PHI DIALOGUE4HEALTH WEBINAR
THE CDC 6/18 INITIATIVE: ACCELERATING EVIDENCE INTO ACTION
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REMOTE CART Captioning

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>> Joanna Hathaway: Hello and welcome to The CDC 6/18 Initiative: Accelerating Evidence Into Action. My name is Joanna Hathaway. Star Tiffany and I will be running today's Web forum. We are looking forward to an exciting conversation and hope you will join the conversation on Webex and with Twitter, and invite you to join in also. Closed captioning will be available throughout today's Web forum. Karen with Home Team Captions will be providing realtime captioning. The closed captioning text will be available in the Media Viewer panel. The Media Viewer panel can be accessed by clicking on an icon that looks like a small circle with a film strip. In a PC this is the top right-hand corner of your screen and in a Mac it is located in the bottom right-hand corner of your screen.
In the Media Viewer window on the bottom right-hand corner you will see a show/hide header text. Please click on this in order to see more of the live captioning.
During the Web forum another window may cause the Media Viewer panel to collapse. Don't worry, you can always reopen the window by clicking on the icon that looks like a small circle with a film strip running through it. If you experience technical difficulties during this Webex session, dial 1-866-229-3239. Write that number down on your screen for future reference. The audio portion of your Web forum can be heard through your computer speakers or a headset plugged into your computer. If at any time you are having technical issues regarding audio, send a question in the Q&A panel and Star and I will provide the teleconference information to you. Once the Web forum ends today a survey evaluation will open in a new window. Please take a moment to complete the evaluation as we need your feedback to improve our Web forum.
The recording and presentation slides will be posted on our website at Dialogue4Health.org. We are encouraging you to ask questions throughout today's presentation. To do so click the question mark icon. Type your question in and hit send. Please send your question to all panelists. We will be addressing questions both throughout and at the end of the presentation.
We will be using the polling feature to get your feedback during the event. The first poll is on the screen now. Please select your answer from the available choices and click the submit button.

Are you attending this Web forum:
A, individually?
B, in a group of two to five people?
C, in a group of six to ten people?
D, in a group of more than ten people.
Again, please click submit. Once you are done answering the poll question, click on the Media Viewer icon to bring back the closed captioning if you are using it.
It is my pleasure to introduce our moderate. The Vice-president for Public Policy and Programs for the Public Health Institute, Matthew Marsom. I'm happy to turn it over to him today. Matthew, please go ahead.
>> Matthew Marsom: Thank you so much, Joanna. Welcome, everybody, to this really exciting Web forum that we have scheduled today. The CDC 6/18 Initiative: Accelerating Evidence Into Action.
We have both a stellar panel we will be presenting to you today and have the opportunity as always to hear from you, our audience, with questions, feedback and comments. We are using the hashtag #CDC6/18. I encourage you to join us on social media with additional questions and comments as well. You can follow me an PHI at Phi_Policy. Do that as well.
It is my pleasure to introduce our speakers today. Thrilled to have returning to Idalogue4Health John Auerbach, Centers for Disease Control and Prevention, where he oversees the Office of Associate Director of Policy, focusing on public health and prevention as components of healthcare and payment reform and health systems transformation.
Prior to his appointment at CDC John was a distinguished professor of Practice in Health Sciences and Director of the Institute on Urban Health Research and Practice at Northeastern University and Commissioner of Public Health for the Commonwealth of Massachusetts. Thank you for joining us.
We also have joining us on the panel Gretchen Hammer, Medicaid Director at the State of Colorado. She oversees the health programs office which administers Medicaid and Child Health Plan Plus, health plan benefits, provider relations. Before joining the Colorado Department of Healthcare Policy and Financing, Gretchen was Executive Director of the Colorado Coalition for Medically Underserved. She served as Connect for Health Colorado Board of Directors and served on the Children's Healthcare Access Board and Health One Board of Trustees. Thank you for joining us on today's panel.
Last of our speakers, first we have Laura Seeff, Director of Health Systems Collaborations at CDC and she is in the Office of the Associate Director for Policy, and in this position she is supporting CDC's focus on maximizing collaboration between public health and the healthcare sector including broadening coverage of population health and advance strategic priorities emerging from transforming U.S. health system. Thrilled to have our presenters here today.
In addition to John, Laura and Gretchen, we are thrilled that additional speakers are including us, including Ann Albright discussing diabetes, Judy Hannan discussing blood pressure, and Elizabeth Herman discussing asthma.
There we go. There is a list of additional CDC representatives.
We want to review the agenda quickly. We will hear in a moment from John Auerbach talking about the CDC goals in public health and healthcare collaboration. Laura Seeff

will provide an overview of the 6/18 Initiative and we will hear from Gretchen about the Colorado experience and the presentations from Ann, Elizabeth and Judy and move to Q&A. Finally we will hear from the president and CEO of the Public Health Institute, Mary Pittman with closing remarks and I'll have an opportunity to introduce Mary at that time.

With no further ado I want to reintroduce John Auerbach. Programming note. All the audio and slides from today's Web forum will be available to download following today's discussion. I want to urge you again as well in the audience, please do send in comments and questions using the Q&A feature on the right-hand side of the screen. We wants to hear from you, the audience, as we walk through today. With that it's my pleasure to hand over to John who will be opening today's Web forum. John?

>> John Auerbach: Thank you, Matthew and welcome to everyone on today's webinar. Let me just add my slides. Today's webinar, as you've heard, is The CDC 6/18 Initiative: Accelerating Evidence Into Action. This is in fact the collaboration that CDC has with insurers or purchasers, providers and I might add a community organizations and consumers. At the beginning of today's webinar I want to share with you a framework that CDC is using, referred to as the three buckets of prevention, that helps us to understand how the work on 6/18 fits into the larger prevention activities that CDC is involved in.

I want to start by pointing out that the 6/18 Initiative is part of CDC's three strategic directions. In particular, it is part of the strategic direction to strengthen the public health and the healthcare sectors' collaboration. The significance of this work can be seen on both a person to person and global basis. I would like to start by looking at the person to person basis. I would like to do so by introducing you to Fran Edwards. As you can see, Fran Edwards is someone who is at the doctor's for the first time in five years. She comes to the doctor with a set of health concerns that she hasn't been able to adequately take care of prior to being insured. But now, like millions of other Americans, she has become recently insured. As a result, she has benefited from increased access to care. She can now receive her medications and see a primary care provider instead of an emergency room doctor.

This is resulting in improved health. However, while she has insurance, some of the services that she needs are not covered. Others are covered but they aren't either being offered or utilized. We will be talking about how to address that with the 6/18 Initiative. An additional reason, though, that even with healths in she doesn't have optimal health now is because of the larger context in which she lives. There are other factors in her life that have a major impact on her health. She has low income. There are major barriers to fit niece due to some of the safety issues and lack of affordable and accessible options to exercise. There is no near by supermarket for her. She's under a lot of stress. She has asthma and lives in housing with mold and mildew.

Now, some of these needs might be addressed with expanded benefit coverage and utilization under the 6/18 Initiative. Some, however, will require the alignment of work with both public health and other sectors' activities often at the community level. CDC already has grants, tools and information to work on these community-level conditions. In addition to that, we are now developing some new materials that will align with the 6/18 Initiative. We are not going to be focusing on those in this webinar, but I did want to highlight that we recognize while 6/18 is an important initiative, it is not all we are

doing. It is in the context of looking at a number of different ways that we have to work on improving the health of the residents of the country.

Now, I'm going to step back from the person to person to the global level and remind us that we are in a period of very significant change. As the visual demonstrates, about percent 87 percent of all Americans are now insured. In addition to increased coverage we are seeing a good deal of work around the country in payment reform as we move from fee for service to value based contracts, we see new models that emphasize patient centered care. We are seeing across the board an increase in prevention from many different sectors, including healthcare and the insurance sector.

As those discussions are taking place in virtually all the states, there are important decisions that are being made that involve often the Medicaid program, governors' offices, commercial payers. But all too often public health, community organizations and consumers aren't involved in those discussions. So 6/18 is in part an effort to help to bring people to the table with tools. So I want to begin by encouraging everyone who is not aware of the activities that are taking place in their community and their state to do what they can to get to the tables where those discussions are taking place. But then, of course, the challenge is determining how to make the most of being at the table. And we believe that it is important that people in public health and community health and consumers themselves have the tools they need in order to play a productive role when they find the table and get there.

The 6/18 initiative is part of giving you a tool which we think will be helpful as you engage in these discussions.

But we need tools for all different types of circumstances. To cover all of the circumstances that we may find ourselves in, in order to promote prevention and the population health, we want to share with you the CDC conceptualization of what we refer to as the three buckets of prevention. Bucket one refers to traditional clinical prevention. Here what we are encouraging is the access to and promotion of the traditional prevention clinical services such as immunizations and screenings and counseling on improving behaviors so patients are less at risk. We have work to do in this arena. 6/18 provides some tools for how to go about doing that.

The second bucket is the innovative clinical prevention bucket and that refers to value based contracting and we can expand care with insurance coverage to cover such things as the use of a community health worker to assess asthma triggers in the home. Or for evidence-based diabetes prevention programs in a YMCA or other community site.

The first two buckets focus on clinical care, both traditional and innovative. The third bucket is not about clinical care or patient-specific care, but rather it focuses on the larger community and thinks about the community-wide interventions that can reach entire populations, for example through the passage of smoke-free policies that allow all people to breathe smoke free air. We believe people need to work in all three of these three buckets. Because we have to work in a variety of different circumstances, we need tools, materials that help us to be prepared and able to make valuable contributions regardless of which one of these buckets are being addressed.

So again, 6/18 is mainly focused on giving you tools for buckets one and buckets two, and we will have other tools that are either currently available or new ones being developed soon for bucket three.

While we are not going to be focusing on bucket three, I will highlight for you that there are resources already available that you may want to look at after this webinar that focus on some of the information that is necessary in order to think about community-wide interventions. We will be making available the access to these websites as well as the new materials once they become developed.
So with that, Matthew, I'll turn things back over to you.
>> Matthew Marsom: Thank you so much, John. Great opening remarks. Seeing the context for where CDC is. I know that the 6/18 Initiative is certainly a major priority for the CDC. We are going to have an opportunity to delve now into greater depth. I want to, if I can, bring up poll 2. I think this is an important question that we need to get a sense from our audience. We have over 600 people listening today to this content. I want to make sure that each gets an answer.
On the right-hand side you see a poll. In your opinion, what is the most influential trend in healthcare that is impacting public health?
We have options as follows. A, greater healthcare coverage, insurance. B, payment reform/outcome based payments.
C, integrated healthcare delivery models.
D, novel technologies, telemedicine, robotics, 3D printing.
E, patient powered care, social media, mHealth, tailored medicine.
And F, other. Please submit your responses in Q&A.
Please do submit your responses on the screen and click submit. You have a minute left on the poll. I encourage you, take a moment to go on to your computer screen and click on that poll question. It really gives us the feedback we need from the panel.
So I thank you again, John. Now I move on to Dr. Laura Seeff. As I do, I remind you, everybody, send in your questions and comments for the panelists in the Q&A on the right-hand side of your screen. We are seeing comments and questions come in, which is fantastic. We are using the #CDC 6/18. With that, Laura, it's my pleasure to hand it over to you.
>> Laura Seeff: Thank you, Matthew and John and everybody. Let me turn us to a deeper view of the 6/18 Initiative. This initiative is a key component of CDC's third priority of increasing collaboration between public health and healthcare that John referred to a moment ago. It also fits neatly into the three bucket framework that he also mentioned. As you'll hear throughout the webinar this effort builds on strong foundational work across CDC divisions and is being implemented as a multiunit collaboration within CDC. It provides a coordinated approach to translate CDC evidence into action by healthcare systems.
The 6/18 Initiative represents a major effort by CDC to engage those who finance and deliver care, so those on the cog on the right, healthcare purchasers, payers and providers, by highlighting those evidence based interventions that were to improve prevention and control of high burden and health conditions and associated costs, those on the left. We envision moving forward with this initiative in lock step with our payer and provider partners including other federal agencies at the table with us already.
The 6 in 6/18 represents the six initial conditions we focused on. Reducing tobacco use, controlling blood pressure, preventing healthcare associated infections, controlling asthma, preventing unintended pregnancies and controlling and preventing diabetes.

If you are familiar with CDC's Winnable Battles, these are also Winnable Battles. They were selected because, they are high burden, very common, very costly, preventible or controllable. There are interventions for prevention that are scalable.
In addition to the things that we can do in the clinical or public health sector to prevent or control these conditions there are also evidence based interventions available that a healthcare system or insurer could implement.
The 18 in 6/18 are those evidence based interventions. Under each of the six conditions as you'll see here in this slide there are a number of evidence based interventions that allow an insurer, healthcare purchaser, payer or healthcare provider to implement and improve control or prevention of these conditions.
As you heard from John, because this initiative is geared primarily towards the healthcare system, healthcare sector, the interventions in 6/18 are intentionally bucket one and two interventions. So let me give you a few examples to make this very tangible. You will hear more about these from our division colleagues who will be speaking next.
In bucket one, pre-productive health colleagues were able to identify specific action items to remove insurance barriers to increase the use of long acting reversible contraceptives as a way to prevent unintended pregnancies.
Bucket two, the come leasts in Million Hearts and stroke disease prevention identified these interventions highlighted in red which better engage patients and community providers in the control of hypertension, to augment what is already happening in the clinical care sector between a hypertensive patient and their provider. We know there are 70 million hyper tenses in this country diagnose. Only half are under control. As a way to engage the patient and community providers in control of their hypertension we want all hypertensive patients in a particular insured population to have access to a home blood pressure monitor, to be trained in using that monitor and to have access to a team of nonclinical providers. So, for instance, a pharmacist and lay health worker or nurse, community health worker who will help monitor and control that hypertension, again to augment what is happening in the clinical care setting. Those are bucket 2 examples.
What is happening on the ground? This slide illustrates our progress to date with the 6/18 Initiative. So we at CDC understood a high need to build capacity and understanding of the current healthcare sector. In its post ACA environment and insurance sector and the need for the insurance and healthcare sector to understand public health. We delivered a four part training series to an internal CDC audience, including presentations from national health systems in sector experts, materials from that training series will be available to both CDC and external audiences in the next few months.
Based on much of that foundational learning we are moving in a staged fashion towards implementation with these partners. We are beginning with partnership with Medicaid, with public payers starting with Medicaid. This is building on a strong CMS/CDC partnership.
Next week we are bringing in eight Medicaid programs and their public health counterparts to partner with us on the 6/18. This he were selected because they were already working in this space and specifically they were interested or already working on some of the specific 6/18 interventions. We did some a priori matching with burden

of specific of the six conditions and the Medicaid population. We will be focusing with those Medicaid programs on asthma, tobacco and unintended pregnancy and the outcome of this meeting will be for these Medicaid programs to leave with a draft implementation plan of how they can get a subset of the 6/18 Initiative into implementation. We are moving quickly into action.

On the commercial side, this is an extremely segmented market. We are developing individual relationships with large commercial insurers. We are again looking for coalesce sense around a subset of the six conditions. We will be again convening a set of commercial insurers here in Atlanta in April or May, likely with focus around how to engage providers in those insured populations.

So in advance of the 6/18 Initiative we will be partnering with organizations under these categories. You heard about our partnership with payers. Let me talk about the purchasers we are also engaging with. At a state level we are engaging with states, at a state level the state is responsible for purchasing the care for all state employees. We are beginning those sorts of partnerships.

At the federal level we are beginning to partner with the office of personal medical management and the federal employee programs who are responsible for insuring many of us feds.

So what do we think these partners can do as they engage with 6/18? This slide lays out how we see each sector engaging. I've spoken again about purchasers and payers. I will pause again on what public health can do. John spoke a little bit about this. First and foremost we want health to have a seat at the table, that will be at the Medicaid table and promote 6/18 in clinical insurance sectors. A key role for public health will be to help measure the impact of 6/18 using public health data.

So how will 6/18 expand? We will likely add interventions to 6/18 as the evidence comes online. But the 6/18 approach is already replicable. We have been able to define steps that have facilitated the focused engagement with potential partners in the public sector. It can and is being replicated now. These steps are highlighted in the graphic to the right and the list on the left.

So first and foremost we want to start by a focus on high burden conditions, either high burden because they are common and preventible or because they are very expensive and preventible.

Associated with those, though, it is important that we have a specific prevention intervention. It is not enough to point to a high burden condition. We need to be able to offer a solution. As a piece of that intervention that has been critical to establish and assemble the evidence base. What is the evidence behind the fact that we feel confident that we can improve, reduce the burden of the condition and improve costs related to it? We've, as I mentioned in a previous slide, done some work to align the epidemiology of the condition with the payer. So, for example, if we are thinking about conditions that are more common in the 65 plus audience we will focus our work with Medicare on those conditions. We used all this foundational information to make the case and begin to engage with purchasers and payers.

Even though this initiative focuses on interventions that are bucket one and bucket two, during that engagement we want to be very intentional about thinking of interventions across all three buckets. As an underpinning to all of this work it is critical for us in

public health to understand the context in which payers and purchasers and providers are currently working.
So how will we measure success? We are being intentional as we launch this initiative to think about how to measure success at the outset. Those will be in three Broadways: Quantitative, qualitative and impact, both health and cost. At the very highest level we are going to be tracking how many insurers are taking up and implementing 6/18. As an example how many Medicaid programs will implement this initiative.
Qualitatively we want to be able to really describe how is this initiative changing the way we are doing business? We are already seeing evidence of that. And then probably most important we want to be able to measure the impact at both the health and cost level of the effect of full up take of this initiative. For example, we will be measuring the reduction in ED visits and the version of associated cost related to asthma among specific Medicaid beneficiaries in participating states through full up take the of asthma interventions highlighted in 6/18. For each of the conditions we are developing similar forecasting models to be able to do that.
So our website has gone live. If you have not been there, we encourage you to go to it. It's here at www.CDC.gov/6/18. This is what the landing page looks like. There is an at-a-glance and in this bar on the left you can shrink to a PDF or Web version of the evidence behind each of the 18 interventions. We have a growing list of FAQs and coming soon there are additional tools including things like the readiness checklist. The graphic I showed you a moment ago, how to be a 6/18 partner and additional tools. Here is a closer look at the page where you can get to the evidence summaries.
So in closing, how does the 6/18 Initiative help Ms. Edwards who you heard about from John? How do each of the sectors help Ms. Edwards improve her health?
With the full implementation of 6/18 and with our bucket three initiatives on the heels, all of the sectors should be geared towards improving Ms. Edwards' health. She should have an easier time of controlling her hypertension and asthma because of easier access to medicines. She had home visits to remove the asthma triggers. The hospitals, we hope she visits less because she's healthier, but those hospitals will focus on healthy mommies by addressing upstream issues before she is admitted. Public health will be fully engaged, promoting preventions to insurers of this kind of work with focus on these specific 18 interventions. And they will be addressing total population health in all communities as an intentional effort to reduce disparities.
With that I'll turn it back to you, Matthew.
>> Matthew Marsom: Thank you very much, Laura. Really great overview of the 6/18 Initiative. I'm sure it prompted additional questions. For anyone in the audience who wants to provide a question for Laura, John or other members of our panel, do send in your comments now using the Q&A. I can see a number of questions have come in. We will be sure to address those at the end.
I also want to be sure to just highlight a couple of responses that came in on poll 2. The comment, the last one in terms of "other" Charlotte Walters responded that access to Medicaid and consolidated services under one roof was the influential trebled to her. Nancy Pappas' response was it is the move towards healthy foods as medicine and a greater recognition of social determinants of the health in community settings.

Thank you for sending the responses to the poll number 2. Before we go to the next speaker, I want to bring up poll 3 on the right-hand side of your screen. Take a look now. It is on the screen. You have about two minutes to respond.
In your opinion, what is the biggest factor that is currently drawing the public health and healthcare sec sectors together?
A, healthcare reform, Affordable Care Act.
B, rising healthcare costs.
C, increasing prevalence of chronic disease.
D, the shift towards value-based care.
E, education/greater awareness of prevention and public health.
And F, other, please submit responses in Q&A.
You have a minute and a half to be respond to that. Please do submit -- I don't know if we have an option -- no, you have to choose one, unfortunately. It can't be all of the above. Do submit your responses to the poll and click submit. Great to hear from you and any comments on the Q&A.
With that, it is my pleasure now to again reintroduce Gretchen Hammer, Medicaid director with the State of Colorado for her presentation. Gretchen, over to you.
>> Gretchen Hammer: Terrific. Thank you very much. We are thrilled to be able to partner with the CDC on the 6/18 Initiative and have had improvements in population health as a core strategy, as part of the broader Hickenlooper Administration, our governor here in Colorado and the director of CDC. In Colorado we have a platform for the initiative or for the governor's administration that we call the state of health. And for those of you familiar with the AAA, you will recognize the underpinning of the best health, the best care and the best -- excuse me, of the best value.
So this really has been the framework that all of the state agencies who are focused on health-related work have been working off of. You'll note that one of the core areas within the framework is the promotion of prevention and wellness. That includes prevention programs, changes to individual behaviors as well as changes to the physical environment followed closely by efforts to expand coverage and access and capacity of our healthcare system.
We are a state that has expanded Medicaid and had been on a trajectory towards some expansion of public programs prior to the Affordable Care Act and then did use the Affordable Care Act for additional expansion.
These are an important relationship between the promotion and prevention and wellness and the expansion of coverage that we believe aligns directly with the CDC's 6/18 Initiative.
Colorado is a large state. We are either the fifth or sixth largest land mass state in the nation. We have very large areas of rural and frontier communities. We have 64 counties in the State. We have the large urban corridor where a lot of our resources and population are centered.
So when we look at the Medicaid population overall in Colorado, we cover 1.3 million Coloradoans. 74 percent of those -- 44 percent of children and 42 percent are adults. That is a leveling out, if you will, of the population as we've gone through the expansion of Medicaid. 7 percent are individuals with disabilities and that's an important reminder that Medicaid plays an important safety net healthcare system role in terms of providing coverage for individuals with disabilities as well as low income older adults.

It is known in Colorado that 74 percent of the adults in Medicaid are working. So I think as John spoke to the social determinants of health or the life circumstances that can impact somebody's ability to maximize their health we know that there are working individuals within our Medicaid program, but they are working at a job that perhaps doesn't offer coverage as a component to that. We are a very small business service-oriented economy here in Colorado. Or are making wages at those jobs that continue to make them ineligible for the Medicaid program.

That is an important component as we think of accessibility of programming and accessibility of services that we account for the working realities that families and individuals covered by Medicaid experience.

When we look at our own personal department performance plan, the earlier state of health is the statewide framework for all of the state agencies and in Colorado and the Governor Hickenlooper platform. In the performance plan for the state Medicaid agency we have called out the importance of partnerships to improve population health. So focusing on delivery system innovation, since we've made changes to the coverage landscape. Now there is opportunity to make sure we are improving and transforming our healthcare delivery system using the tools of transformation that we have available to us as a payer. So those are our payment methodologies, our health information technology infrastructure. Those tools that we have in our tool box as a state Medicaid agency to really support the transformation of the healthcare system in Colorado. Then we specifically call out partnerships to improve population health out of a direct connection to both our sister agency at the Department of public health and environment, but also our sister agency at the Department of human services that includes programming related to childcare assistance and to food assistance and other things.

Then lastly a commitment, overall commitment of the Department towards operational excellence.

When we any about that partnership to improve population health work, I wanted to just recognize or call out for those that we have 64 counties, 54 local public health agencies. We use health statistics areas, as I mentioned. Some of the populations are quite rural and frontier. From a statistical stability perspective we have to roll up beyond our county and public health agency level to what we call health statistics areas. Within the state Medicaid area we have primary case management platforms for the programming. We have five behavioral health, four state agencies, which have jurisdiction over our workforce regulatory infrastructure and we are a SIM grantee, state innovation model grant. Our grant in particular is focused on physical health services and behavioral health. Again this population partnership health work. When we looked at the 6/18 opportunity provided by the CDC we looked across the population and all of the metrics that these entities are working towards and really settled in on tobacco cessation and the result of unintended pregnancies. When you look at rates of smoking within the Medicaid population they continue to be higher than the general population. In addition we continue to have high rates of unintended pregnancies and pregnancies among young women within the State of Colorado that we thought the opportunity to look at our benefit package, partner with our local public health departments as well as the state public health agency and figure out how we can improve tobacco cessation, programming within the Medicaid agency and access, I think, as Dr. Seeff suggested,

looking at if there are barriers within our policies that are leading to challenges of accessing services or long acting reversible contraceptives and other things that can be known to reduce unintended pregnancy.
So one of the things that I was also asked to speak to a little bit is early lessons learned. I think that one of the most important lessons that we have learned so far is that state agencies must model these effective partnerships and leverage the unique strength of each agency.
There is a role for the state Medicaid agency in this work. There's a role for our Department of Public Health and Environment. There's a role for our partners at the Division of Insurance, NDORA as well as the Department of Public Services. If we ask for local partnerships to come together and address the common challenges that we have to hold ourselves accountable to modeling those effective partnerships as well.
We found that shared metrics bring together people in powerful ways. When we look at either our community health needs assessments driven through the public health improvement planning processes or other sort of local initiatives led by either the hospital 990 requirements or some other requirements, the notion of shared metrics or of a shared focus on reducing tobacco utilization or reducing unintended pregnancies can bring together powerful new partnerships. We as payers in this work can nudge or support some of these new relationships through our contract requirements.
So putting into our contracts with our local county human services administration pieces the opportunities or carrots, if you will, if they form a productive and powerful relationship with their local partners in this work. There are mechanisms as payers that we can use around our contract requirements to support and nudge new relationships.
And then despite the fact that there is great evidence, I think, as circumstances 18 has shown, that work to improve public health must align with local community priorities. It is through those local community prioritization processes that we really come to understand what is the nature of the challenge for that community and then we can put the right supports of the 18 interventions that have been identified as evidence based. Which ones are the appropriate ones to bring to that community.
An important nod at all times to the prioritization at the local level and then figuring out which tools we have available to us to bring to that community.
So I will stop there as a piece of sharing the experiences that we have had here in Colorado. I'll turn it back over to Matthew and look for to the questions and answers.
>> Matthew Marsom: Thanks, Gretchen. Wonderful level of what is happening at the state level, which is important to our audience. Making sure we have examples of what is really happening at the state and local level and within communities is can critical. I want to acknowledge questions and comments from our audience. It is important to get to those. In answer to poll 3, the biggest factors currently drawing public health and healthcare sectors together, I want to call out, Danielle roach said that for her it's a reconnection on healthcare and public health historical roots in social justice and community activism. Julian for the other response, the contrast between ever increasing expenditures for health in quotes and ever worsening health outcomes that is driving the public health and healthcare sectors together.
Thank you both for sending in those responses. I want to make sure we are hearing from you on the Q&A on the right-hand side screen in the audience today. There's over 600 of you listening to this. On social media make sure you join the conversation at

hashtag CDC circumstances 18. We heard opening remarks from John Auerbach and Laura Seeff provided an overview of 616 and Gretchen talked about the Colorado. Now we will hear from division speakers from CDC. We're thrilled to have the panelists join us today to look at specific disease conditions and some of the interventions that are demonstrating success for each of these. We'll hear from Judy Hannan, Ann Albright and Elizabeth Herman. Ann, we will be able to hear from her and walk through her presentations. Thank you again for the division speakers and over to you.
>> Ann Albright: Hi, everybody. Thanks, Matthew. I want to quick check that you can all hear me.
Let's just jump right in to the issue of diabetes and there are certainly issues around control and prevention if one needs to be reminded why we need to focus on diabetes, this hopefully gives you a very quick visual image of what happened with the number of people with diabetes and those who are developing diabetes each year, or incidence. If my slides will -- there we go. If you take a look we have been doing nothing but steadily increasing the number of people, again new cases, and the total prevalence. We have a glimmer of good news at the very sort of just turning the corner, we hope. This is the first time we have been able to report this kind of data in more than two decades because it has been a steady increase. We are just beginning to see what we consider to be something we'll talk about, which is a reduction in these new cases and prevalence. What that should tell all of us is that this is really the time to be pressing hard on prevention because it demonstrates that the work we have done to date has been making a difference. This is obviously not just CDC's work and all of our partners, but a number of other things going on. It should give us all a pretty bright glimmer of hope that we can indeed reverse this trend and begin to have fewer new cases of Type 2 diabetes which is the most common form of the disease, makes the biggest contribution to the health burden.
When we look at 6/18, we really have chosen to focus, our division focuses work on both those that have diabetes and those in which we are trying to prevent new cases. Since you can only prevent Type 2, our focus is really for 6/18 in preventing those new cases of Type 2 diabetes. We have primary interventions that are large in scope and have several lanes of work feeding them. The first is to expand access to the National Diabetes Prevention Program. This is the most proven lifestyle intervention for preventing new cases of Type 2 diabetes or people at high risk or prediabetes. The blood sugar is higher than normal but not yet high enough to receive a diagnosis of Type 2 diabetes.
The next is to screen for glucose in those who are obese or overweight and have cardiovascular assessments. We have a strong body of evidence. Everything from randomized controlled trials. We highlighted one here called the DPP which is a prominent randomized control trial. There has been an ongoing outcome study as a result of this original trial. This population has been studied now from a for 15 years. We also participate in other randomized trials.
We have a number of subsequent translation studies that have done a lot to add to our knowledge about how do we make these randomized control trial results work in the real world? How do you actually reach people where they live and work? And really need to implement things that have been proven to work in pretty pristine circumstances.

Then we also have now a variety of positions and recommendations that have come from groups like the U.S. preventive services task force and the community preventive services task force. They touched on each of our two interventions. We have two from USPSTF, one on obesity, behavioral counseling for CVD risk reduction and we have shown that these interventions are effective and cost effective. Our team was involved in the economic review.

We also have the USPSTF report that came out in October that recommends screening for prediabetes and for diagnosing Type 2 diabetes. It is intended to be as part of a CVD risk assessment. Again a strong body of evidence that positions us well to be implementing these two interventions.

How are we doing that? We have actually constructed a framework for what we do refer to, as I mentioned earlier, the National Diabetes Prevention Program. It is more than the intervention itself. It is a multiple part component endeavor that touches on these four major components. For 6/18 we really again are focused on this intervention sites and the delivery and these payment modeling and getting coverage. But central to that is the fact that CDC is managing and is the ones overseeing the recognition program or some refer to it assert indication. So it is a really important role for public health. It allows us to collect data, provide technical assistance to delivery programs. This intervention brings together multiple sectors. It brings together the payers and the health care providers. It brings together nonprofits who are out in communities who can deliver this intervention. Brings together the government and the business sector, because we have for-profit organizations that are working on delivering this intervention as well. So this is an incredibly quick glimpse at the National DPP itself. Really wanted to give you that flavor because as we finish giving you what has come of that, what progress we have made, we now have over 775 organizations that have CDC recognition. They are delivering this lifestyle intervention in all kinds of places. We have out of about not quite half of those organizations on which we have data, about half of them we're serving almost 34,500 people. We've got organizations who are now delivering virtually, a couple of them on their own are serving over 30,000 people. We are now able to scale something and get it into the thousands, hundreds of thousands and then the millions. Since there are 86 million people with prediabetes, 29 million with diabetes. The average weight loss is 4.5 percent. This tells us as a nation we are moving ourselves to meeting important standards that are supported by that evidence that demonstrates you can actually prevent new cases of Type 2 diabetes. This intervention has been demonstrated to reduce the new cases by about 58 percent. 71 percent in those over 60.

Importantly we've now got over 40 commercial health plans that are providing some form of coverage and nine states where they are getting state employee coverage, which allows us really to provide this for over 1.5 million covered lives.

So in closing, just to give you a flavor of the kinds of health plans, when you are describing this work with health plans, as Laura indicated, work with commercial health plans is, you need to meet with them sort of individually. And so you will have them giving this intervention or paying for coverage for a segment of their population. Maybe in a market area. It may be in a portion of their covered lives. What is on this slide is strictly an example, or examples. Because you can't say oh, yes, everybody at united healthcare has coverage for this. But united healthcare, for example, is now offering it

in a number of their markets. We have some plans like a Molina and emblem that are now offering Medicaid. They are just starting. We have MVP, an advantage plan. Kaiser is coming on, Humana and some are coming on with a portion of their own employees and they may be rolling it out to other portions of their beneficiaries.
This is what we consider to be a staged rollout. It is tremendous progress. We are working with Medicaid and Medicare. We launched a Medicaid demo to help states understand how to navigate that payment coverage pathway. We will see as we get very close to Medicare coverage. So with that, let me turn it back to Matthew.
>> Matthew Marsom: Thank you, Ann Albright, there with an overview of the experience they are having and the work they are doing in the division related to diabetes. Rich presentation, Ann. We will move quickly to Elizabeth Herman to provide us with a deep dive on asthma. Because of the speed we are moving with these presentations, my colleague Joanna is going to move your slides. Say next slide when you want to move forward.
>> Elizabeth Herman: Thank you, Matthew and everyone. Next slide, please. As you know, asthma is a common condition that affects over 22 million Americans. As shown on this slide disproportionately affects racial minorities. The burden is high in terms of ED visits, deaths, costs to the system, but the good news is that asthma can be controlled by currently available medications and devices as well as by avoiding the irritants or allergens, things we call triggers that make asthma worse. Unfortunately as illustrated in the map on the left-hand side of the slide, asthma is not well controlled. The white areas are states for which we have no data, but even in the lightest blue areas between a quarter and a third of children report asthma that was uncontrolled in the prior 30 days. In the darkest areas, around 50 percent of children report asthma was uncontrolled. Next slide, please.
In addition, the prevalence of asthma markedly increased over time, with the rate doubling since the 1980s. This illustration shows the increase of prevalence with the darker areas showing higher rates in asthma between 2000 and 2011.
Next slide. So CDC's approach to asthma is a step wise or tiered approach to focus high intensity on high cost interventions on those who are at greatest risk of hospitalizations, ED visits and other indicators of poor control.
As a first tier, everyone with asthma should receive medical management following the national asthma prevention program or NAEPP guidelines developed by an expert panel convened by the national institutes of health. This includes medications and devices for asthma control. People who are not controlled with medical management alone and those with moderate or severe asthma should be will referred for more detailed information than can be delivered in the context of a brief office visit.
Asthma remaining controlled after that, patients can be given a home visit to provide or reinforce the education and identify triggers that can make asthma difficult to control. The will range of reported ROIs for these interventions is indicated on the left side of the slide.
Next slide, please.
To date, CDC's national asthma control program has established and published the evidence-based approach and has incorporated it into our work with state asthma control programs. We have shared the data on return on investment in a national governors association brief that is part of a series on health investments that pay off.

We have also developed and distributed a white paper on developing a business case for asthma for state asthma programs.
We have learned a great deal from our efforts and those of our partners to engage health plans around this approach. We've learned that although return on investment is important in improving quality measures is also an I am important incentive to change. Building on existing partnerships and infrastructure has been key to the success stories that we have. And using a health plan analytics is extremely useful in identifying and targeting individuals at greatest risk and in yielding a positive return on investment. Next slide, please. So I'll conclude with a brief description of Michigan's match program. Managing asthma through case management in homes. This program targets people with poorly controlled asthma and high utilization rates and it provides home based self management education, home environmental assessments and resources to reduce exposures to environmental asthma triggers.
The program has been serving people with asthma since 1999 and has achieved reductions in asthma related hospitalizations and ED visits that yield a return on visit of $2.10 for every dollar of program costs.
This led the Michigan Department of Health and human services to convene a payer summit following which several additional payers agreed to reimburse for the home visits, thus expanding access to services across the State. At that point I'll thank you and turn it back to you, Matthew.
>> Matthew Marsom: Thank you so much, Elizabeth. Another really valuable presentation, being able to describe the scope of the work happening already on asthma and talk about some of the partnerships and successes. We'll have an opportunity to discuss when we talk about the Q&A. Just a reminder to send in questions. We're having some good ones coming in from the audience. We'll be sure to get to those in the next 30 minutes before we close today. It is now my pleasure to introduce the last of the division speakers to talk about blood pressure, which is Judy Hannan. Over to you.
>> Judy Hannan: Thank you very much, Matthew. I appreciate the opportunity to speak for the Million Hearts initiative and the heart disease and stroke are the leading causes of death with over a 800,000 deaths each year in addition to those deaths there are also 750,000 heart attacks and almost 800,000 strokes each year.
Cardiovascular disease is a major contributor to differences in life expectancy of African Americans compared to Whites. No matter how you look at it, cardiovascular disease takes a toll on our nation and hypertension affects.
I refer you to these editions from Vital Signs that describe the statistics in terms of heart age and preventible deaths. Million Hearts is a national initiative to prevent a million events an co-led by CDC and CMS. It was designed based on simulation modeling. One of the greatest contributors to cardiovascular events, if modified what is the greatest number of events that can be prevented. From the Million Hearts initiative, half of the events prevented are on changing the events and half the events prevented are optimizing care which is what I'll focus on today. For us when we talk about that, we are talking about focusing on ABCSs, aspirin for those who had an event, blood pressure control, cholesterol management and assistance in smoking cessation.
Next slide. We are focuses the majority of our efforts on adults between the ages of 45 and 84. These are the individuals that have the vast majority of events and the highest

prevalence of hypertension and other risk factors. They are commonly covered by Medicare and large private insurers.
Within the purchaser and payer arena, this slide shows what we think are some of our early successes. From the modeling effort we knew that hypertension was a major driver and we have consistently focused on that. Gretchen Hammer, she was talking about the need for shared metrics. I say one of our other big successes is before the launch of Million Hearts, constantly since the launched we focused on decreasing the number of metrics and aligning to a small number of clinical quality efforts on the ABCs. We aligned the federal partners to be using the same small set of metrics. We developed clear and compelling asks of insurers, payers, on these topics.
Within the CMS payment structure we aligned and embedded the core measures I mentioned in as many programs as possible to incent and improve performance. We are also extremely excited about the CVD reduction model zest that is just starting with participants in randomized control in the first pay for prevention for cardiovascular events.
Next slide.
We are also very excited to be working at the federal level with the office of personnel management that covers all federal employees. We are grateful four their leadership. What we considered early wins is covering of tobacco cessation medications and nicotine replacement and low or no out-of-pocket costs for cholesterol medications and within the last year one of the federal plans covering home blood pressure monitoring devices for high risk individuals. And while we were very excited about each of those individual coverage wins over the years, we really are also very excited about what they have put forward for 2016 and the next couple years going forward, which is a planned performance zest: It links payments to quality. The profits from the insurers are related to performance on a couple of key indicators.
Next slide. I want to talk briefly about one of the early wins which was before ACA, the FEHP covering tobacco cessation benefits. We were excited about the adoption of the full coverage of the services. One year after the benefit went into place, OPM surveyed employees and found one in ten of those smokers were aware of these benefits. This is really a cautionary tale about getting coverage not equaling services.
Next slide. The obstacles to assuring that the benefits are used remain high. I believe that brings, that is what brings us to the value based reimbursement world. Paying for outcomes is where OPM took the cardiovascular work and for the 2016 federal employee benefits plans, plan profits are tied to their performance in 19 measures. With performance and hypertension control and advising smokers to quit weighted heavily. Regardless of which world we are navigating, having the science behind what interventions matter is absolutely necessary.
I also noticed that one of the questioners was asking where the evidence based -- where are we using the evidence based strategies. I want to say we are. They are totally driving what we are asking people to do in hypertension control. So the asks within the 6/18 are improve access and adherence to anti-hypertension, and promoting team based approach to prevention and control and self administered blood pressure monitors. Those are all within the community guide.
With that I'll turn it back to you, Matthew.

>> Matthew Marsom: Thank you so much, Judy. I want to just take this moment to thank each of our presenters from the division. Really wonderful presentations that provided an overview with the right amount of depth into the interventions and strategies and the evidence that each of you in diabetes and asthma and high blood pressure are addressing. Thanks to you, Ann Albright, Judy Hannan and Elizabeth Herman.
I want now to move to what I think is certainly after the valuable presentations the richest part of the presentation which is the time for Q&A and dialogue. Before we close, we'll have an opportunity to hear from the President and CEO of Public Health Institute with closing remarks. In addition to John, to Gretchen and Laura, I want to make sure that our other division presenters and their colleagues have an opportunity to respond to some of the questions as well when we get them.
If I could ask John, Laura and Gretchen to take themselves off mute. I'll start with John and Laura. Either of you could take this question. I mean, certainly we've heard from listening to the presentations today the scope and the breadth and depth of 6/18, which is really impressive. There will be a lot of folks in the community across different sectors, healthcare, public health, as well as the collaborate ors and partners in the community will be biting at the chance to get involved. I know, however, that there are other federal initiatives. For example, Winnable Battles. Million Hearts has been mentioned today. There's SIM. Could one of you perhaps address how this differs from as well as aligns with the other initiatives, so people can understand where the connections are?
>> John Auerbach: Sure. These are all important initiatives that are supported by CDC. And we feel like they are in fact complementary. The distinct characteristic of 6/18 is that it is a program that is focused on making the case with providers, with payers and with purchasers that there are evidence-based prevention interventions that should be covered, promoted and used by patients. In order to address those populations with that goal, we have to pull the information that is available from those other he complementary initiatives and package them in a particular way that is of interest and relevant for this purpose.
But as I said at the beginning of my presentation, there are many different aspects of our work at CDC and in public health more broadly. What we are doing in 6/18 fits into a particular niche which has to do with insurance coverage and availability in clinical sites.
>> Matthew Marsom: Thank you. Another question that has come in from Sarah March, who is in the audience today, and perhaps Laura can address this. Questions are related to the preventive task force, mentioned earlier by one of speakers. How and where are the evidence based recommendations from the community preventive services task force in the 6/18 initiative, particularly problems such as tobacco, alcohol and she referenced specifically sugar. Is that something you can speak to, Laura?
>> Laura Seeff: Thanks, Matthew and thanks, Sarah. Excellent question. I'm going to take you back for a minute to the buckets. Again the 6/18 fits into the three bucket framework. Bucket one is traditional clinical prevention for services we deliver to individuals in a clinical setting. Bucket two extends care from the clinical setting into the community. And then bucket three are the true population health initiatives, some of which are the kind of things you are referring to. I would say community guided interventions tend to be two and three. In the Venn diagram, the 6/18 initiative is more

bucket one, bucket two. Some of our interventions are community guided interventions, for example, use of a home monitored blood pressure cuff. Some of those things delivered not to individuals but communities will be in this parallel initiative that we are assembling, this kind of bucket 3 initiative.
I will just add we have been pleasantly surprised how much insurers, payers, providers, are beginning to think about bucket 3. We focused on clinical and clinical into the community. I hope that answers the question.
>> Matthew Marsom: That's very helpful indeed. At the same time I know that there will be many in our audience as well as those who will be listening to the download of this who will have questions about other key issues like mental health or behavioral health. I wonder if I can ask the panel, John and Laura, to address perhaps why there isn't a specific initiative targeting those two issues?
>> John Auerbach: With 6/18 we started by approaching the subject matter experts at CDC and asking them to provide us with the interventions and approaches where there was already a very well established evidence base regarding impact on cost and health outcomes in a five-year time period or less.
And we recognized that there were many different interventions that were valuable, where there was a growing body of evidence of efficacy. But because we focused on looking for the programs that had, that met that criteria, a certain ones just weren't either available to us now or they were in process where people were gathering information, gathering the evidence and not quite ready for inclusion in the initial 6/18.
But our belief, as Laura mentioned, is that we will be adding additional interventions for those high burden conditions like behavioral health in the future, as we identify interventions that meet the criteria.
>> Gretchen Hammer: This is Gretchen. I would add, in Colorado we are making that connection between the clinical measures, our public health winnable battles, the task force recommends, CDC recommends and then Medicaid measures. We've crosswalked across all of the different target areas with the clinical measures in an attempt to really support our provider community to not have multiple interventions that they are trying to implement with slightly different measures or metrics or slightly different areas of focus.
So that includes, I raise the point because our SIM work in stick is related to the integration -- work -- when we move towards a more integrated delivery system within the healthcare side we will hopefully be able to address issues of depression, tobacco utilization, perhaps obesity and hypertension, because we will have an integrated care team working with the individuals within the clinical setting. We wanted to hold metrics that went across all of these areas. We believe through an integrated care approach we will be able to be more comprehensive in our approach to individuals in the public health space and the clinical delivery space.
>> Laura Seeff: Matthew, I wanted to really reinforce what you just said, Gretchen, that's fabulous and reinforce the response that John gave a while ago. 6/18 should layer over existing initiatives where opportunities allow so it doesn't look like it is not intended to be integrated. It is wonderful that it's happening already in Colorado.
>> Matthew Marsom: To that end just to be specific in terms of, I know that CMS is a critical partner with the centers for Medicare and Medicaid services. Could you talk about what dialogue you have had with them about 6/18? To what extent -- obviously,

Gretchen, you are a perfect example of the way that you are aware and integrated this. How is CMS being engaged as a partner federally and across the country?
>> John Auerbach: I'll start, I think Laura will probably add comments as well.
CDC and CMS have had an unprecedented partnership over the last few years. We work together on a daily basis sharing information and collaboratively planning. We have in particular paid attention to the areas of working on prevention and population health. In part because of the creation of the CMS innovation center which has a population health unit and the state innovation model grants.
So within those discussions with CMMI and CMS, we have had very strong support for the 6/18 Initiative and we have, in fact its development came through the input and participation of key people at CMS. We hope to continue to have that strong linkage in those various programs from the communication that goes out to state Medicaid programs to work with the Medicare program, to many of the innovative approaches in the innovation center. 6/18 will be a part of those.
>> Matthew Marsom: I want to go to another question that came in from our audience and a come of questions that came in. I want to reference specifically Tony Vilano. I'll paraphrase a couple together. We talked about the role of healthcare. We talked about the role of public health -- and we'll go deeper -- but I want to talk about community partners, in specific the role of business. I wonder if you can speak about the role for business leaders to play in 6/18 collaboration. The question that Tony had specifically, initiatives that support and promote healthy life styles. Gretchen, can you talk about a state example? But John and Laura, can you talk about how business leaders can get engaged as you roll this out?
>> Laura Seeff: Gretchen, do you want to start?
>> Gretchen Hammer: Sure. We have found that local community collaborations that either include their Chamber of Commerce or have a relationship with the local business community are often most successful. So many of the issues that we are talking about at their core are related to economic opportunity. People who are well are able to be productive members of the workforce in a community, to contribute to the civic infrastructure of a community. I think when we make the connection between these kinds of direct interventions and the overall health of a community, both from an economic and a physical health perspective, that we do better.
So in our experiences, those relationships are at the local level. And there are also opportunities for state chambers of commerce and others to be involved.
So I do think there's an opportunity from both a philosophical perspective to understand the relationship between well people and thriving communities, but also these very practical things that you've mentioned. The role that, for example, a local drugstore chain in some local communities that were known to be food deserts, when they were building a new drugstore, they added a fresh food section to that store. They tried for years to get a full-sized grocery store in that neighborhood. So the new local drugstore added a fresh food component. There are localized opportunities where local business can partner with healthcare collaboratives to figure out what the solution needs to be.
Another example, one of our local district hospitals did a community health and needs assessment. One of the issues, it was a rural community here in Colorado. There wasn't a clear place to exercise. So on the hospital campus, the local hospital district used their community benefit investments to build a, you know, 1.5-mile walking track

with some different exercise stations on the hospital facility because in a rural community that hospital was one of the local collaborating, sort of convening institutions.
So without question there are those opportunities both from a philosophical perspective as well as I think from a direct investment perspective.
>> Laura Seef: I guess that's fabulous. The other thing I would add is that businesses themselves are healthcare purchasers and payers. So more and more businesses are insuring their own employees. So that's another very tangible way they can engage and become providers. If you think of retail pharmacy as a business. That's another way we are reaching to businesses as purchasers, payers, providers, but I agree absolutely with Gretchen. John, I don't know if you want to add to that.
>> John Auerbach: Nothing to add.
>> Matthew Marsom: So one of the other questions that's come in from Christine, I'm scanning through the questions. My screen just updated and I'm scanning down. While doing that, a reminder to our audience on social media, the Twitter and elsewhere, that follow along with the conversation and #CDC6/18 Initiative. Here it is, the question is many of those listening today are engaged in health and all policies work. We are a public institute with our work with the State Department and others, many other agencies in California. But I'm wondering if you can speak to the way that perhaps 6/18 may work with other non-HHS agencies and departments such as HUD. Christine specifically calls out in light of the recent call for smoke-free housing. John and Laura, are you engaging with other federal agencies on 6/18?
>> John Auerbach: Again, what I would do is put 6/18 in the framework of a much larger response that we are making on population health and prevention. I think that the points that have just been made relate predominantly to what we refer to as bucket 3. Namely, working with other sectors to try to create those conditions in communities, workplaces, schools, et cetera, that promote health. CDC is actively working with those other departments on those initiatives. Those initiatives are complementary to 6/18. 6/18 fills a particular niche. That niche is working with the healthcare sector to get prevention coverage as part of the expansion of healthcare, insurance, and value-based contracting. It won't be doing everything, but it fills a particular niche which we believe if it's done in a complementary way, working at the community level and those larger initiatives will maximize the likelihood of a positive health outcome.
>> Matthew Marsom: I am not going to ask a question but make a comment from the audience. Tony raised an important point that speaks exactly to what you are addressing, the reference about transportation sector has a real opportunity to be engaged in 6/18 as it rolls out and particularly around bucket 3, to promote active transportation, busing, walking, buying over sedentary methods primarily the car. Thank you for that comment, Tony, which underscores the points raised today.
I will transition in a moment. We have about six minute left. I want to move to having some closing remarks. As we are doing so if we can bring up poll 4. I do want to make sure we hear from our audience about the way in which their experiencing collaboration across sectors. On the screen at the moment is the question: What is your level in the audience of experience collaborating across sectors? Public health partnering with purchasers, payers and providers to prevent let. No experience at all, somewhat experience or very experienced? If you can submit that to us, it would be very helpful.

I want to just take this moment, if I can, before moving to Dr. Mary Pittman to thank specifically the presenters and ask you, John, and Laura and Gretchen, each of you just for one quick minute each for your recommended next steps, closing remarks on what you think, before we move to Mary, what you want the audience to take away from today. What is the take home message, working at the local department, within a healthcare sector, health plan, hospital. What is the one message they want to hear? I'll start if I can with John, then to you, Laura, and Gretchen, before we move over to Mary.
>> John Auerbach: My message would be, this is a time of tremendous opportunity as a result of the expanded healths in options and healthcare reform. And that it's important that people who care about public health prevention and population health are taking advantage of those particular types of opportunities with regard to insurance coverage and healthcare availability.
As a complement to the wide range of different activities we should also be engaged in.
>> Matthew Marsom: Thank you, John Auerbach. Gretchen Hammer?
>> Gretchen Hammer: You know, I think would share that there are opportunities to work with payers. Whether that payer is your state Medicaid agency or whether that payer is a private purchaser in your community, there is shared alignment towards population health. And I think as a state agency, our mission is to improve the health of those that we serve and to be good stewards of the public resources that we have jurisdiction over. The partnerships described in 6/18 are the areas of work aligned directly with that duality of improving people's health and being a good steward of the resources so we can continue to serve individuals.
There is alignment. It is the hard work of sitting down and figuring out what can be implemented and for which populations would the implementation be most impactful for.
>> Matthew Marsom: And Laura Seeff, thank you.
>> Laura Seeff: My closing remarks would be that we develop this initiative both because it will help us improve the health condition and costs associated with the six conditions, but also as a very tangible approach to bring the clinical care sector closer to public health. We really recommend that each of you, regardless in what sector you are sitting in, each of you think about where you see yourself. Take it and run with it.
>> Matthew Marsom: Thanks so much to each of you. And I'm now going to move to Dr. Mary Pittman, the president and CEO of the Public Health Institute. Provide thoughts, as you listened to the discussion, Mary, what is striking you on 6/18, in closing remarks for our audience. Mary?
>> Mary Pittman: Thank you very much, Matthew. I want to start out by thanking CDC for the hard work they have put in to pulling together this evidence and sharing it with us today. I know I look back to when Secretary Burwell announced the fundamental transformation on how we pay and deliver care to move towards a more patient-centered system that would have quality and value at its center, I wondered how we could possibly move Medicare and the publicly funded programs quickly this way to a whole new way of thinking as well as financing.
I think what the 6/18 Initiative gives us is really some of the tools for the transformative change that is needed to make a whole new set of strategies and new sources of support and metrics so that we are able to be more accountable and to have the kind of

improvement that is needed to be able to achieve those goals that Secretary Burwell outlined.
As I see it, the CDC 6/18 Initiative it is a tangible structure for public health and healthcare to work together. It is something that we've heard over and over again when people talk about the ACA and the triple aim and population health. There has been a lot of confusion. Particularly I heard it from the healthcare sector saying we are willing to move this direction, but what are some of the tangible things we can do? Well, CDC has now provided a wonderful addition to the evidence around a set of high burden conditions that are preventible, scalable, and if implemented we should be able to see costs saved to the overall system.
I think it is likely that we will also see that there is an outcry from people who are seeing that they are getting their needs met in ways that they were hoping to have them met under the ACA. So I think that it is a win-win if we see much broader implementation using the 6/18 framework.
But why, I think you raised the question earlier. Why should people pay attention to this initiative when there are so many other initiatives out there? As mentioned by John and others, this is not a whole separate initiative. It is framing and it is taking many of the efforts to address preventible conditions across sectors that hospitals and health systems and public health can work on together and really can't achieve the goals that we want working alone.
Through the revised community benefit guidelines and the IRS 990 guidelines several years ago, we are fortunate that now communities have done much better assessments of their population health issues and where the greatest burden of disease is and health departments have also been doing increased assessments.
I would be surprised if most communities have not prioritized many, if not all of the six high burden conditions and are looking at many of the 18 interventions that have been put together in this initiative. And I think Gretchen mentioned, you know, for Colorado at a state level they prioritized two of them, tobacco control and unintended pregnancies.
What is exciting is that CDC has outlined and provided roles for each sector are in terms of how they can move ahead together working on these 18 interventions.
I have them up on the screen there. This is the slide that you saw earlier, but it went quickly. For those of you who want to take a look and maybe go through a checklist and see what you are already working on.
To me what is exciting is the opportunity to scale and spread these interventions, and at the state level there is a lot of innovation emerging through the CMS state innovation grants. CDC has been providing grants for state innovations as well. This is bringing together those two sectors, CMS and CDC have been working together. I think they have come up with a wonderfully concrete way to provide a roadmap for moving directionally towards more coordinated approaches that both states and at the local level can see implementation. As was mentioned earlier it is also an excellent way to apply health in all policy tools because many different departments and partners can join in to make these interventions come alive at the local and state level.
To me what is exciting is the leadership that CDC has shown. We are ready to help CDC and our own state here in California. We've developed a population health innovation lab. I think this provides a roadmap for the work that we are going to do. So

again, thanks to CDC for the wonderful webinar today and I'll turn it back to you, Matthew.
>> Matthew Marsom: Thank you, Dr. Mary Pittman, president and CEO of Public Health Institute. Those remarks really encapsulated the discussion today. I want to thank again our presenters and speakers, John Auerbach, the associate director for polity at the Centers for Disease Control and Prevention; Gretchen Hammer, the Medicaid director with the health programs office at the State of Colorado; and Dr. Laura Seeff, the Director of the Office of Health Systems Collaboration at CDC. Thank you to all of you as well as your colleagues at the CDC Divisions: Diabetes, Ms. Ann Albright; we heard about asthma practice from Dr. Elizabeth Herman and Judy Hannan spoke about hypertension.
I also want to thank Lisa Romero, Steve Babb and Elizabeth Mothershed for their leadership on the other three conditions, although they didn't speak today.
Thanks also to Jocelyn Wheaton, Erin Malone, Joanna Hathaway and Star Tiffany. And I want to thank the Public Health Institute for sponsoring the Dialogue4Health webinar. We will make sure that the audio and the slides are available to you on the 6/18 landing page on the CDC site. This has been another Dialogue4Health web forum. I'm Matthew Marsom, Vice-president for Public Policy and Program at Public Health Institute. And we'll see you on the next D4H forum. Thank you so much and have a good day.
(The webinar concluded at 4:35 p.m. EST.)
(CART provider signing off.)