

PHSSR Research-In-Progress Series:

Bridging Health and Health Care

Wednesday, December 10, 2014 at 12noon -1pm EDT

Integrating Public Health and Healthcare: Lessons from One Urban County

Conference Phone: 877-394-0659

Conference Code: 775 483 8037#

Please remember to mute your computer speakers during the presentation

PHSSR NATIONAL COORDINATING CENTER AT THE UNIVERSITY OF KENTUCKY COLLEGE OF PUBLIC HEALTH

Agenda

Welcome: Rick Ingram, DrPH, National Coordinating Center

Presenter:

Integrating Public Health and Healthcare: Lessons from One Urban County

Erik L. Carlton, DrPH, Health Systems Management and Policy, The University of Memphis School of Public Health

Commentary:

Paul C. Erwin, MD, DrPH, Public Health, University of Tennessee – Knoxville

Crystal Miller, MPH, Public Health Director, Wedco District Health, Kentucky

Questions and Discussion

Future Webinars and Announcements

Presenter



Erik L. Carlton, DrPH

Assistant Professor

Health Systems Management and
Policy

The University of Memphis School of
Public Health

Integrating Public Health
and Healthcare:
Lessons from One Urban County

Erik L. Carlton, DrPH, MS
The University of Memphis

Presenter Disclosures

- The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

No Disclosures

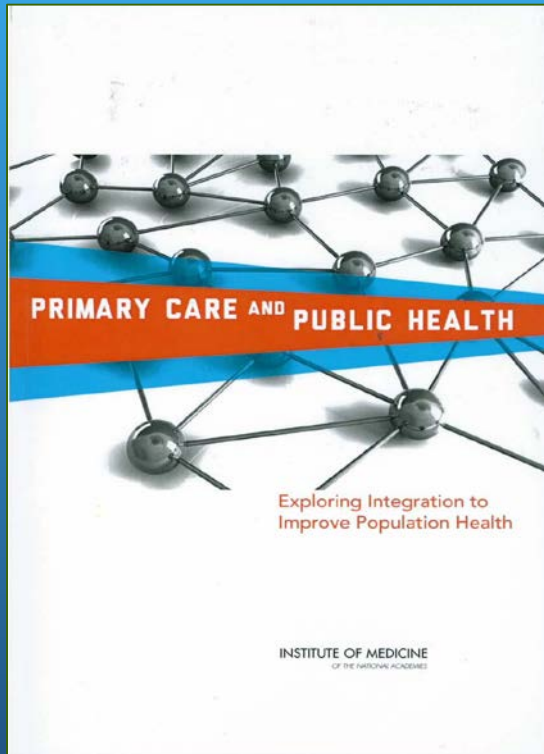
Acknowledgments

- Study funded by Robert Wood Johnson Foundation and the National Coordinating Center for Public Health Systems & Services Research
- Additional support provided by The University of Memphis School of Public Health
- Dr. Paul Erwin, Univ. of Tennessee - Knoxville, provided keen mentorship throughout this study

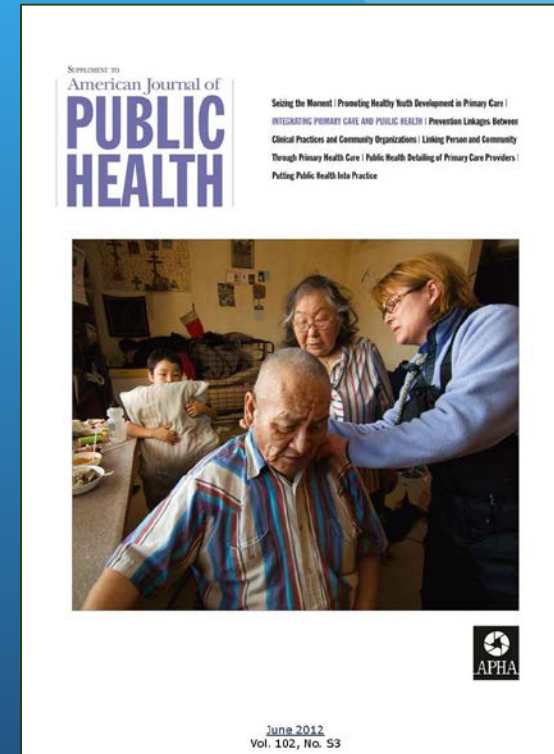
“A major deterrent to our efforts to fashion health care that is efficient, effective, comprehensive, and personalized is our lack of a design for the synergistic interrelationship of all who can contribute...”

Source: Institute of Medicine (1972). Educating for the Health Team. Washington, DC: IOM.

Focus on Integration



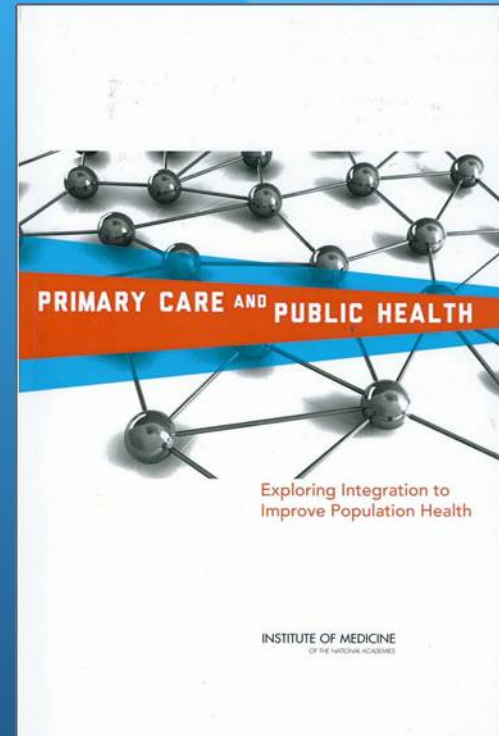
*National Academy of Sciences (2012).
Primary Care and Public Health:
Exploring Integration to Improve Population Health.
Washington, DC: NAP.*



*American Journal of Public Health
vol. 102 (s3), June 2012
Integrating Primary Care & Public Health*

IoM Report: Pub. Hx & Pri. Care

- Integration Principles
 - Shared Goal of Pop. Hx
 - Community Engagement
 - Aligned Leadership
 - Sustainability
 - Data Sharing/Analysis



Source: National Academy of Sciences (2012). Primary Care and Public Health: Exploring Integration to Improve Population Health. Washington, DC: NAP.

Defining Integration

- “The linkage of programs and activities to promote overall efficiency and effectiveness and achieve gains in population health.”

Types of Integration

Levels

- National
- State
- Local

Partners

- Specific to Level

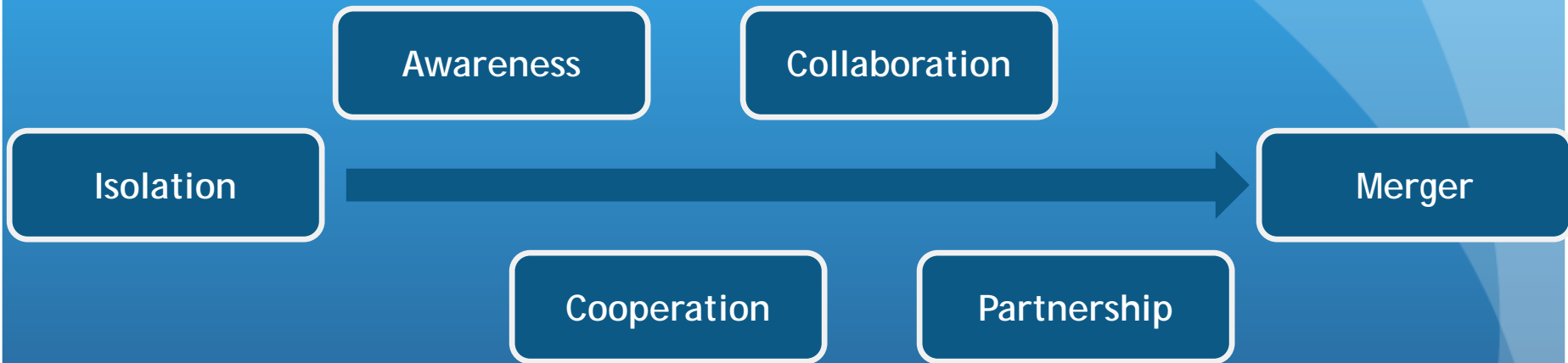
Actions

- Programs
- Activities

Degree

- From Isolation to Merger

Degrees of Integration



Source: National Academy of Sciences (2012). Primary Care and Public Health: Exploring Integration to Improve Population Health. Washington, DC: NAP.

Failing to Connect

Healthcare

- Fragmentation
- Duplication
- Practice variability
- Limited access
- Episodic & reactive care
- Insensitivity to consumer values & preferences
- Limited targeting of resources to community needs

Public Health

- Fragmentation
- Constrained resources
- Practice variability
- Limited reach
- Insufficient scale
- Limited public visibility & understanding
- Limited evidence base
- Slow to innovate & adapt



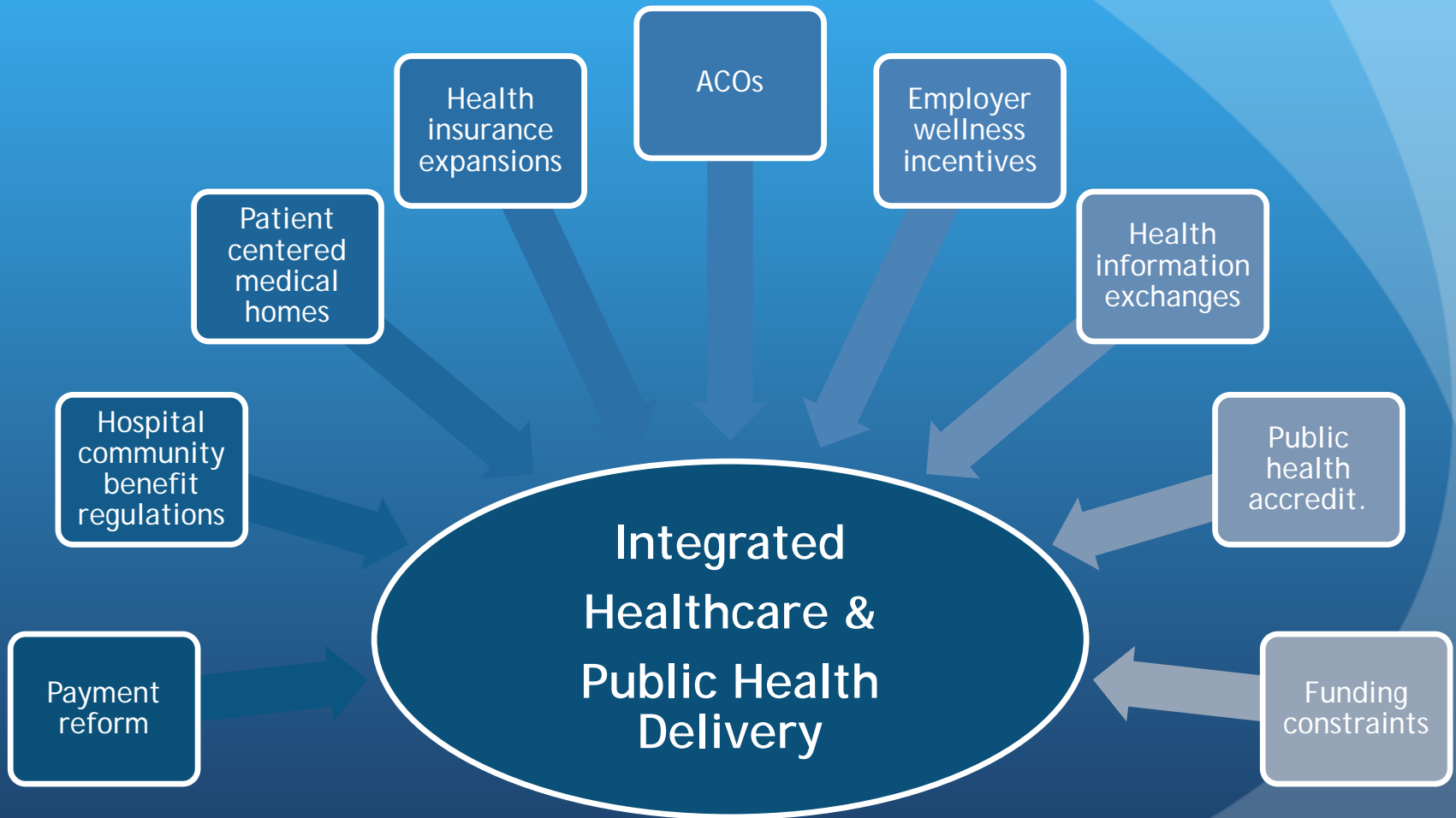
Inefficient Delivery

Inequitable Outcomes

Limited Population Health Impact



Bridging the Gap: Why Now?



Note: This slide adapted from Dr. Glen Mays, University of Kentucky

Research Question

- What conditions and strategies facilitate productive interorganizational relationships and patterns of interaction among healthcare/primary care and public health organizations?

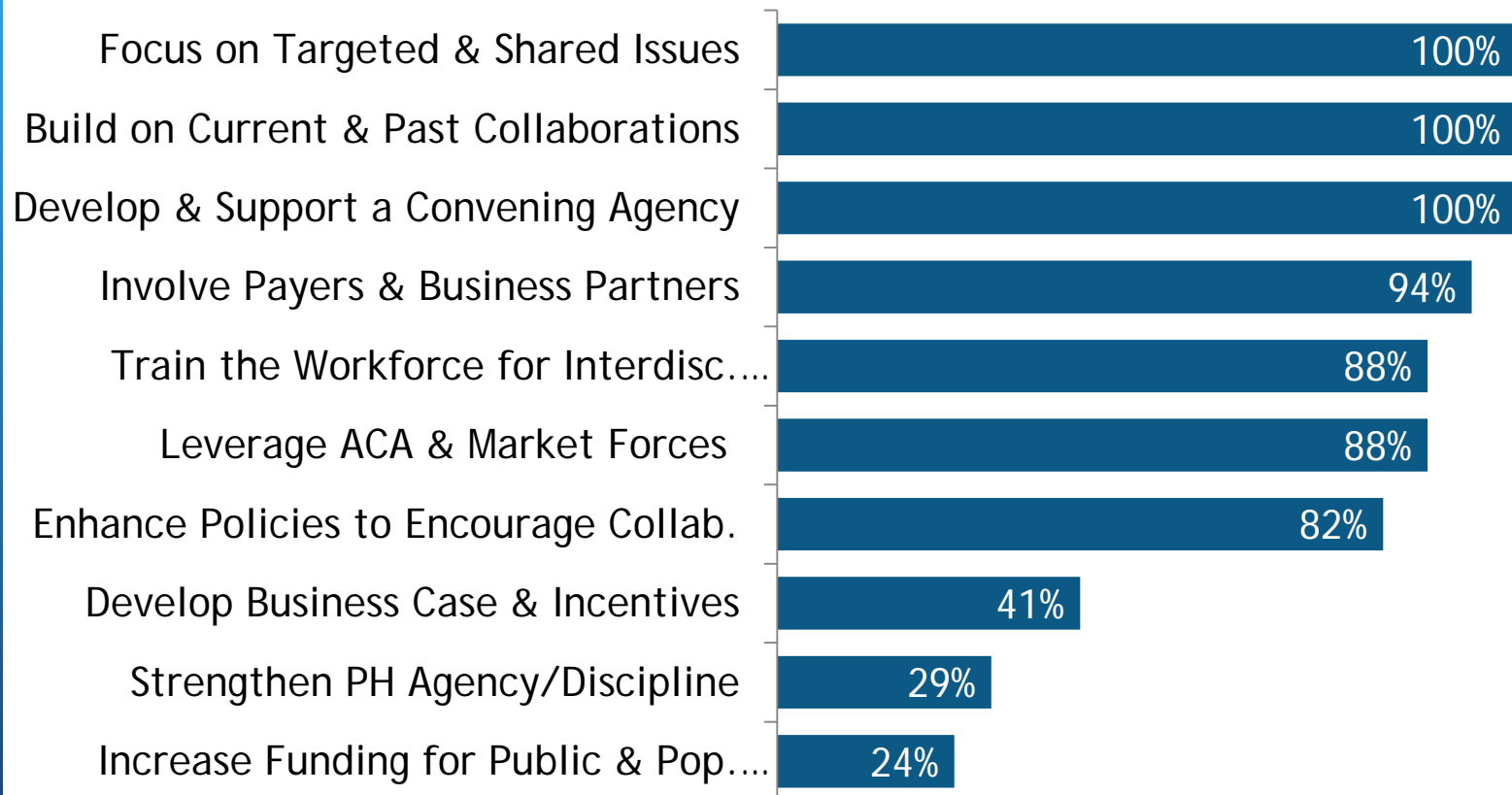
Methods

- Semi-Structured Key Informant Interviews with a Modified Snowball Sampling Procedure
- Sample
 - Hospital, health department, and health-oriented community non-profit executives (n=17)
 - One urban county
- Analysis
 - Code-Recode Procedure
 - Reflexive Field Journal
 - Member Checking

Results

Demographic	N (%)
<i>Gender</i>	
Male	9 (53%)
Female	8 (47%)
<i>Race/Ethnicity</i>	
Black/African-American	4 (24%)
White/Caucasian	13 (76%)
<i>Primary Job Title/Position</i>	
Hospital/Health Center CEO	5 (29%)
Hospital/Health Center Pres./Other C-Suite	6 (35%)
Health Department Executive	1 (6%)
Non-Profit Executive	4 (24%)
Other/Govt.	1 (6%)

Results - Themes



% of participants indicating barriers/facilitators. 10 most frequent themes shown.

Results

- Key Themes
 - Finding safe, shared, & targeted issues to tackle together
 - Building on current/past successes
 - Role of payers/business
 - Workforce training
 - ACA/policies & market forces as key drivers
 - Strong convening agency

Safe, Shared, & Targeted Issues

- More bridges between systems
- Finding the common denominators
- Leveraging shared poor performance

“Why are we competing on this? No one is doing a particularly stellar job.”

(Non-profit collaborative director re: rational for hypertension collaborative)

Safe, Shared, & Targeted Issues

“We need to get beyond who has the better billboard. We can compete on the clinical determinants of health and collaborate on the non-clinical determinants.”

(former CEO/board chair)

Role of Business/Payers

- Engaging business community and payers is critical
- Larger, non-health market voice
- Fundamental incentive for improvement/change

“We need a broader definition of who’s involved in changing health. Healthcare is the smallest percentage of those with influence. What about education? What about business and economic development? We need to get out of silos and have a whole cadre of people who care.”

(convener of health-concerned businesses)

Workforce Training

- Silo'd educational model creates different languages, values, perspectives

"We're simply not trained to work across the divide...Public health needs to quit talking to itself. Healthcare needs to quit talking to itself. Our successes are when we start talking to others. We need to speak in a language the other understands."

(former state health commissioner)

Policies & Market Forces

- Role of incentives and disincentives in driving private sector collaboration?
- New/enhances policies (with teeth...)?
- Competition breeds dissent and slows process
- Need investment in population health
 - “A substantial pool of investment beyond traditional governmental public health.”
- Making room for innovation in healthcare and public health services delivery

Role of the Convener

- Role of School of Public Health?
- Potential for a public/population health institute
- Existing health-oriented groups
 - Business Group on Health
 - Aligning Forces for Quality project
 - IHI Triple Aim project
 - County Mayor's initiative(s)

Role of the Convener

- Role of Health Department?

“The Health Department has statutory responsibilities that transcend economics and other factors. For others, it’s their choice to make a difference.”

(health department executive)

Limitations

- Small sample size (n=17)
- Focus on one urban county
 - Generalizability of findings?

Implications for PH Leaders

- Understand how prevention and population healthcare fit with and enhance healthcare corporate strategy
- Understand incentives/disincentives to encourage hospital/healthcare participation in population health issues
- Leverage community benefit activities to truly benefit the community
- Encourage collaborate where there is no competitive advantage

Implications for PH Leaders

- Enhance training and workforce development activities with shared language of and skills in population health
- Build on existing and past successes
- Target issues with shared potential to gain small wins
 - Shared goal of population health starts with a shared goal for one health outcome
- **DON'T WAIT TO LEAD!!!**

Some Final Perspective

“At some level, we have both a moral and an economic imperative to change how the system works: An *economic imperative* to save money, reduce costs and waste.; and a *moral imperative* to both save lives and improve health...

“Those with a *democratic imperative* for a given population must own it.”

- *From one hospital president*

Contact Information

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Thank You!

Commentary



Paul C. Erwin MD, DrPH

Professor and Director, Department of Public Health

University of Tennessee – Knoxville



Crystal Miller, MPH

Public Health Director

Wedco District Health Department, Kentucky

Questions and Discussion

2015 PHSSR Keeneland Conference

April 20-22, 2015



Call for Abstracts

**Deadline: December 10, 2014
by 11:59 pm ET**

Go to:

www.keenelandconference.org

Also see:

www.publichealthsystems.org

Future Webinars – PHSSR Research in Progress

All webinars from 12-1 pm, ET

2015: Save the Dates!

January 7:

Impacts of the Affordable Care Act on State & Local Public Health

**Michael Meit, MA, MPH, Program Area Director,
Public Health Research Department, NORC at the University of Chicago**

January 14 (Wednesday)

January 22 (Thursday)

February 4 and 11 (Wednesdays)

February 19 (Thursday)

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