season, so the Blues are playing tonight against Chicago. So for any of you sports fans, I'm with you. So thanks for the opportunity, Ed.

ED HOWARD: Of course the Nationals always win against St. Louis, don't they?

JULIE ECKSTEIN: Except in the playoffs.

ED HOWARD: Those of you of a certain age will remember that the Washington Senators, who used to inhabit this city, were designated as always being – well, I guess it wasn't the Senators, it was Washington itself that was called "First in war, first in peace and last in the American League." So we switched leagues, what can I say?

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We are now at the point where we want to get the broader audience involved in this conversation. As I mentioned, you have question cards where you can write one down and hold it up and someone will bring it forward for the panelists. Folks are already congregating at least at one of the microphones that you can use to ask questions orally to any or all of the panelists. And I would also encourage our panel members to make observations or ask question of their colleagues up here on the dais. And also, obviously Susan has a few question and quizzical looks on her face from time to time and you should be chiming in. I believe that the gentleman in the dark suit was first. And I would ask each of you to identify yourself and your affiliation and try to keep your question as brief as possible so that we can get to as many of them as possible. Yes?

AUDIENCE MEMBER: Mike Miller, I am the physician in residence at the National Governor's Association and Judy and Julie both raised sort of budget financing funding challenging and one thing we have seen at the NGA and seen for years if not decades, the challenge of crossing silos for affiliation or alignment of work between the payers and public health agencies in states or more broadly. And particularly now, about sort of who pays and who benefits and trying to get payers, particular in the states, Medicaid funding to support public health activities because public health activities help save money in Medicaid, but Medicaid has a hard time spending dollars for those public health activities. I know it's part of the broader breaking down the silos – you know, Judy mentioned ACOs as a way to do that and there are some other avenues in the ACA moving that along, but I wonder if some of the panels could talk more about how to promote some of that greater alignment both in activities but also in cross funding and sharing of funds.

JULIE ECKSTEIN: I'll take a quick crack at that, just with a story of what I experienced at the state level, because not every public health agency around the country also deals with Medicaid, so mine was one of them that did. And the very high cost. Seniors and disability services were in my department, so that was always a big challenge and we worked very closely together. Some people might remember Missouri's Medicaid Reform Commission back then and putting a sunset on our Medicaid program, etcetera, but what I wanted to share with you was, the infrastructure and the actual Medicaid program didn't have any opportunity, any professionals that were health professionals, to take information from the public health specialists. I remember talking to the Medicaid director himself and saying, you know, we have got data about what we are facing in the Medicaid clients and I have got specialists in my department that are chronic disease specialists, you name it, I have got it. Can't we help you? Can't we work together? And he said, you know – and he was a physician, a brain surgeon, and Medicaid was harder than brain surgery. So he said, it would be great to hear from your people but I have no one for you to talk to in my Medicaid program. So that was one of the changes that we created in Missouri, but it's not fixed, I can tell you that. There still is not the development of the breaking down the silos, the integration of real health information into Medicaid. It's still more of a payer rather than a health outcomes organization and I

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think we have a lot of work to do yet around the country on that. Although I commend CDC, ASTO, NHO, all those organizations for doing more and more over the last couple years to try to integrate public health with Medicaid.

JUDY MONROE: I will just chime in, thanks. Thanks for the question because that is really an excellent question and it gets to the heart of a lot of fundamental things. Just to give you an update, CDC is working closely with the Centers for Medicare and Medicaid Innovation, CMMI and the State Innovation Model Award, so we get to ACOs and patient centered medical homes and so forth. But we are beginning to do work – so as an example, just two or three weeks ago we had a meeting with Medicaid medical directors and state health officers to begin to talk about how do we work together to get to great population in health and I would also reference some of the work that is now being posted on the Institute of Medicine’s round table on population health, because you are asking a really critical question.

JULIE ECKSTEIN: But for many health officers, Medicaid is like a foreign language. If its not in their department, they know very little about it, so we have a long way to go.

ED HOWARD: Judy, I noticed that in your budget, you had an item for fees that you collect. When you provide immunization and other services that are covered by Medicaid, you collect Medicaid dollars?

JUDY MONROE: Yes, we do.

ED HOWARD: And do you expect that – I guess there is no Medicaid expansion yet in Missouri, but there is presumably an increase in enrollment at least from the people who were already eligible. Do you anticipate getting more money out of that?

JULIE ECKSTEIN: Well, if more people who have coverage definitely come in and we can bill for it, that is always a great thing. We do charge – we don’t do a lot of charity care, so I mean, we do some free. But not a lot, actually. And we don’t do anything with Medicare, interestingly. So it’s either private pay or a sliding fee scale or the Medicaid reimbursement. And in our STD clinic, we don’t do any of the above. We decided to just charge a flat \$10 and be done with it.

ED HOWARD: Go right ahead.

DR. CAROLINE POPLIN: I’m Dr. Caroline Poplin, I am a primary care physician. I am also an attorney and I can help you with your colonoscopy coding problems, I understand exactly what you are talking about. But my question for the panel, especially for the public health people that I am really glad to see here, are we over medicalizing prevention? The medical system is very expensive. There has been some question now about preventive measures like mammograms. And Pap smears. That we are doing too many. That a lot of women are being treated for breast cancers that would have been

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indolent and have regressed. And that really, the best prevention – real primary prevention is diet and exercise. Not flu shots or new vacs at 65. And that because – the reason this happens is because the medical procedures are profitable and diet and exercise is not profitable. Unless I suppose you are a gym. But do you see any – first of all, do you think that is right? Second of all, has any thought been given to other measures besides putting responsibility on the individual to go get advice on diet and exercise? And instead, looking at – well, the kinds of things New York City has done. Taxing high sugar. Looking at menus in fast food restaurants. One reason we have obesity is because the industry is spending billions of dollars advertising terrible foods. And people have – their defense are directly addressed by the advertising.

JUDY MONROE: So first of all, I agree 100%. There is no question – if we are talking about primary prevention, nutrition and physical activity and no smoking, I would add in there, are at the core of so many of our chronic diseases and that is – much of the effort, if you look at the community preventive guide that I pointed out, if you look at many of the strategies in there, its going to be looking at those community level – not so much the individual, because the individual – many times if you live in a food desert – that is not an individual problem, that is a community problem. And so we absolutely – in terms of over medicalizing, yes, in this country we have and I'm a physician, I have seen it. I saw patients when I practiced medicine – the less I did, the healthier they were many times. We over medicalize deliveries of babies in this country and that has been a pendulum that we are swinging now the other way with stopping the elective c-sections for pre-term babies. We were causing harm, not good. So you are exactly right. But there is a spectrum. Primary prevention, secondary prevention and tertiary and we do want to have early detection of disease as well. So – but the more that we can be on that upstream, primary prevention, that is where we need to be.

JULIE ECKSTEIN: Definitely I agree as well and as I said, where my passion lies at the prevention and opportunities for community coalition building and the healthy communities model. In presentations that I do, I often use the data that Judy mentioned about the 80% of our health status being related to our behaviors and choices, but only a very small percentage – five to ten percent of our funding, three percent, I think you used today, is funded. And I turn that into a roulette wheel. If any of us were betting people and knew that 75-80% of something was related to this – isn't that where we would be putting our funding? Yes. Instead we are putting it on that ten to twenty percent. So it's very frustrating that we don't get better funding for that prevention because we know the outcomes are there. We have proven best practices for what we can do at the community level and its just getting there.

LYNDA FLOWERS: And I would just add that the ACA did include a requirement that fast food chains of a certain size do have to post their calories publicly, so that would get at your issue about calories and posting that.

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JULIE ECKSTEIN: And education is an important piece, which that is. Providing information, transparency of all kinds, to consumers so that they can make better choices. I think you would find a lot of people in the country though – regulators, legislators, that aren't going to be in support of the taxing on high sugar, especially these days, is it sugar or is it wheat that is causing some of the obesity problems? A lot of discussions could be had on that one.

SUSAN REINHARD: Before you leave, I was serious; there is a question about this, so we are going to interject in a moment. What do you think is the best way to address barriers related to coding and billing? Don't go into a whole lot of technical yet, do we need guidance from the Department or is it better to work with provider organizations?

DR. CAROLINE POPLIN: CMS controls coding. CMS – I mean the AMA technically is in charge of making all the codes. But they are submitted to CMS and they come from CMS and what has happened with the colonoscopies, it's the distinction between a screening colonoscopy and a diagnostic or treating colonoscopy. Screen colonoscopy means the first colonoscopy in someone who has no special risk factors. So just an average person off the street. That is a screening colonoscopy. If you are doing it for any other reason because they are high risk, because they had a polyp before, once they find a polyp, then it's not screening anymore, it's treating. And that can all be changed. Between CMS and the AMA, you just change what the codes are. The CPT codes. And you can solve that problem. Everyone uses the same – the codes are set by the AMA working with CMC and then everybody uses the same codes. They just charge different amounts.

KEVIN LUCIA: In our work, we found it interesting, when you talk to providers, a lot of providers see preventive services on a spectrum. So you go in for a blood test and you find out that you might need a colonoscopy to see if there is a polyp. But it starts here and it kind of keeps going until you get a diagnosis.

DR. CAROLINE POPLIN: Right, but screening is a technical word. It has a technical meaning.

KEVIN LUCIA: I understand, but I think that from a definitional perspective, for many physicians, there is a philosophy of almost like an umbrella of prevention and so maybe you are right, maybe there is a need to re-evaluate these codes to reflect more of what physicians see as far as this continuum of preventive -

DR. CAROLINE POPLIN: It's all done in one place. You don't have to do it for different providers. Different states. It all comes from the same source. We all use the same CPT codes. And if you change the codes and CMS is authorized to changed the codes, you can take care of this. You can say, a polyp is part of the screening colonoscopy. You can define it that way. Polypectomy in a screening colonoscopy. New CPT code. And you are done.

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ED HOWARD: Continue this a little longer, but Kevin in your presentation you talked about the need for more federal guidance about the situations not covered by the first set of guidance that you referred to. What are the chances that that further guidance is gonna come anytime soon and do you hear any rumblings about maybe doing something about the Medicare situation?

KEVIN LUCIA: Well, I think Lynda is probably best to talk about the Medicare question, but you know, I think that the HHS was well aware of these other situations because these complaints were coming up through the states about the colonoscopy after the blood test and then the high risk questions and they were even starting to get concerns about – or states were starting to voice questions about mammograms – high risk mammograms and women having to have a diagnostic one for the rest of their life after they found a lump in their 20's and so they took a pass in answering those questions and I have heard no other rumblings. And I think most people were pretty appreciative of the fact that they weighed in on the polyp removal question, but maybe we need to put up the heat a little bit more.

LYNDA FLOWERS: So I just add to that, on the Medicare side, there is a bill up. It is HR1070 that would take care of the polyp issue for the Medicare population. It has 60 co-sponsors, it's in committee – AARP is a strong supporter of it. And so hopefully there will be some action on the Medicare side to resolve that issue.

KEVIN LUCIA: Does that just cover the polyp removal or - ?

LYNDA FLOWERS: It covers the polyp removal. It doesn't get at the FOBT conversion and the high risk either. Although -

JUDY MONROE: Is there CBO scoring for that?

LYNDA FLOWERS: I believe there is. Ramona Shaw is gone, she was here from American Cancer Society, but in our discussions, it wasn't terrifically expensive. That was sort of what we found. So hopefully -

ED HOWARD: Okay, you have been very patient.

AUDIENCE MEMBER: Carl [name] with the AIDS Institute. I think we have all acknowledged here today – you know, there is great opportunities with coverage of preventive services with the Affordable Care Act. Actually, this has been in existence – didn't just start January 1st. The coverage for Women's Preventive Services for private plans has been around now for a couple of years and given that we are in such resource constraint times, that many of you have acknowledged, what is the CDC doing to help it's grantees, to help the states, to help educate people. Just American people about these opportunities? And help with billing, with the grantees with billing. We are trying to get

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HIV testing covered – great success on the policy side. Good coverage from the US Preventive Service Task Force, but now to translate that on the ground, we are encountering a lot of problems and like – bundled payments with Medicaid and managed care. We just need some help and I'm sure we are not alone, but there is great opportunities and potential and I think this is the movement of prevention in the future and I think we are a little slow to enact these good policies.

JUDY MONROE: So thank you for that. There are efforts, like our STD program, I know is doing a lot around billing and trying to help grantees with that. But I would love to even talk to you afterwards to hear more detail about it so that I can take that back to CDC. There might be more that we can do. We have a lot of opportunity – I agree.

AUDIENCE MEMBER: But today's session was on implementing the Affordable Care Act Preventive Services and I just thought we would hear a little more on what the CDC is doing in this regard.

JUDY MONROE: Yeah, we have had a number of publications on that, there was a morbidity and mortality weekly review that went through – it was dedicated on the clinical preventive services. I mean, CDC does a lot of data collection, as I mentioned, and a number of our programs are working on that. But I can get more information to you if you would like that. Or Ed Hunter is here in the room as well from our CDC Washington office and can get more granular on what we are doing.

ED HOWARD: Yes, please.

AUDIENCE MEMBER: Hi, good afternoon. I'm Camille Banta and I represent the American Society for Gastrointestinal Endoscopy and our physicians perform colorectal cancer screening colonoscopy and they are also on the receiving end of the angry phone calls they get from Medicare beneficiaries when they found out that they went in for a free colorectal cancer screening colonoscopy, but then the gastroenterologist took out a polyp to prevent cancer and then they get a bill for co-insurance. Miss Flowers pointed out that there is legislation – bipartisan legislation pending in the House, HR1070. I'm pleased to say that Senator Sharon Brown will be introducing companion legislation over here in the Senate, but to address the question of whether or not that this can be taken care of administratively. We would like it to, but as Mr. Lucia has mentioned, the administration has so far taken a pass on correcting this while they did it on the private side, creating this disparity. And it's not something that can be easily fixed with coding. Physicians are coding correctly for the most part. They code one way when there is a screening and then they have to code a different way when a polyp is taken out and that is what triggers a liability for the co-insurance. But my question is, for colorectal cancer screening colonoscopy and the Medicare beneficiary population, depending on where you live and depending on where you get your colorectal cancer screening, the costs can be anywhere between \$100 and \$300 in co-insurance and that is just for the procedure, there may be some added costs – cost sharing for pathology of anesthesiology. And what I was

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hoping perhaps you could answer is, do you have any information on what that tipping point is for patients with respect to cost sharing where they will decide that they are not going to pursue a preventive benefit because of the financial barrier. Is it ten dollars, it is twenty dollars? Is it fifty dollars? What have the studies shown? Thank you.

LYNDA FLOWERS: I actually haven't seen any studies on that, but I would surmise that a lot of it would depend on your income level, whether or not you could afford to take that kind of cost. I also worry a lot about using the term "free" and – I mean, if we are going to say it's free, then it needs to be free. If it's not going to be free, we need to have upfront discussions with individuals about; these are the potential costs you could incur. Because I think we want to – we don't want to erode trust in the system and have people just shut down and share with their friends – oh, they said it is free, it's not free, don't go. That is not what we want to have happen. So I think from my perspective, it's really important to nuance the message that we send to consumers and to make sure that we can get – in the meantime, until we get all of this straightened out, get providers educated enough to be able to have these kinds of discussions with their patients. We think there may not be anything, but these could be the financial liabilities you might face. I think that is transparent, it builds trust; people can then make their informed decisions.

ED HOWARD: Yes sir.

AUDIENCE MEMBER: My name is Eric Garpe, I'm with the Men's Health Network. This question is mostly directed to Dr. Monroe, but anyone on the panel who can speak to the issue of actually getting people connected with these preventive services, letting them know that this is something they can do. So much like in a lot of what we do, our biggest barrier, our first barrier is that men are just not invested enough in their own health. Are you seeing any specific problems in getting men engaged in this? And are there any approaches that you are taking in response to that?

JUDY MONROE: So as a clinician, starting out, you are right. Sometimes it's the women that need to push the men into clinical care. We have seen that sometimes be effective. But CDC – I will go back to the data – each of our programs track the data regarding the uptake of clinical preventive services and they have – we know the demographics around that. And then that in turn becomes technical assistance to our grantees that are receiving funding from us and sometimes the specific funding that would go to the grantees, for them to be able to do community outreach, because there is a lot of that going beyond the walls of the office. So what we have learned at CDC that pamphlets are not the way to do it – we have gotten a lot into social media. Trying to understand where we can reach the most people. So that is an avenue that continues to be explored at CDC and I know a lot of our grantees are using social media as well to try to get the word out. But it's working through our partnerships which are really – as Julie said, it's that community coalition and whether it's reaching schools or universities or businesses or wherever folks might be, so there are a number – I can't give you all the

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fine detail, because there are a number of programs at CDC that are very much concerned about that.

AUDIENCE MEMBER: Thank you.

ED HOWARD: Speaking of social media, by the way, I neglected to point out to you the hashag behind me that you are looking at. If you are trying to tweet about this briefing, the hashag is #preventionbarriers. So feel free. Yes, go right ahead.

AUDIENCE MEMBER: Yes, my name is Mary Tierney, I'm a pediatrician, and pediatrics prevention is our bread and butter and it's 90% of what we do. I am also the daughter of a woman who died at 52 of colon cancer. She never saw me graduate from medical school. Having said that, I have had numerous experiences just as a consumer with having to make sure that my physicians get me my colonoscopies all the way to my tetanus shots. I used to run preventive services for a Medicaid program, EPSTD – early and periodic screen diagnosis and treatment. We even have a periodicity schedule, birth through 21, as many of you know. What can we do about educating our providers so that more proactively, so that you don't have to like – I have even had to ask and beg for a colonoscopy.

JUDY MONROE: I will jump in, I guess. You know, I think you are hitting it at the heart of something, again, that is critically important because we don't always see in the provider's offices the folks being offered the preventive services. Part of that has to do with the systems in which the physicians are working. And so I think it has to be approached by – there is much being looked at with electronic health records today in terms of reminders and there is evidence around giving providers reminders. But our systems need to be improved. We are not where we need to be. The other part of this is how physicians are taught. And the ancillary staff in the doctor's offices because obviously nurses can help drive that or others around them, so it's a team effort, I believe, what we are doing at CDC, we have been reaching out to clinical organizations. Many of our national associations through the American Academy of Family Physicians and I was just at the ACP meeting with the internist last week, we have – there is something called Milestones, you might be familiar with, for resident training and we actually have partnered with the folks working on the Milestones to really push a population health module or milestones where all physicians in this country would, in their training, understand the importance of what you are talking about. Instead of always treating the disease after we have made a diagnosis.

LYNDA FLOWERS: I would just add to that, I think it's important to look at it from the consumer perspective as well and empower and educate consumers to go in there and ask. I think the more information that is out there in the public, the more people start to Google things on the internet. I think it's empowering. It gives them the information that they need and they feel much stronger that they can go in and ask their physician, why –

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it said I should get this, why aren't you getting it to me? So I think we have to attack the issue from both perspectives.

JULIE ECKSTEIN: And an example of what can be done at the community level, two different things. I was on a panel last week about health literacy and one of the things we were talking about were the great programs, educating physicians and medical schools about health literacy and the other related topics like preventive services. So there are programs now in place that are getting better at educating the med students about all these complex issues. But the thing that I wanted to say about, at the community level, related to some of this – and the educational opportunities. Again, just a fun story. One of the things that was great that we did in a community coalition, we knew that our immunization rates of kids was abysmal. We needed to increase that. We started looking at what are root causes of that. And anybody that has been a parent and you have gone home from the hospital and you have this bag of stuff and when do you ever look at the bag of stuff? Maybe at 2:00 am when you are breastfeeding, maybe you might grab something next to you. But maybe not. And so we are looking at all the root causes of not only our physicians making sure they are connecting with their pediatric population to give the immunizations, but what is that parent's responsibility to get that child immunized? What we decided to do was put together – and this was before social media, so it would be all different today. But a magnet that was – we used volunteer nurses and they put that child's name and the date of birth and when everyone of that child's immunizations were due. We sent it home to them after they were home from the hospital without all that other bag of stuff. And we made follow up phone calls. The follow up phone calls were amazing. If we got the dad, it was, "Is your child up to date on the immunizations?" And it was usually – "I don't know, but let me go look at that magnet." Because we had taught them in the letter and everything else, the education – put it on your refrigerator. Which again wouldn't work these days because of stainless steel refrigerators. But the magnet was on the refrigerator with dots and with a marker of when they had gotten the immunization. If it was the mom who answered the phone and was the one taking care of the kids now, it is reversed in my household because my husband is a stay at home dad, so he would be a little offended by that story, but if it was the mom, usually it was, "Yes, and I can tell the date because I put it on the magnet." So there are all kinds of aids like that that are educational, that are memory, that in our busy lives, just some people aren't even aware of when they need to get their child immunized. There are many, many things we can do at a local level and all of it is around innovation, partnerships and just a little bit of funding.

SUSAN REINHARD: I also just want to mention the quality metrics. Prevention is starting to work its way into even payment of physicians based on the quality metrics. And so we will see how effective that is.

JUDY MONROE: And technology to track immunizations in the state registries and through CDC's. This is with some of that as well.

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ED HOWARD: Okay, I believe the two ladies at that microphone preceded the gentleman at the microphone, so go right ahead.

AUDIENCE MEMBER: Hi, I am Eli Briggs, I'm with the National Association of County and City Health Officials and – thank you Julie for the shout out to me. I wanted to actually ask a question to Julie about – you mentioned all the great things that you would like to do if you had more resources and you also mentioned that your county is providing a lot of funding, but your state funding has really gone down. Can you talk a little bit about what that decrease in funding has meant to your community? Are there things that you have had to stop doing or cut backs you had to make in various programs because of the budget cuts?

JULIE ECKSTEIN: Yeah, definitely. We've lost positions over the last several years. Actually just now an opportunity to increase a little bit of that. You know better than anybody the data about the number of positions that were lost since 2008. I think it's almost 50,000 positions across the country in local health departments because of the funding decreases. So it has meant definitely a decrease in programs, decrease in services, decrease in bodies to provide those services. One of the things that I think has been the biggest loss to us was the health educators. Like I said, we have one health educator for a population for 380,000. And she is out in schools, out in juvenile detention centers, out in businesses, on the road constantly every day doing education and we can't meet the demand. And we can't do all the other things that we would like to do with the health educator, because we are just meeting the demand. It's not being real proactive; it's being reactive to all the requests. So that funding decrease means different things in different communities as you well know. In many of the communities there in Missouri, it's rural health departments and so you might have three or four, five people max that are the health department. I have 64, which is even low, again, for a population of 380,000. But we will definitely not be going up unless we have better state and federal funding. Our local community is giving all they can. We don't have a health tax in our county. Other communities do, so right across the river from us is St. Louis County, they do have a health tax. And so they have much, much, much more funding for their population than we do.

AUDIENCE MEMBER: Good afternoon, I'm Shanta Whittaker; I'm a Senior Disparities Analyst for the Del Marba Foundation. So of course I'm very interested in disparities, but I'm going to ask Julie a question about, at the community level – so I'm based on Baltimore, that is where I live. We are establishing more of a health and all policies model, where we are trying to incorporate not just the Health Department but Energy and Parks and Recs to really drive at reducing disparities within different communities and I was wondering, are you guys considering a similar method to try to pull together your resources?

JULIE ECKSTEIN: Definitely. There are initiatives throughout the country both that NHO's involved in ASTO – the Association of State and Territorial Health Officials.

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That is really taking on that issue of health in all policies. It's one of those opportunities to ensure that health really is at the center of our conversations in this country and I'm excited that health finally is on the radar screen. It wasn't just ten, fifteen years ago, that's for sure. In Missouri, we talked about it being a health note. You know, there are fiscal notes required on legislation; we tried to get a health note in place as well. Meaning, what would be the impact on health of anything that was being considered as legislation? That didn't happen. But I think the opportunity to have continued discussions around the health in all policies is a huge, huge opportunity because its kind of like in schools, whenever we would want to go in and do one more thing that was health related, the push back was always, "Our curriculum is set, it has to integrate with the curriculum, we don't have time for one more thing." So we always had to figure out, okay, how do we get it in the curriculum? How can we use a statistics class to talk about alcohol and drug abuse? How can we use the math class to do this? How can we use the history class to do this? And it was very successful. We had to hire some great curriculum writers to help us cross over from health to curriculum standards, but we had some evaluation done, it was very, very successful, so it is that kind of integration, ending the silos, to make sure that we can get health as one of the things on top of mind in environmental things. In Parks and Rec and every other opportunity. Great, great question.

ED HOWARD: Yes?

AUDIENCE MEMBER: Bob Griss with the Institute of Social Medicine and Community Health. ACA is clearly an opportunity to systematize and regulate our healthcare delivery systems in a more rational way. At a federal level, at a state level. At a community level. Its not just an opportunity to expand coverage to the uninsured and this panel is really identifying a number of issues that beg for more rational coordination. So I'm curious what the real reasons are for the small percentage of dollars in healthcare, going to preventive services, compared to the clinical services. I'm not talking about clinical health, I'm talking about healthcare that 97% versus the 3% that was posted up there. What is the politics behind that and how can we use prevention, the need for improving preventive services as a catalyst for a social movement so that you are not just depending on physicians deciding it's actually profitable for them to provide colonoscopies according to certain coding procedures or educating people who would like to have a better health but don't understand that there are things that they could be doing differently if they take the initiative. If public health is really interested in upstream solutions, what are the strategies that could be used if the political barriers didn't exist or to counter those political barriers so that more of the dollars go to the preventive care, where you say ROI returns on investment are much higher than in clinical care.

JULIE ECKSTEIN: I will take a stab at that, I love that question and topic. First of all, definitely one of the barriers had been for years, a lack of data to really show that there is an ROI on prevention and so more and more research over the years, even related to corporate wellness type programs and prevention there. So there is finally data that would share that kind of information. So it's available if anybody needs to get some of that data,

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there have been great studies. So while that might be available now, there is still an awful lot of policy makers who are responding to here and now, rather than invest today to get a payback five, ten years from now. Because it's all about my next election, my next campaign, what am I going to do for constituents today? So it's really hard for many of them to say no to continued funding for the healthcare delivery side when there is one pie. Its not gotten bigger for us to take money out of direct care to put in prevention and I always used to say about Medicaid, it's the big sucking sound. If anybody cares about public health or education or anything else, you better find a solution to Medicaid issues and the challenges around it, because it just grows and grows and grows and grows and takes part of that finite pie from something else. They have to fund that once a state does a Medicaid program. So they automatically are going to take money from somewhere else if the pie is not growing and especially when the economy was bad. So I think our opportunity now is to use that data better, more effectively and a lot of it is about messaging. In public health, we haven't traditionally been very good marketers. In Missouri, we have just within the last year taken on a project called The Public Health Messaging Workgroup. A group of us that realized, we have to take action now to try to avoid the bad legislation that is happening that was going to – whether it was reducing restaurant inspections or opportunities for local boards of health to pass policies – I mean, we had bills that were going to do all of that in Missouri. And so how do we stop the bad and how do we get more of the good? And educating the legislatures were a big part of that. There were many people who had never stepped foot as a health director – had never stepped foot in our capital. Didn't know the first thing about creating a relationship with our legislators, even their local legislators, much less the head of the budget committee or the health committee or any of those things. So we put together a whole strategy for how to do each of those things. How to teach our colleagues about policy, how to teach them how to do the conversations, almost a refresher on how a bill becomes law. Because that is not their expertise. They were within public health and passionate about health and prevention and communicable disease and you name it, but not about being a leader when it comes to messaging around policy. So we are trying, that is just one example of Missouri. I know there are a lot of people trying to do similar, but we are not good at it.

JUDY MONROE: So a couple comments on your question. First of all, I mean, if we look at other countries with better health outcomes, they put much more investment in upstream and in the social determinants of health. And then spend less on healthcare but they have better health outcomes. So I think we need to keep that in mind, thinking about moving upstream. But in terms of the ACA and going back to the Centers for Medicare and Medicaid Innovation, they really are trying to change the incentives. There is a lot of experiments going on right now in the country to try to change the fee for service model, which really has incentivized overmedicalization in this country and to turn that around. There was a nice article in the New York Times on Cumberland, Maryland, a nice experiment where the hospital – they have changed payment. Less people are in the hospital now, people are much healthier and they have moved out into the community to keep people health and have wrap around services and so forth. So I am hopeful that we will see more and more of these really positive experiments come out and it's really

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medicine and public health working together. We have to get the incentives right in this country as well.

JULIE ECKSTEIN: It definitely is all about incentives. One again, local story. I was working in a health system in St. Louis and was a Director of Community Programs, so the community flu outreach program was one of ours. We had gotten so good at doing flu shots in the community. Partnered with banks to do drive through to fight the flu. So people didn't even have to get out of their cars. I was literally told to stop because the inpatient flu population was down. Because we had gotten so good at giving flu shots. It's all about incentives. It's all about the money. So payment reform is the key lever, I think.

LYNDA FLOWERS: I think payment reform is part of the answer, but I also think we need to do work with our citizenry in general and change the mindset of our general population, which is more sick care focused and not well care focused. Because the squeaky voter wheel is going to get the grease. If we can revolutionize the way people think about healthcare, they are going to demand from their Senators, Congressman and other officials to fund these programs because they mean something to them. So I think that is the work that we have to do and we have to figure out ways to do it and maybe in coalitions and groups to start to educate, you know, use public health to start very early in the life cycle to say, this is what real healthcare is and not sick care and so then we inculcate and we have another generation of people who think differently about care.

KEVIN LUCIA: I would just say too, on the private side, remember millions of people are going to buying through marketplaces and you know, the hope is, down the road they will be competing on quality and value and this incentive for issuers to show that they actually can help maintain health in a way that they don't have to right now in the – well, prior to the 2014 in the individual markets. So I think that is another opportunity, this new kind of – this new entity that is going to be at the table.

ED HOWARD: We have three folks waiting to ask questions, we may be able to squeeze you all in if both the questions and the responses are concise. Yes?

AUDIENCE MEMBER: My name is John Percelli, I work for Iona Senior Services Research and Policy. So we have talked a lot about overmedicalizing and how that has been a problem. My roommate is actually from Belgium and we had a conversation last night where he said one of the weirdest things is how he sees prescription drugs advertised on TV. Did a little research and that only happens here and in New Zealand actually. All over the world, those are the only two places. So my question is – we say that consumers must be educated upon prevention, but daily, consumers are bombarded with ads for prescription drugs with little to no advertising or PSAs on healthy living. As I said, the USA and New Zealand are the only place in the world that you can do such a thing. Do you feel that the ability to advocate and advertise for prescription drugs has made us more reliant on using drugs after the fact, then being proactive and preventative?

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ED HOWARD: Well, in the absence of anybody on the panel wanting to step up. Yes. Being in the age group at which most of those ads are directed, I can tell you that it's very hard to ignore, unless you have a mute button on your remote. The messages that come at you, not just on television, but in the metro billboards and every other medium that you can imagine. So there is only so much room for inculcating habits in people's minds and I'm sure that the pharmaceutical industry has chosen some of the more effective ones.

JULIE ECKSTEIN: I think it's why my 14 year old daughter wants to be a pharmacist though, because she can tell you all of the drugs and their contraindications and side effects and everything else. And if anybody is feeling a little depressed, she will tell you what can help.

AUDIENCE MEMBER: My name is Teresa Devrees, I'm from the Healthcare Leadership Council. We have talked a little bit about barriers and CBO came up briefly and I was just wondering if you could talk about savings and how we can face the challenge of people living longer when they are going to get their preventive services and Kevin, I'm hoping actually you can speak to some of what insurers maybe have seen on the private side now that the fix is – now that is has been adjust a little.

ED HOWARD: One of the questioners wrote on this card, people eventually die and they get sick between the time they get something prevented and the time they die. So those costs get cranked into that calculation. Anybody want to - ?

JULIE ECKSTEIN: We should want to die young at a very old age.

ED HOWARD: The squaring of the demographic. Yes?

AUDIENCE MEMBER: My name is Cara Townsend, I work with Capital Advocacy Group and much of my recent research has been around an alternative payment model, direct primary care. And it basically encourages patients and families to find a medical home and find someone who would know that you do have a history in your family of colon cancer and could be more aware of your comprehensive care and I'm just curious if you think that this sort of model is movement in the right direction toward the preventive care and building those patient/physician relationship and how that will impact the future of preventive care?

ED HOWARD: When you say "this model", you mean the ACA?

AUDIENCE MEMBER: The direct primary care model.

JULIE ECKSTEIN: The medical home type model.

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AUDIENCE MEMBER: It basically would keep patients from going to an urgent care center and the ER, connects them with their community health provider.

JULIE ECKSTEIN: Very much so and I think you started by saying that you are talking about a payment model change. Again, yes, the model of care is right on target for focusing on individual patients and what we need in trying to avoid us from being patients. And it's only with appropriate payment that we will get there. So private pay is moving that way a lot with concierge medicine, people really wanting that one on one focus. But our systems, our payers are not there yet.

ED HOWARD: Okay, we have come to the end of our time. Let me first of all ask you, as you listen to the final golden words coming out of my mouth, to pull out the blue evaluation form and fill it out if you will. But also I want to take a moment to thank you for asking a lot and high quality questions of our panel. Our colleagues at the AARP Public Policy Institute are also to be commended for helping us to put the program together and co-sponsoring it and I would ask you to join me in thanking our panel for a really illuminating discussion. [applause]

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