# AcademyHealth ARM Panel Submission 2016

Session Title:
Exploring Local Public Health and Primary Care Collaboration: A Practice-Based Approach
Session Description:
The Institute of Medicine makes a compelling case that increased integration of primary care and public health is crucial to population health, and the Affordable Care Act provides incentives and expectations for such integration. Yet currently there is no consensus on terminology, definitions or measures of integration between these two largely separate systems of care. In the face of new incentives and pressures to increase quality, contain costs and improve outcomes, action is needed to advance a common understanding of primary care and public health integration among practitioners and researchers in both fields. Practice-based research networks from primary care and public health in four states, Minnesota, Colorado, Washington and Wisconsin, have come together to conduct a mixed-methods study of integration at the local jurisdictional level. Research questions include: How does the degree of integration between PC and PH vary across local jurisdictions? What factors facilitate or inhibit integration, and how can PC and PH leverage those factors to increase integration? Does the degree of integration differ based on health topic? Do areas of greater integration have better health outcomes? This research panel presents qualitative and quantitative results from this three-year study, which is in its final year. Study results give voice to what is needed to advance integration at the local level; promote infrastructure and capacity needed for integration; developed measures to monitor integration over time; and suggest ways to build stronger cross-sectoral research relationships to increase future collaboration.
Type:
Oral

**Abstract ID# 10337:** Developing a Model of Primary Care-Public Health Integration: A Mixed Methods Approach
**Speaker: Rebekah Pratt, PhD**, University of Minnesota, Minneapolis, MN
**Research Objective:**

While little is known about how to measure local primary care and public health integration, the literature has long called for such integration to promote population health. The 2012 Institute of Medicine report makes a compelling case that such integration—and research on integration—is of paramount importance. To begin addressing this topic, this study posed these questions: what are the key factors for integration from both primary care and public health perspectives? How can we best characterize local jurisdictions in terms of their degree of integration? Ultimately, this study has developed an emerging, multi-dimensional model of integration.

**Study Design:**

Qualitative and quantitative methods were used to identify key factors for integration, as well as to classify those factors into a framework. Key informant interviews informed and enhanced an online, quantitative survey administered to public health and primary care respondents in Spring, 2015. Qualitative results were analyzed using a thematic analysis approach, NVivo software. Frequency distributions were calculated for quantitative survey results using SAS 9.1.

**Population Studied:**

Public health and primary care leaders were identified for all 241 local health jurisdictions in four states: Minnesota, Colorado, Washington and Wisconsin. Forty paired key informant telephone interviews (representing ten matched leaders from five different jurisdictions in each state) were conducted using a standard protocol. Eighty percent of all local health directors across participating states completed an on-line survey (n=193). A parallel survey was administered to one or more primary care leaders in all jurisdictions. The 31% primary care response rate (n=128) represents 50% of jurisdictions studied.

**Principle Findings:**

Several key factors emerged as being necessary for successful integration and collaboration between primary care and public health. These factors sorted into Foundational and Energizing characteristics. Foundational aspects include features such as aligned leadership, communication, shared valued and mutual awareness. These foundational aspects contribute to the extent of integration through facilitating sustainable processes for working together. Energizing characteristics, in contrast, are somewhat more dynamic and action orientated, such as shared strategic planning, data sharing, innovation and exploring opportunity.

**Conclusion:**

The proposed multi-dimensional model offers new ways to build on and further the work of the Institute of Medicine continuum. This has potential to guide development of strategies to support effective integration of public health and primary care, particularly in areas identified as shared priorities, such as mental health and addressing the social determinants of health.

**Implications for Policy or Practice:**

Conceptualizing local public health and primary care integration as a multi-dimensional framework provides key opportunities to target recommendations and action steps.

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**Abstract ID# 10331:** Local Variation in Primary Care-Public Health Integration: A Practice-Based Research Approach
**Speaker: Betty Bekemeier, PhD, MPH, FAAN**, University of Washington, Seattle, WA
**Research Objective:** Although local and state health departments have long been key actors in promoting health and reducing disparities, the efforts and services of public health systems are increasingly viewed within the context of inter-sector partners that share accountability for population health. To our knowledge, few published studies have examined the degree of integration from both primary care and public health perspectives, and linkages between local integration, service delivery, and health outcomes. This study examined the question: how does integration vary across local jurisdictions and are there factors associated with such variation?

**Study Design:** We developed and fielded a 38-item, quantitative online survey in Spring 2015 to measure collaboration factors from both primary care and public health perspectives at the local level. The relative contributions of “foundational” and “energizing” principles were used to calculate collaboration scores for each jurisdiction. Scores were then used to classify jurisdictions within the multi-dimensional model of integration. Descriptive statistics were generated for all survey variables. Regression models are in process to examine potential associations between the distribution of jurisdictions across the integration framework and selected health indicators, including jurisdiction-level rates of childhood immunization, smoking, and youth and adult physical activity.

**Population Studied:** Local health directors and primary care leaders from the 241 local health department geographic jurisdictions in four study states received survey invitations.193 public health respondents completing the online survey (80%). Primary care respondents were oversampled to increase the overall response rate, resulting in 128 primary care responses (31% overall response rate, 50% jurisdiction-specific response rate).

**Principal Findings:** Both primary care and public health respondents generally agreed that foundational principles – such as mutual trust and respect, shared mission/vision, and basic communication -- were present in current cross-sector working relationships within their jurisdictions. Respondents from each sector were less likely to agree that current relationships feature factors promoting sustainability (e.g.,

financial and staffing capability), clearly defined roles/responsibilities, or innovation. Overall, public health respondents were more likely to report highest levels of working together. Public health respondents were slightly more satisfied with the working relationship (59% vs. 56%) and tended to report more ways in which they currently work with primary care.

**Conclusions:** Both sectors value working together, but remain unclear regarding next steps toward building those relationships. Public health appears more likely to report a stronger working relationship and higher levels of satisfaction perhaps because they are more traditionally grounded in community outreach and coalition-building. Identifying shared priorities could be critical to helping primary care see value in public health's contribution.

**Implications for Policy or Practice:** Opportunities exist to build on the growing recognition that primary care and public health should jointly engage efforts toward health equity. Yet this will require a mindset change, particularly for primary care, and concrete demonstrations of the value of public health to primary care, such as demonstrating that integration can reduce workload, affect social determinants that impact health, and benefit individual health.

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**Abstract ID# 10229:** Barriers to Public Health and Primary Care Integration: Taking Action to Support Collaboration

**Speaker: Susan Zahner, DrPH, RN**, University of Wisconsin-Madison, Madison, WI

**Research Objective:** With the age of the Affordable Care Act and health reform, there is growing pressure on public health and primary care to identify ways in which they can collaborate and increase the efficiency and effectiveness of service delivery and population health promotion. Yet, even with the best of intentions, serious barriers still exist to such integration. This study sought to identify which barriers are most problematic, from both a public health and primary are perspective? And how might local public health and primary care entities take action to promote their level of integration and overcome such barriers, while grounded in a practice-based perspective?

**Study Design:** Qualitative and quantitative methods were used to identify key barriers to integration. Key informant interviews and an online, quantitative survey were administered to public health and primary care respondents. Qualitative results were analyzed using a thematic analysis approach, NVivo software.

**Population Studied:** Local health directors and primary care clinic directors from local jurisdictions across four states participated in key informant interviews and an online, quantitative survey. Twenty key informant pairs (one primary care, one public health), for a total of 40 key informants, participated in the interviews.

**Principal Findings:** A wide range of barriers that may challenge integration were identified by participants. Limited resources and lack of capacity were identified as key barriers, however other barriers emerged which may be more easily addressed by partners as they develop working relationships. These barriers include challenges really understanding each other's discipline and approach, communication, ways to engage in data sharing and different priorities.

**Conclusions:** Drawing on our earlier work, it is clear that key foundational characteristics need to be developed and nurtured in order to address some of the common barriers, particularly in relation to understanding each partner's perspective and contribution in partnerships. Additionally, coming together to engage in energizing characteristics, such as engaging processes to develop data driven processes to establish shared priorities, could offer concrete strategies towards addressing common barriers.

**Implications for Policy or Practice:** Linking suggested action items to jurisdictional placement on the multi-dimensional framework of integration is an important next step for local public health and primary care to work on improving their level of collaboration. Energizing activities may lack sustainability without

the support of Foundational characteristics, and likewise, Foundational characteristics that are absent Energizing characteristics may fall short of their potential. Developing a more nuanced understanding of the assets and barriers facing partnerships based on this multi-dimensional model may help support more targeted development of partnerships.

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Chair
Beth Gyllstrom, PhD, MPH

Discussant
Kim Gearin, PhD

# Public Health-Primary Care Collaboration Study

AcademyHealth Annual Research Meeting

June 27, 2016

MDH Minnesota Department *of* Health

HEALTH PARTNERSHIPS DIVISION

Minnesota Public Health
RESEARCH TO ACTION NETWORK
*Conducting Research. Making Change. Improving Health.*

# Acknowledgements

Robert Wood Johnson Foundation

The Minnesota Department of Health is a grantee of *Public Health Services and Systems Research* (PHSSR), a national program of the Robert Wood Johnson Foundation.

This research would not be possible without the local PH directors and local clinic medical directors & staff who participated in the interviews & surveys, as well as all who participate on their practice-based research networks and have provided guidance on the implementation of this study.

MDH Minnesota Department *of* Health
HEALTH PARTNERSHIPS DIVISION

Minnesota Public Health
RESEARCH TO ACTION NETWORK

# Practice-Based Research

PH/PC practice leaders + Academic researchers =

PUBLIC HEALTH Practice-Based Research Networks

PRACTICE-BASED RESEARCH NETWORKS
Research in Everyday Practice

Practice-based research networks (PBRNs) study the effectiveness, efficiency & equity of public health and health care strategies in real-world practice settings.

# Public Health-Primary Care Collaboration Study

- Research partnership between public health and primary care practice-based research networks in four states:

  --Minnesota
  --Colorado
  --Washington
  --Wisconsin

- Three year, mixed-methods study, began in fall 2013

Minnesota Public Health
RESEARCH TO ACTION NETWORK
*Conducting Research. Making Change. Improving Health.*

# Minnesota

Beth Gyllstrom, PhD, MPH, Principle Investigator,
Minnesota Department of Health
**Rebekah Pratt, PhD, Co-Principle Investigator**,
University of Minnesota
**Kim Gearin, PhD, MS, Co-Investigator, MDH**
Carol Lange, MPH, Co-Investigator, UMN
Kevin Peterson, MD, Co-Investigator, UMN

## Washington

**Betty Bekemeier, PhD, MPH, MSN, RN**
University of WA

Laura-Mae Baldwin, MD, MPH
University of WA

WPRN
Collaborative Research. Innovative Care.
WWAMI region Practice and Research Network
ITHS

## Colorado

Lisa Van Raemdonck, MPH
CO Association of Local Public Health Officials

The Public Health ALLIANCE of Colorado

Don Nease, MD
University of CO-Denver

SNOCAP
State Networks of Colorado Ambulatory Practices & Partners

## Wisconsin

**Susan Zahner, DrPH, RN**
Tracy Mrochek, MPH
University of WI-Madison

WPHRN
Wisconsin Public Health Research Network
*Improving Public Health Practice Through Research*

David Hahn, MD, MS
University of WI-Madison

Wisconsin Research & Education Network

# Research Questions

- How does the degree of integration between PC and PH vary across local jurisdictions?
- What factors facilitate or inhibit integration, and how can PC and PH leverage those factors to increase integration?
- Does the degree of integration differ based on health topic?
- Do areas of greater integration have better health outcomes?

# Study Design & Timeline

The study combines existing health data with new data collected through telephone interviews, an on-line survey, and focus groups.

February-May 2014: Conduct key informant interviews
April-July 2014: Qualitative analysis, present early findings
July-December 2014: Qualitative results dissemination; Online survey development & testing
Early 2015: Field online survey (REDCap)
2015: Quantitative analysis, mixed methods analysis
→ **2016:** Translation and dissemination activities

Paul A. Harris, Robert Taylor, Robert Thielke, Jonathon Payne, Nathaniel Gonzalez, Jose G. Conde, Research electronic data capture (REDCap) - A metadata-driven methodology and workflow process for providing translational research informatics support, J Biomed Inform. 2009 Apr;42(2):377-81.

# Mixed Methods Approach

## Qualitative Component

- In early 2014, each state conducted at least 5 pairs of key informant interviews that engaged a public health director and primary care representative from the same jurisdiction. 40 interviews analyzed in total; 10 in each state
- Qualitative results were used to answer research questions, as well as to develop the quantitative surveys.

## Quantitative Component

- Local health directors identified for all local jurisdictions across the four participating states.
- 2-3 primary care respondents identified for each local health department jurisdiction
- Online survey (complementary public health and primary care versions) fielded throughout early 2015 using REDCap

# Survey Results

- Public Health= 80% (n=193)
- Primary Care=31% overall (n=128)
  50% jurisdiction-specific*
- Paired PC-PH Responses=71 jurisdictions (29%)
- Included a range of different health department and primary care clinic structures, jurisdictions of different population sizes, % poverty and % self-insured.

*Primary care survey oversampled jurisdictions to increase overall jurisdiction-specific response rates

# Panel Structure

- Developing a Model of Primary Care-Public Health Integration, Dr. Rebekah Pratt
- Local Variation in Primary Care-Public Health Integration: A Practice-Based Approach, Dr. Betty Bekemeier
- Barriers to Public Health and Primary Care Integration: Taking Action to Support Collaboration, Dr. Susan Zahner
- Discussant:  Dr. Kim Gearin

# For More Information

- Minnesota Research to Action Network: www.health.state.mn.us/ran
- Research Findings: Search for: Measuring Variation in the Integration of Primary Care and Public Health: A Multi-State PBRN Study of Local Integration and Health Outcomes

# Developing a Model of Primary Care-Public Health Integration: A Mixed Methods Approach

Dr. Rebekah Pratt

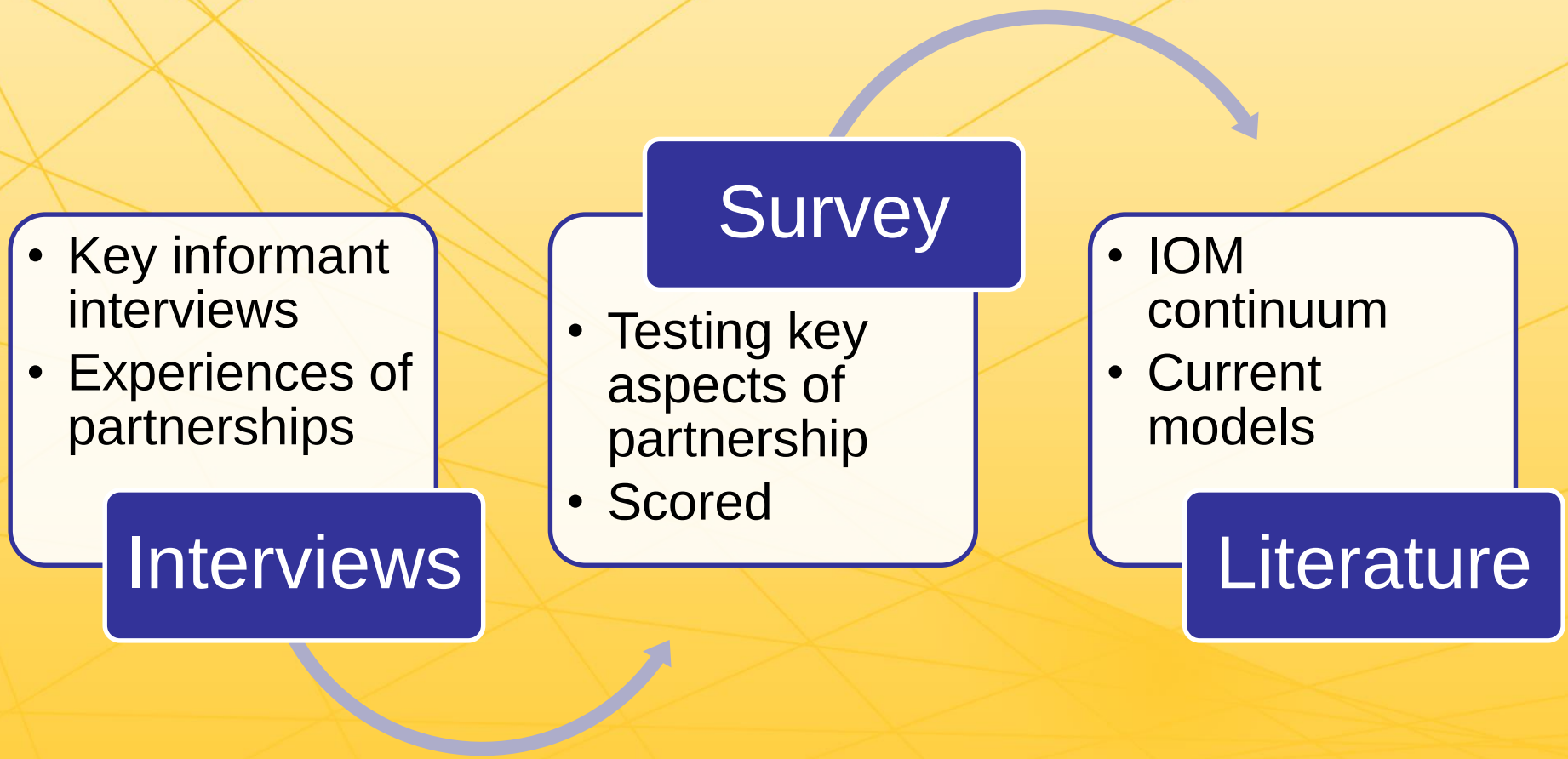
AcademyHealth Annual Research Meeting

June 27, 2016

UNIVERSITY OF MINNESOTA

# Research Objectives

- What are the key factors for integration from both primary care and public health perspectives?
- How can we best characterized local jurisdictions in terms of their degree of integration?


Interviews
• Key informant interviews
• Experiences of partnerships
Survey
• Testing key aspects of partnership
• Scored
Literature
• IOM continuum
• Current models

# QUALITATIVE FINDINGS

# Foundational Aspects

- Communication
- Leadership
  - *We have 5 local public health agencies that have come together around community health improvement. And at that table then we have people from the hospitals and the health plans as well as public health. And so if we agree on something at that level, there may be an opportunity to, through the system itself to go back down and influence the clinical site. (Minnesota Public Health)*

- Formal Processes
- Mutual Awareness
  - *I think one of the things would be education on both sides of what the other has to offer. You know, because if you don't know what they have available or what their knowledge base is or how we could access them, it probably wouldn't be at the top of our radar screen to say oh, gosh. We should talk about this. (Wisconsin Primary Care*

- Shared Values
- History of Relationship
  - *So the relationship built provided a solid foundation to take on various projects in a way that can be a win-win and so it's so much, it's like so much of the work we do, based on building relationships so that as initiatives emerge, we have, you know, the relationship built to be able to call and talk through what that may mean to each entity. (Minnesota Public Health)*

# Energizing Aspects

- Shared strategic vision
- Shared data
  - *Physicians are scientists. They look at the data. And then they have some good ideas on what might work to change it from the point of view of having seen these patients every day. So I think there's a logic associated with the work that we're trying to do and I think the statistics that public health is able to bring forward, you know, is validated at the primary care experience level, and then it's a matter of what can we do, how can we work together and how can we affect change. (Washington Public Health)*

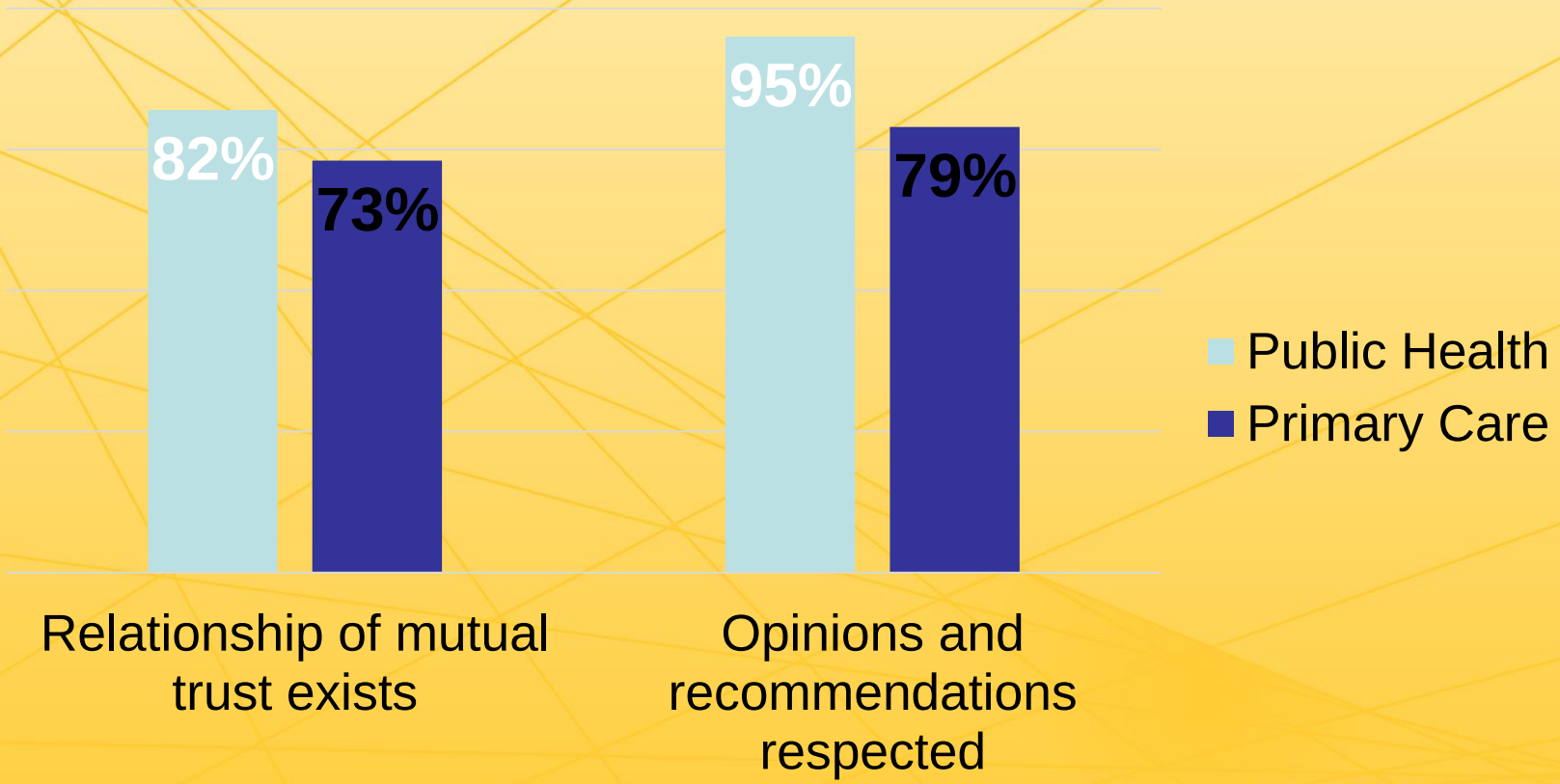
- Shifting cultures in PC and PH
- Opportunity
  - *During the H1N1 pandemic we were having sometimes daily, weekly meetings with the health care community and that was really a good example for us because we really did come together as a community. You know it had a lot going on at the State level as well, but our doctors wanted to sit down with our emergency management in public health and really talk about what's going on in (our) County and how are we going to manage it. (Colorado Public Health)*

# What did we learn?

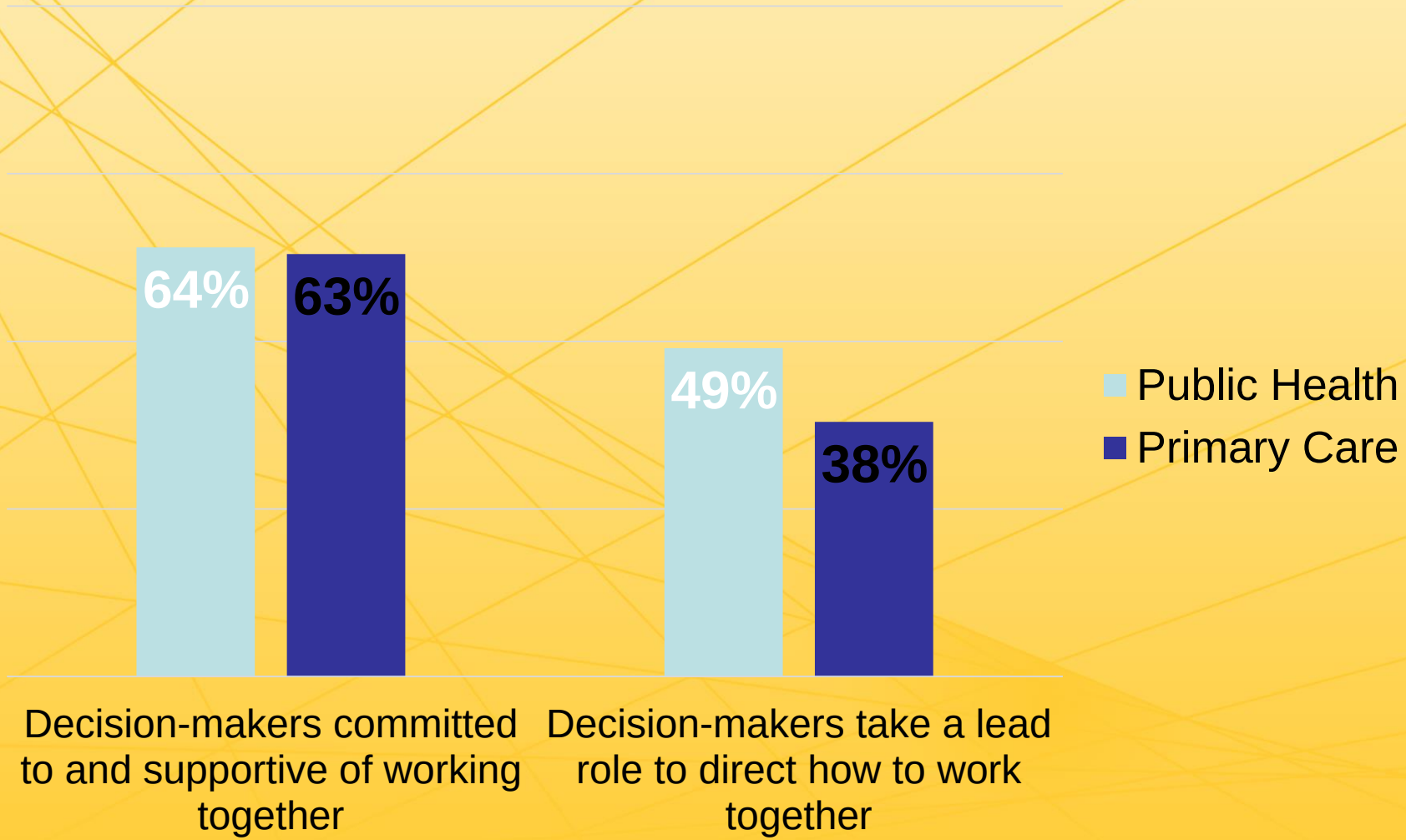
- Some aspects of partnership build and maintain **foundations**
- Some **activities** raise energy and action.

# SURVEY FINDINGS

# Mutual Trust and Respect

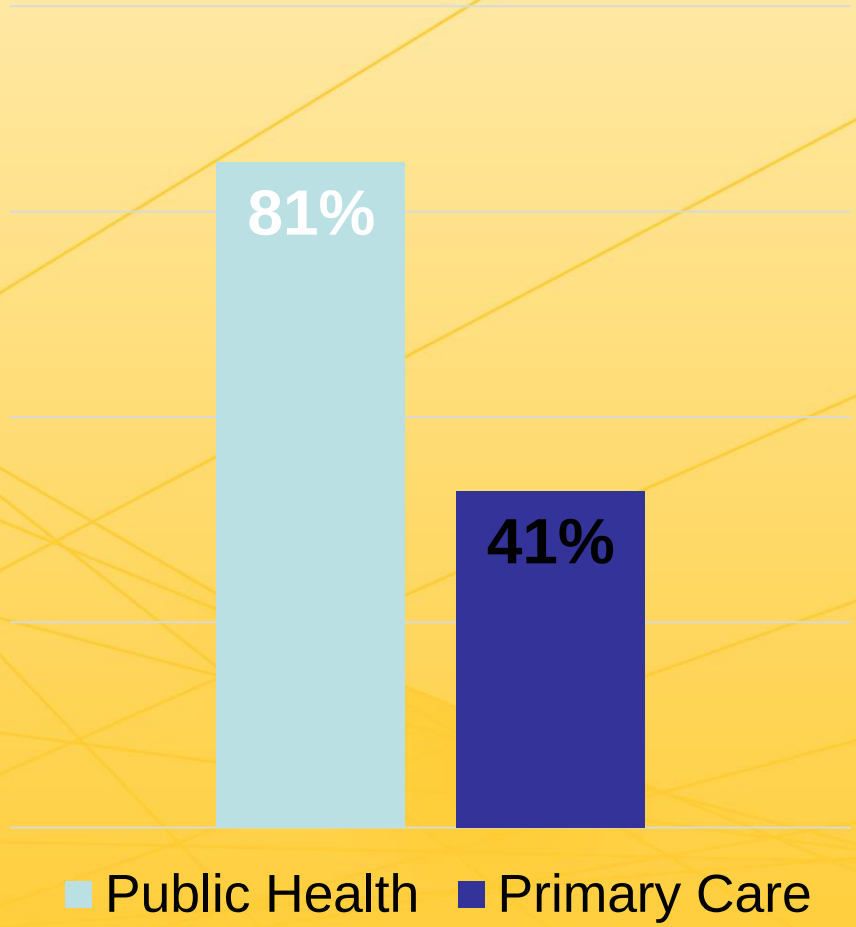


# Leadership Support

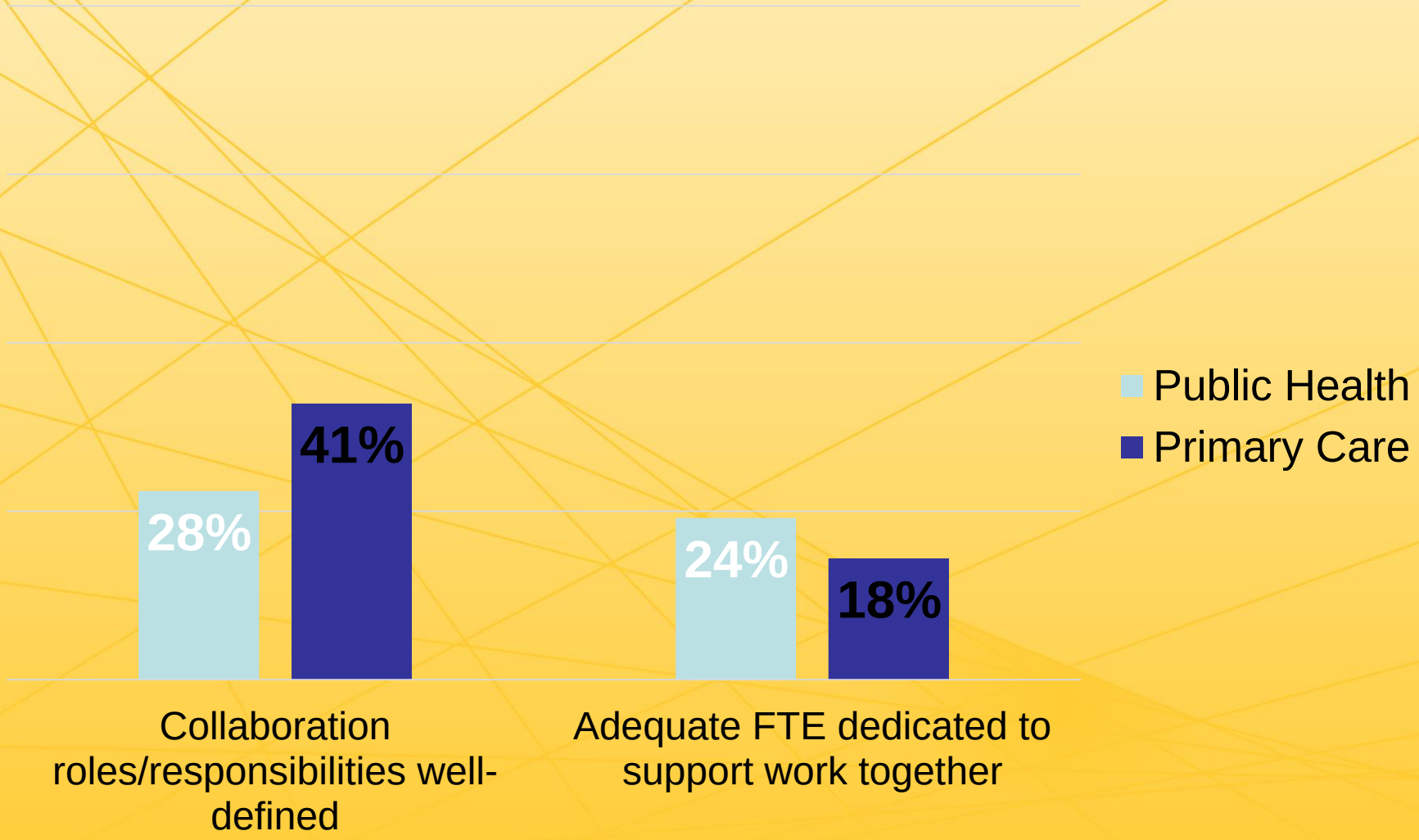


# Relationship-Building

Public health more likely to report that staff are knowledgeable about how to build and support the working relationship—higher capacity in this area

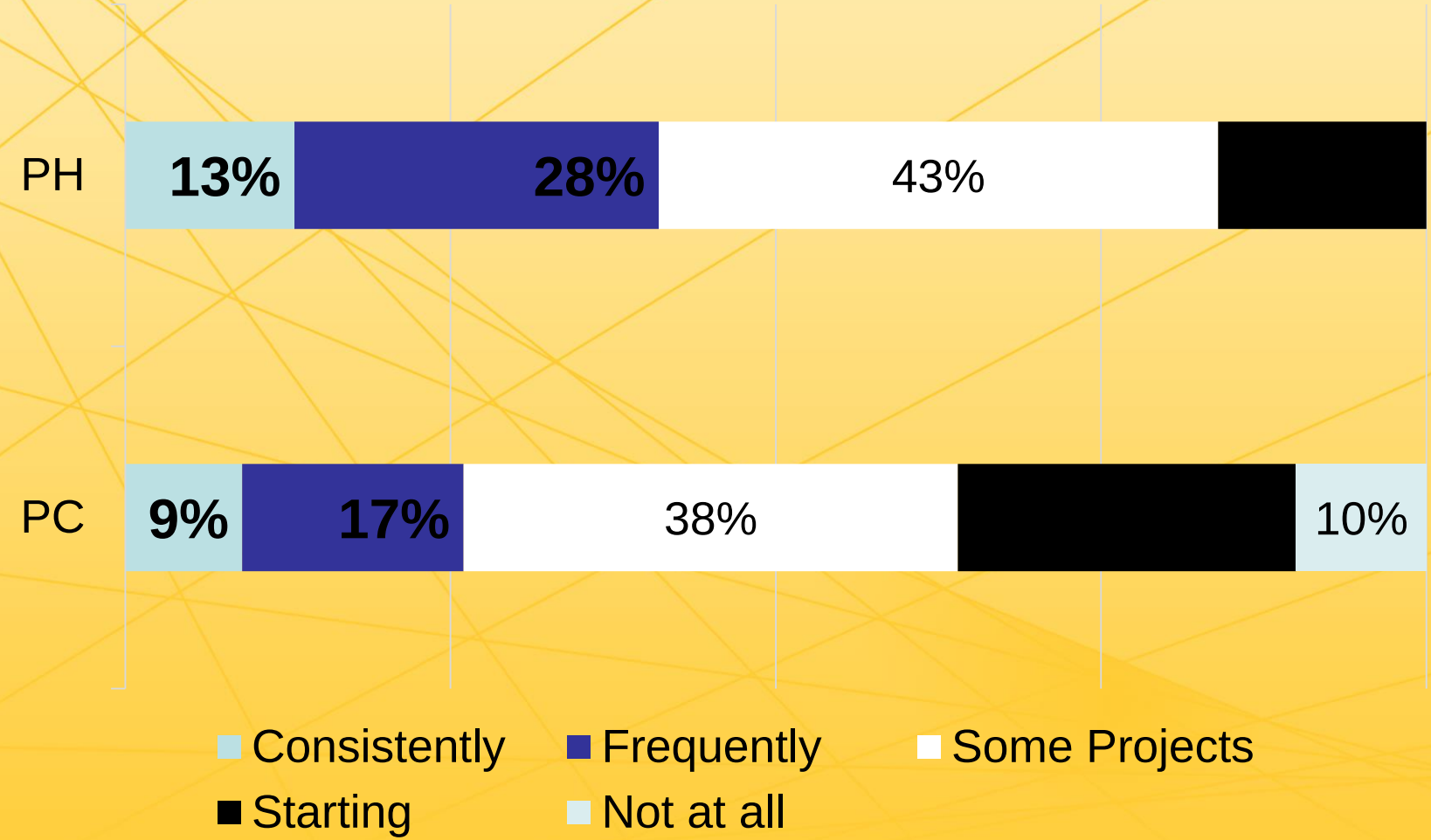


# Relationship-Building

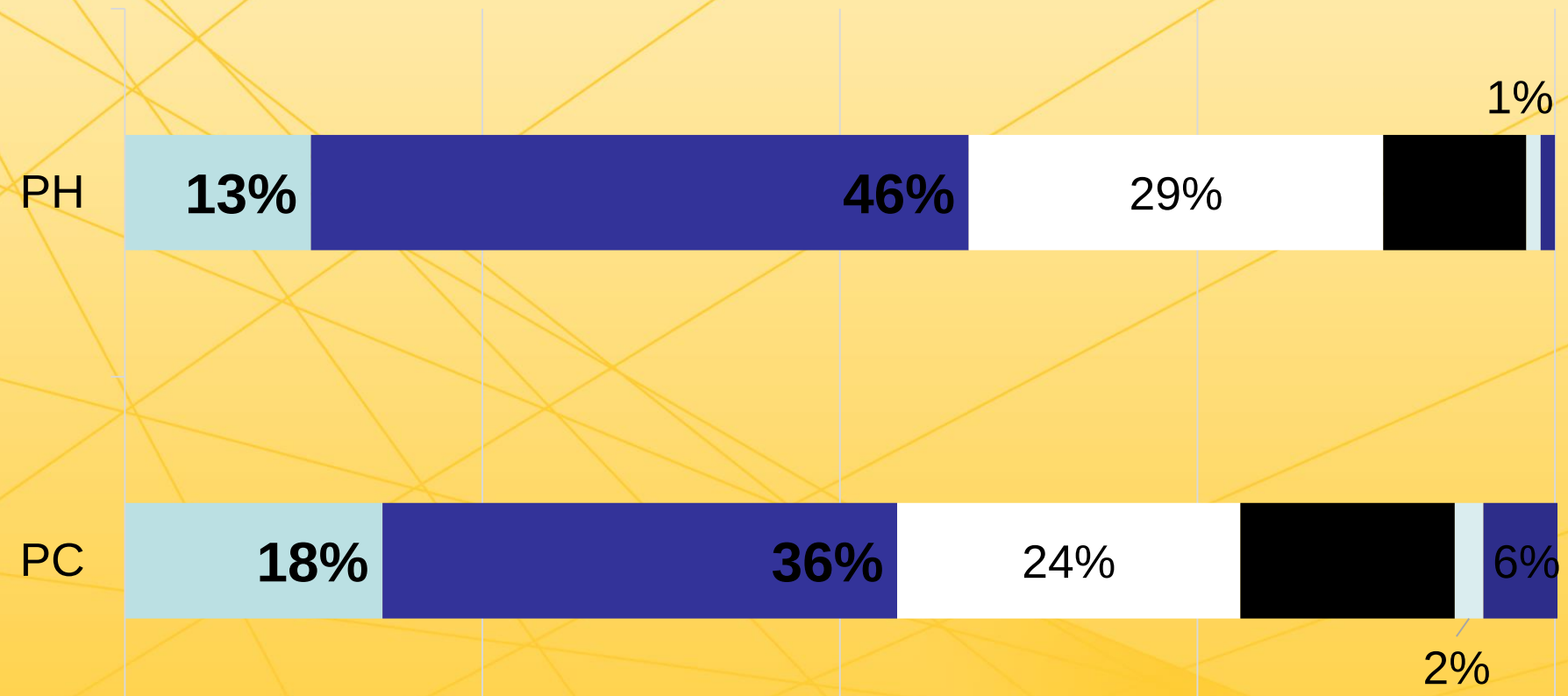


# Sustainability

# Self-Rated Relationship Level



# Overall Satisfaction



# What did we learn?

- Some aspects of partnership build and maintain **foundations**
- Some **activities** raise energy and action.
- **Satisfaction** is not the same as **action**.
- Agreement that **collaboration is important**.

# MODEL COMPARISON

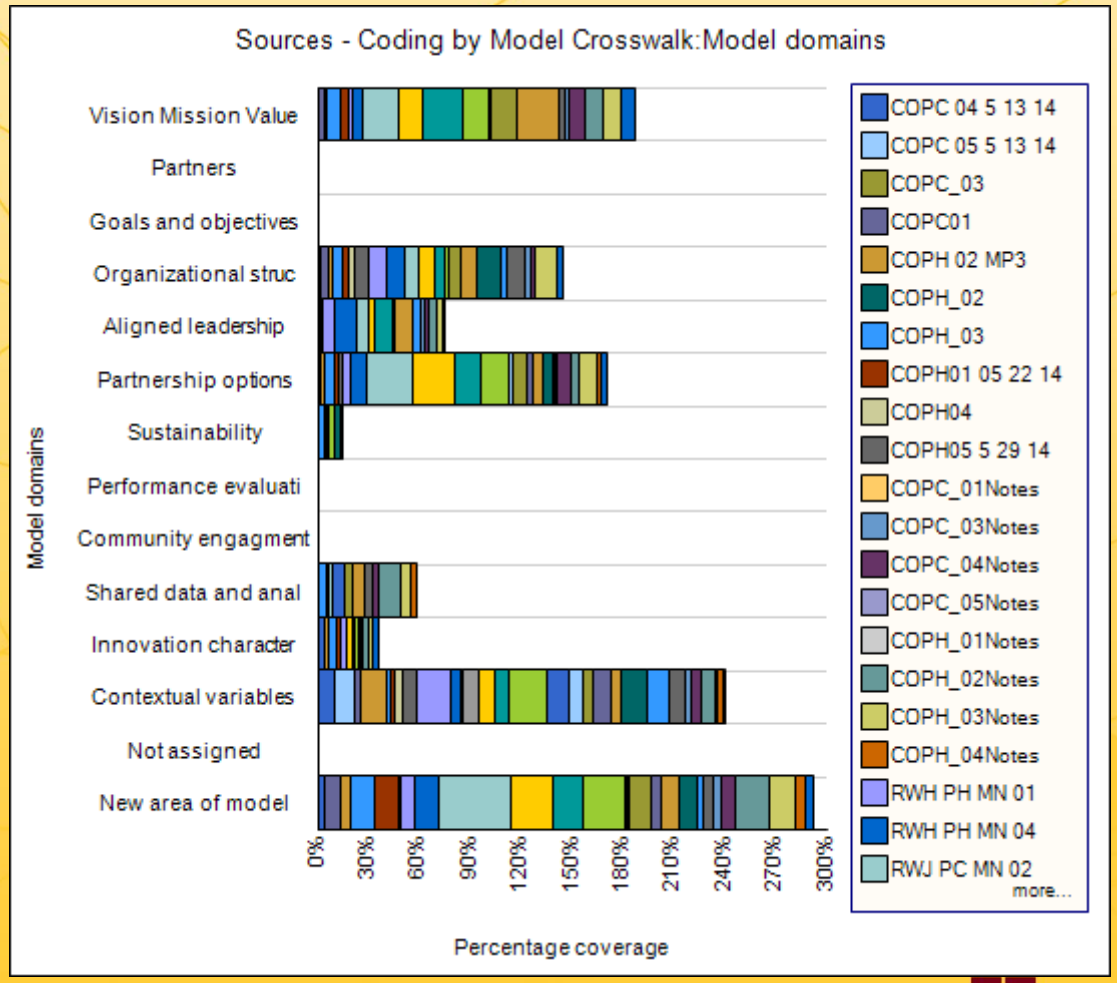
# Framework Analysis

- Data coded initially blind to the models
- Data analysis indicated key themes and areas in the interviews
- Key themes cross coded with framework characteristics
- This allows us to see how our coding relates to the current frameworks

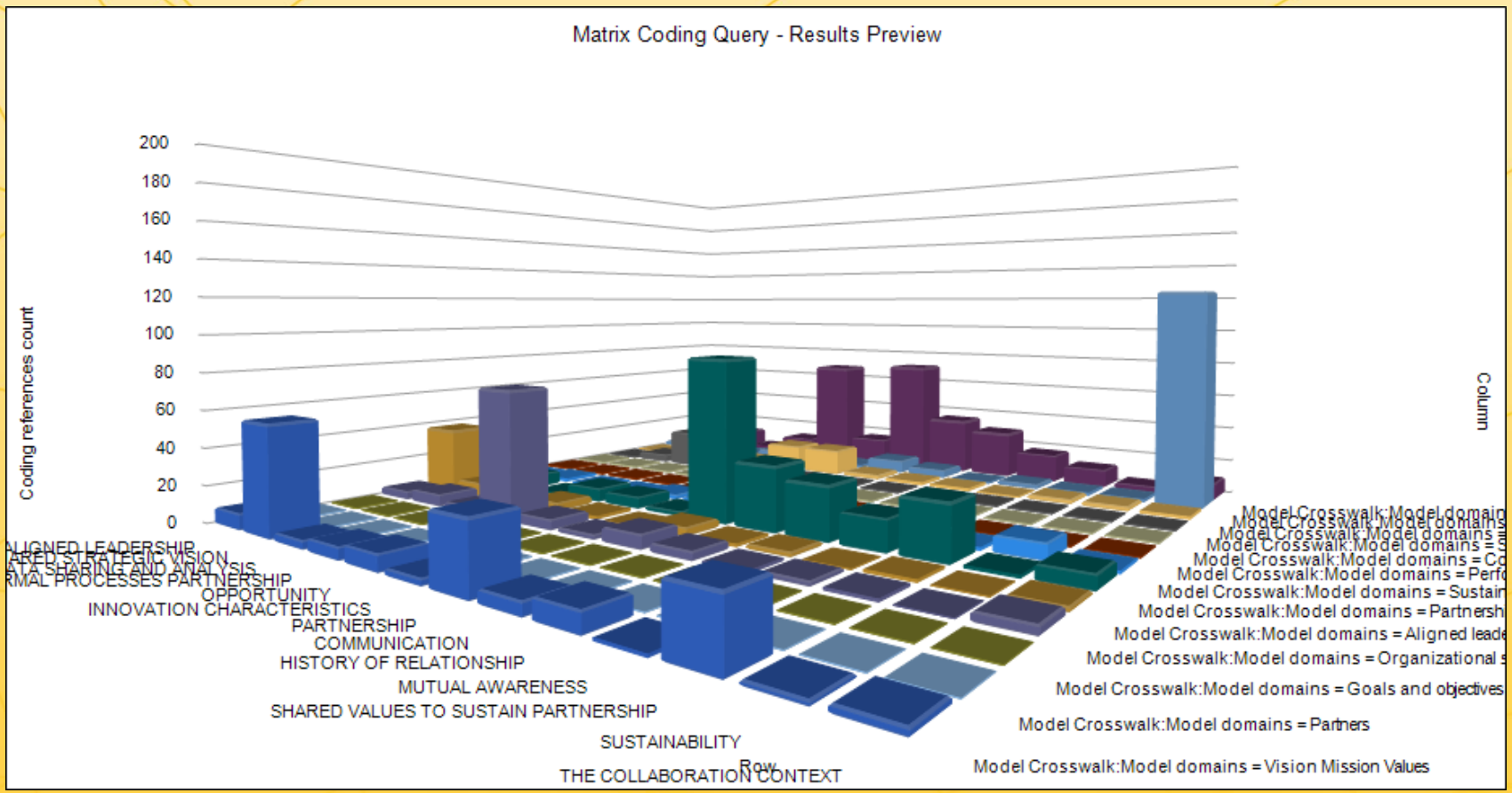
# The Crosswalk:

| Models of Integration and Partnership | Vision, Mission, Values | Partners | Goals & Objectives | Organizational Structure | Aligned Leadership | Partnership Options | Sustainability | Performance Evaluation | Community Engagement | Shared Data & Analysis | Innovation Characteristics | Contextual Variables |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| American Hospital Association/University of KY Prybil, Scutchfield, Killian, Mays, Levey | √ | √ | √ | √ | √ | √ | √ | √ | | | | |
| Practical Playbook Duke University/ASTHO/de Beaumont Foundation | | | √ | | √ | | √ | | √ | √ | | |
| Linkages between clinical practices and community organizations Porterfield, Hinnant, Kane, Horne, McAleer, Roussel | | | | √ | | | | | | | √ | √ |
| Primary Care Assessment Tool (PCAT) LeBrun et al. | | | | | √ | √ | √ | | | √ | | √ |
| Developing communities of practice: continuity relationships between LHDs and primary care practice Frank, Menegay, Dixon (Ohio PH PBRN) | √ | | | | | | | √ | √ | √ | | |
| Clinical-Community Relationships Measures (CCRM) Atlas AHRQ | | | | √ | | √ | | √ | √ | | | |
| Medicine & Public Health Lasker | | | | | | | | | √ | √ | | |
| Environmental Scan Jacobson & Teutsch | | | √ | | | | √ | | | √ | | |
| Framework for Understanding Cross-Sector Collaboration Bryson, Crosby & Stone | √ | √ | √ | √ | √ | √ | √ | √ | √ | | | √ |

# Cross coding to our data



# Framework Analysis




UNIVERSITY OF MINNESOTA

# Key points:

- Some good areas of agreement
- Some new areas or expanded areas
- Areas that didn't yield much overlap
- A need for a more nuanced model

# What did we learn?

- Some aspects of partnership build and maintain **foundations**
- Some **activities** raise energy and action.
- **Satisfaction** is not the same as **action**.
- Agreement that **collaboration is important**.
- There is a need for a more **dynamic model** to describe partnerships.
- Integration is likely **not linear**.

# EMERGING FRAMEWORK

Foundational aspects

**Interaction**

Energizing aspects

Energizing Characteristics

**Low Foundation/High Action**

**High Foundation/High Action**

**Low Foundation/Low Action**

- Lack partnership basics
- Lack project- or program-specific interactions
- No dedicated staffing or financial commitment

**“Land of Opportunity”**

**High Foundation/Low Action**

Foundational Characteristics

Energizing Characteristics

**Low Foundation/High Action**

- Come together on specific project or to address crisis
- Formal structures to support work
- Leadership strongly directs work
- Lack partnership elements that contribute to ongoing work together

***"Jurisdictions have higher levels of acting together, but weak partnership foundation"***

**High Foundation/High Action**

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- Partnership elements: shared vision, mutual trust & respect, value
- Committed leadership
- Lack tangible ways to work together (e.g., projects or program-specific interactions)

***"Strong partnership foundation, though limited action actually working together"***

Foundational Characteristics

Energizing Characteristics

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***"Jurisdictions have higher levels of acting together, but weak partnership foundation"***

**High Foundation/High Action**

- Partnership elements: shared vision, mutual trust & respect, value
- Committed leadership that takes strong role directing work
- Formal structures to support work
- Ongoing working relationship

**Low Foundation/Low Action**

- Lack partnership basics
- Lack project- or program-specific interactions
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**"Land of Opportunity"**

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***"Strong partnership foundation, though limited action actually working together"***

Foundational Characteristics

# Local Variation in Primary Care-Public Health Integration: A Practice-Based Approach

Betty Bekemeier, PhD, MPH, FAAN

AcademyHealth Annual Research Meeting

June 27, 2016

Funded by RWJF PHSSR Program (RWJF #71270)
Led by the Minnesota Department of Health—Beth Gyllstrom, PI

UNIVERSITY of WASHINGTON

# Presentation Disclosure

No off label, experimental or investigational use of medications are discussed during this presentation.

We have no interests of commercial services, products or support that requires disclosure.

# Background

- **Increased collaboration between primary care & PH crucial to population health**
- **ACA provides new incentives & expectations for such partnerships**
- **Triple Aim goal of improving population health, increasing quality of health care services and reducing costs**
- **Little knowledge of the degree to which public health and primary care work together at the local level.**

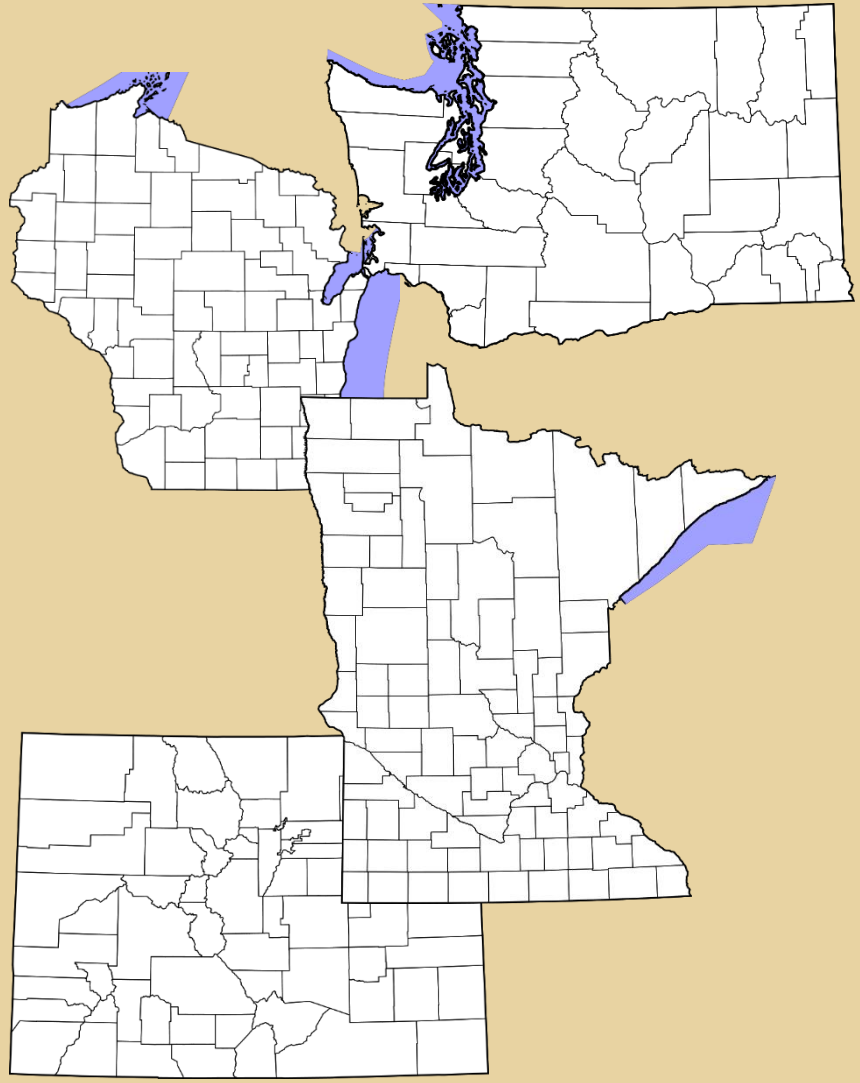
# Research Questions


- **How does PC/PH integration vary across local jurisdictions?**
- **Does it matter whether you ask a PC or a PH leader to describe the level of local integration?**
- **Are there factors associated with variation in integration?**

# Survey Implementation

Quantitative data collected Spring 2015

- **Sample**
  - **Drawn from**
    - **241 LHD jurisdictions in 4 states (CO, MN, WA, WI)**
    - **LHD directors**
    - **PC leaders**
  - **Respondents**
    - **193 PH (80%)**
    - **128 PC (31% overall, 50% geographic-specific)**
- **Questions**
  - **38 online items**
  - **Collaboration factors from each perspective**



# Methods: Analysis

- **Frequency distributions of response options for PH & PC separately**
- **Created PC/PH dyads in jurisdictions with at least 1 respondent in each**
  - **71 dyads across the 4 states**
- **Examined % agreement & correlation of responses between PC & PH within dyads**
- **Used PH, PC, & PC/PH dyad sets to examine distribution of jurisdictions within the multi-dimensional model of integration**
- **Compared model assignment to selected health indicators**

# Assigning Jurisdictions to Multi-Dimensional Model of Integration

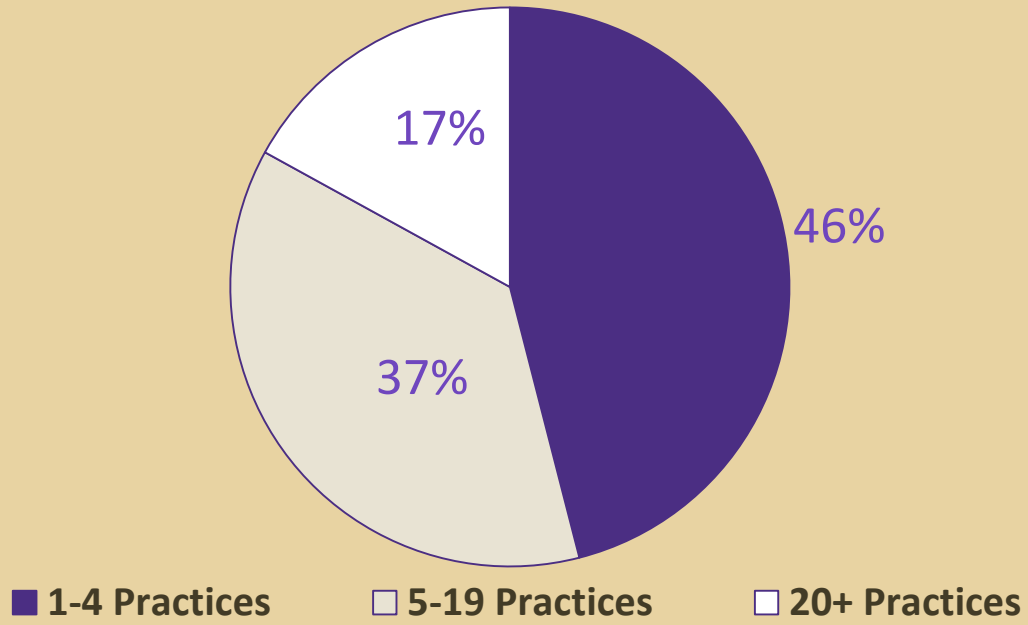
- **Questions assigned to “Foundational” or “Energizing” Characteristics.**
- **Responses to those questions were**
  - **assigned values**
  - **used to calculate scores**
- **Score distributions were assigned cut-points for jurisdictions placement in 1 of 4 quadrants**

# Jurisdiction Descriptions

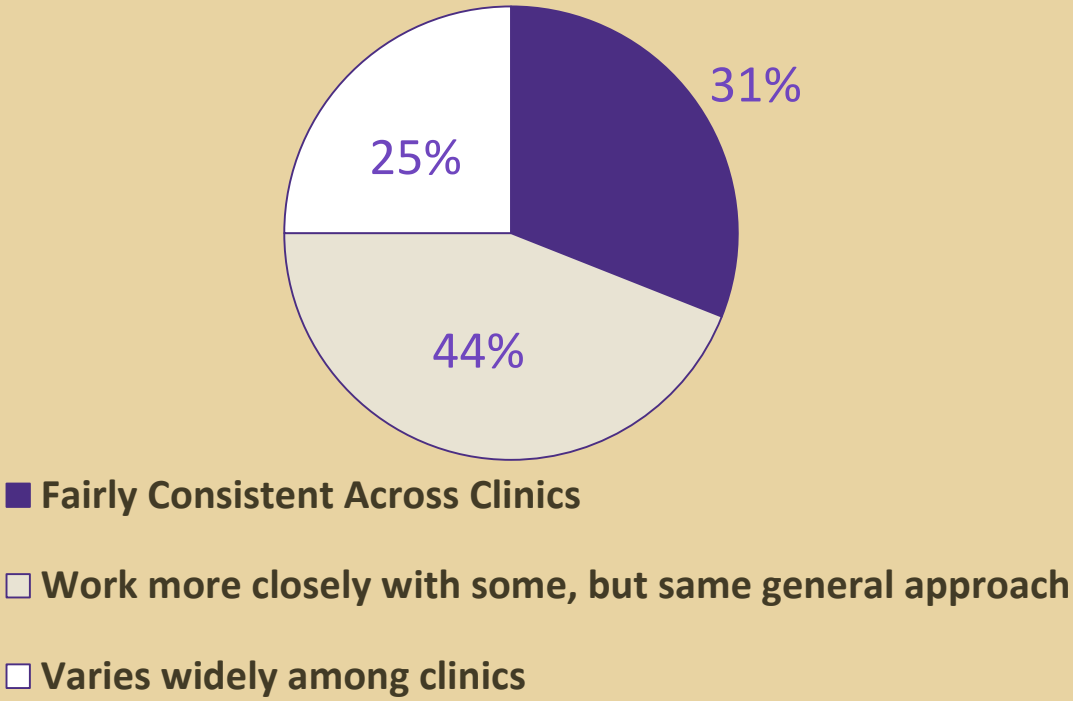
| | | Response Profiles | | |
|---|---|---|---|---|
| **Jurisdiction Characteristics** | **Potential Jurisdictions (n=241)** | **PH Only (n=193)** | **PC Only (n=128)** | **PC-PH Dyad (n=71)** |
| Population Size | | | | |
| Less than 50,000 | 64.2% | 64.8% | 44.0% | 47.9% |
| 50,000-100,000 | 16.5% | 16.1% | 12.8% | 14.1% |
| Greater than 100,000 | 19.3% | 19.1% | 43.2% | 38.0% |
| % Poverty | | | | |
| Less than 10.9% | 35.4% | 33.2% | 28.9% | 36.6% |
| 11-14.9% | 38.3% | 38.3% | 39.1% | 28.2% |
| 15% or higher | 26.3% | 28.5% | 32.0% | 35.2% |
| % Non-White | | | | |
| Less than 5% | 39.9% | 39.9% | 35.2% | 28.2% |
| 5.1-8.9% | 31.3% | 31.1% | 24.2% | 40.9% |
| 9.0% or higher | 28.8% | 29.0% | 40.6% | 31.9% |

# PH's Working Relationship with PC

**Estimated # of Free-Standing PC Practices in Jurisdiction**




**Working Relationship with PC Practices**



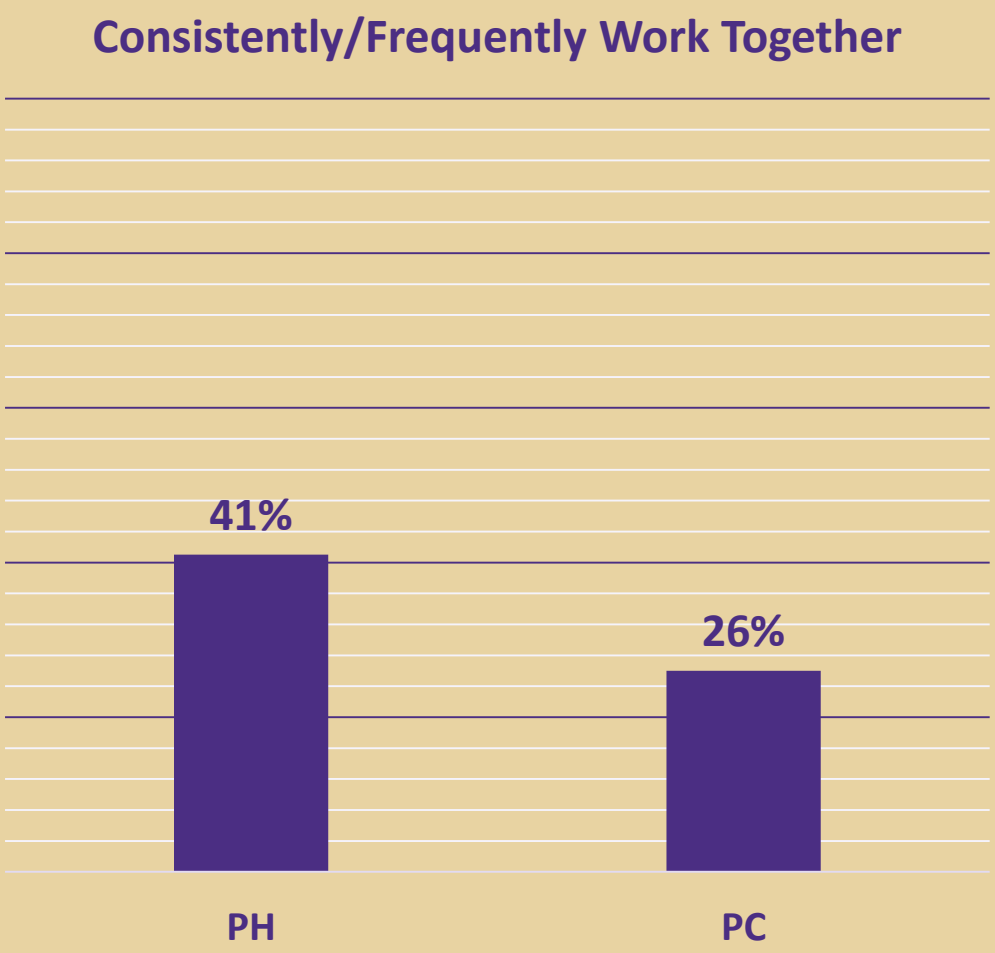
# Ways of Working Together

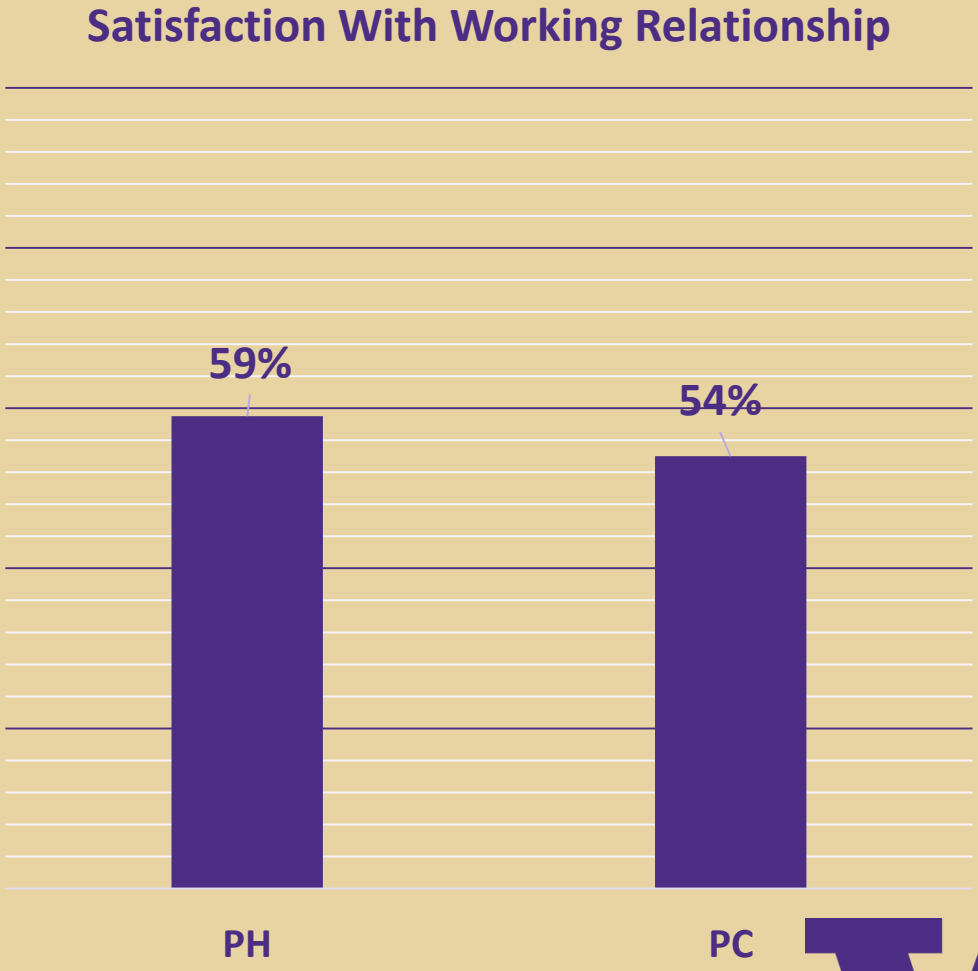
| Response Options | PH | PC |
|---|---|---|
| Respond to immediate events (e.g., outbreak) | 95% | 57% |
| Work together on specific clients | 77% | 50% |
| Come together for meetings/conferences/committees | 80% | 45% |
| Project-specific work, such as CHNA or strategic planning | 80% | 37% |
| Quality improvement initiatives | 17% | 23% |
| Ongoing, long-term working relationship | 69% | 41% |

# Reasons for Working Together

| Response Options | PH | PC |
|---|---|---|
| Improve population health in community | 95% | 79% |
| Good PH practice (PH only) | 91% | n/a |
| Engage more stakeholders in work | 81% | 31% |
| Improve individual patient care | 79% | 59% |
| Meet specific program requirements or mandates | 60% | 38% |
| Extend population/demographic reach | 53% | 36% |
| Build more credibility in community | 50% | 18% |
| Share costs & maximize resources | 44% | 29% |

# Current Working Relationship



# PH/PC Jurisdiction Distribution: **PH Only**

| Energizing Characteristics | | |
|---|---|---|
| | **Low Foundation/High Action**<br>**10% (n=20)**<br>***"Jurisdictions have higher levels of acting together, but weak partnership foundation"*** | **High Foundation/High Action**<br>**37% (n=71)** |
| | **Low Foundation/Low Action**<br>**42% (n=80)**<br>***"Land of Opportunity"*** | **High Foundation/Low Action**<br>**11% (n=22)**<br>***"Strong partnership foundation, though limited action actually working together"*** |
| | Foundational Characteristics | |

# PH/PC Jurisdiction Distribution: **PC Only**

| Energizing Characteristics | | |
|---|---|---|
| | **Low Foundation/High Action**<br>**12% (n=15)**<br>*"Jurisdictions have higher levels of acting together, but weak partnership foundation"* | **High Foundation/High Action**<br>**18% (n=23)** |
| | **Low Foundation/Low Action**<br>**62% (n=79)**<br>*"Land of Opportunity"* | **High Foundation/Low Action**<br>**8% (n=10)**<br>*"Strong partnership foundation, though limited action actually working together"* |
| | Foundational Characteristics | |

# PH/PC Jurisdiction Distribution: **Paired Dyads (n=71)**

| Energizing Characteristics | | |
|---|---|---|
| | **Low Foundation/High Action**<br><br>**16% (n=11)**<br><br>***"Jurisdictions have higher levels of acting together, but weak partnership foundation"*** | **High Foundation/High Action**<br><br>**18% (n=13)** |
| | **Low Foundation/Low Action**<br><br>**65% (n=46)**<br><br>***"Land of Opportunity"*** | **High Foundation/Low Action**<br><br>**1% (n=1)**<br><br>***"Strong partnership foundation, though limited action actually working together"*** |
| | Foundational Characteristics | |

# Most precise assignment?

- **PH only has closest relationship to self-rated degree of working relationship for both PH & PC respondents separately**
  - **LHD directors may be better positioned to reflect on working relationship given their broad community role**
  - **More variation in roles represented in PC**
- **PH jurisdiction profile most similar to entirety of potential jurisdictions across the 4 states**
- **Distribution likely falls somewhere in between PC & PH only distributions**
- **Both perspectives important & valuable**

# Conclusion

- **Both sectors value working together,**
  - **…but unclear regarding next steps towards building relationships**

- **Paradigm conflict**
  - **PH more likely to report a stronger working relationship**
  - **Neither group reports high levels of working together**
  - **Both report being satisfied**

- **PH more traditionally grounded in community outreach & coalition-building,**
  - **PC may see value in the partnership as they continue to identify shared priorities.**

# Limitations

- **Dyads**
  - **Differences in response rate between PH & PC limited ability to create representative dyads**
- **Recruitment**
  - **Difficult to identify 1 PC leader to represent jurisdiction**
    - **Especially where multi-practice settings**
  - **Hard to recruit PC respondents**
    - **Too many time demands**
    - **Response bias from particularly committed PC leaders**

# Policy/Practice Implications

- **Health equity could provide a joint focus for work & engagement**

- **Demonstrate that such partnerships can**
  - **reduce PC leader workload?**
  - **affect social determinants?**
  - **benefit individual health?**

- **Changing reimbursement models**
  - **To support such partnerships**
  - **Lack of financial support & dedicated staff time undermining sustainability, as indicated by both sectors**

# Barriers to Public Health and Primary Care Integration: Taking Action to Support Collaboration

Susan Zahner, DrPH, RN, FAAN

AcademyHealth Annual Research Meeting
Boston, MA
June 27, 2016

Funded by RWJF PHSSR Program (RWJF #71270)
Beth Gyllstrom, PI, Minnesota Department of Health

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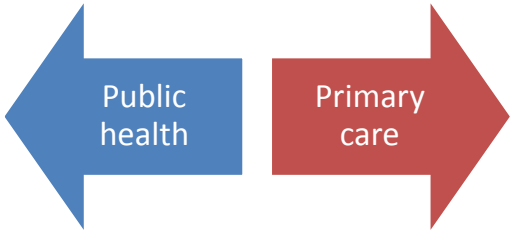
# Presentation Disclosure

No off label, experimental or investigational use of medications are discussed during this presentation.

We have no interests of commercial services, products or support that requires disclosure.

# Background

- Pressure on public health and primary care organizations to collaborate is growing
- Expectations for increased efficiency and effectiveness of services and population health improvement
- Barriers to system integration
- Collaboration is challenging



# Research Questions

- Which barriers to public health-primary care integration are most problematic?
- Does this differ based on public health vs. primary care perspective?
- How might local public health and primary care entities take action to promote their level of integration and overcome such barriers, while grounded in a practice-based perspective?

# Methods

- Qualitative interview data
  - 40 key informants from 4 states
    - 10/state
    - 20/sector
- Survey responses
  - 193 public health surveys (80% response)
  - 128 primary care surveys (31% response)
- Stakeholder discussions

# Results : Key barriers

## Partnership Related Barriers

- **Communication**
- Data sharing
- Lack of capacity
- Lack of prior partnership
- Lack of shared priorities
- Not understanding each other

*There are some other places, where I think we could just provide better communication with them if we had a way to electronically share information. I think it would enhance our being a part of their team, where they could rely on us for more easy communication.*

(CO Public Health)

# Results : Key barriers

## Systems Related Barriers

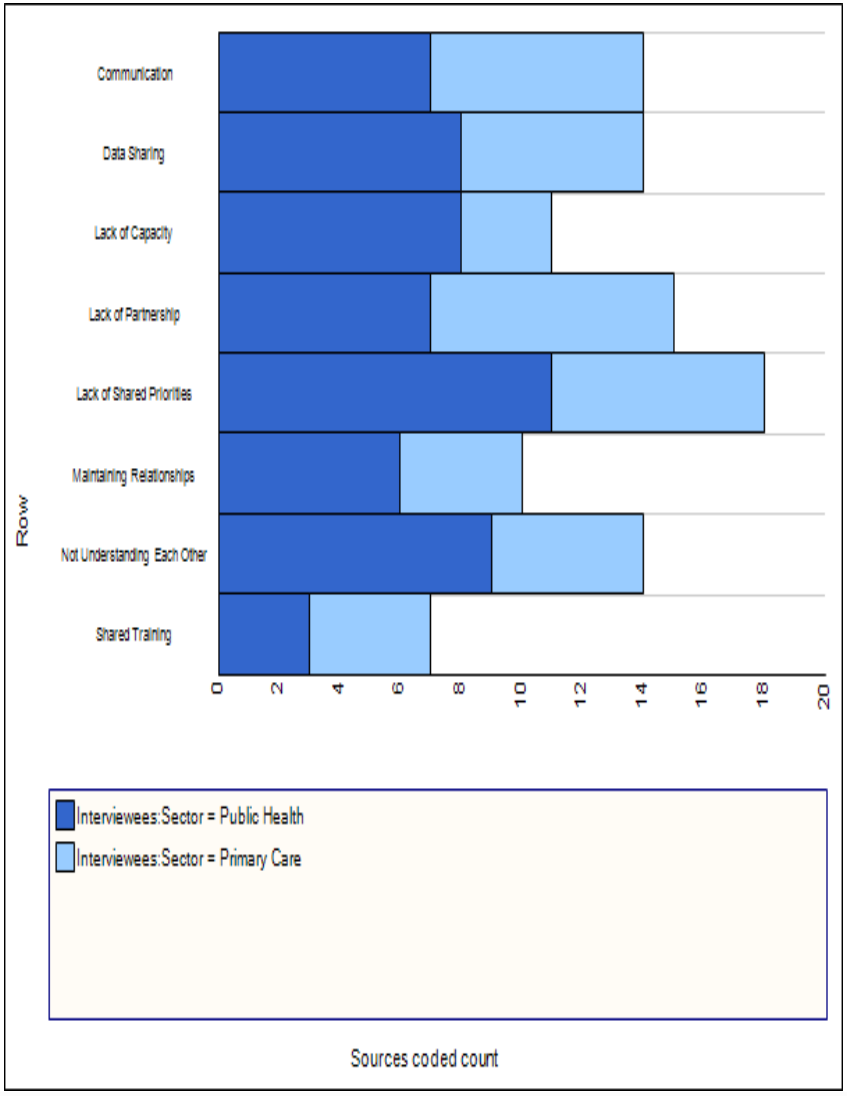
- Constant change
- Funding environment
- Geographic
- **Primary care context**
- Resources
- Need for systems change

*It sure would be nice if the health department had access to all our data, you know, from our health records to run studies to learn more about the health of populations. In our community has I think there are 3 different EHRs in our community. So it's not a simple system thing. If there's somebody in the health department that was, became highly trained in our EHR they could you know help themselves to data and help us too.*

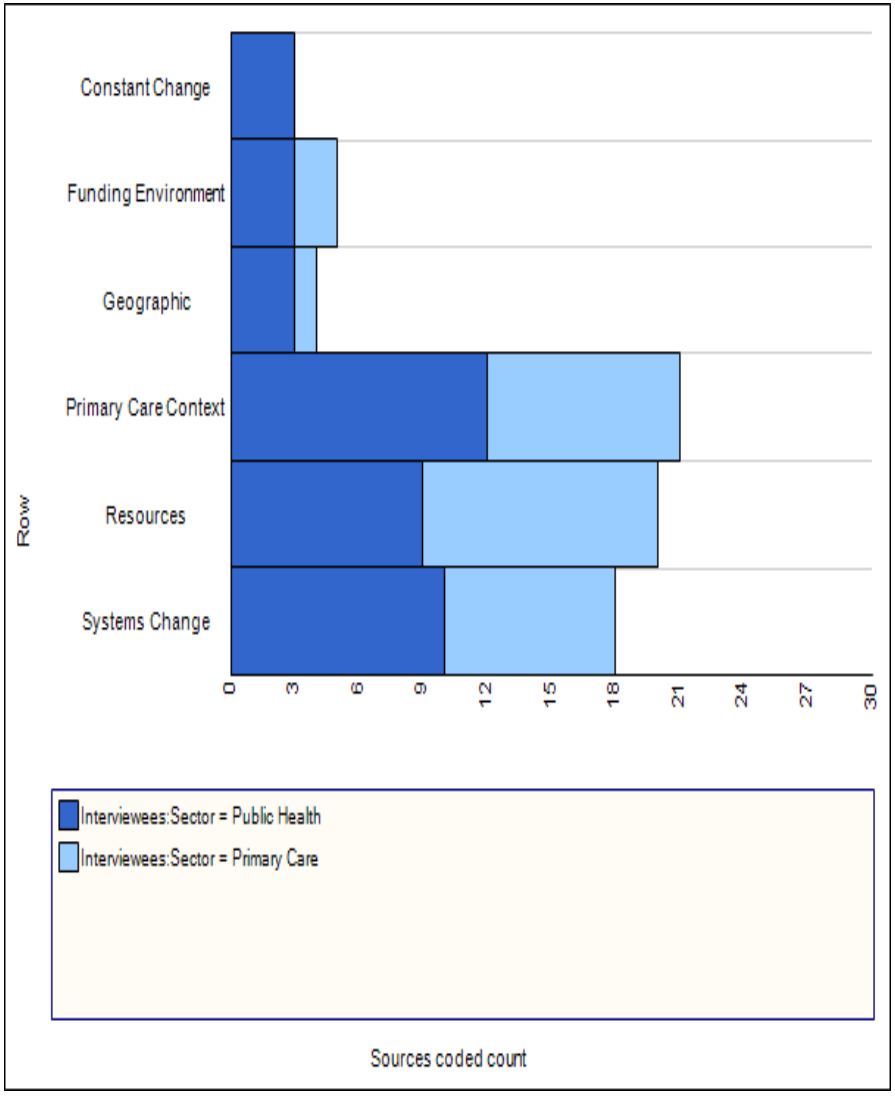
(WA Primary Care)

# Results : Key barriers

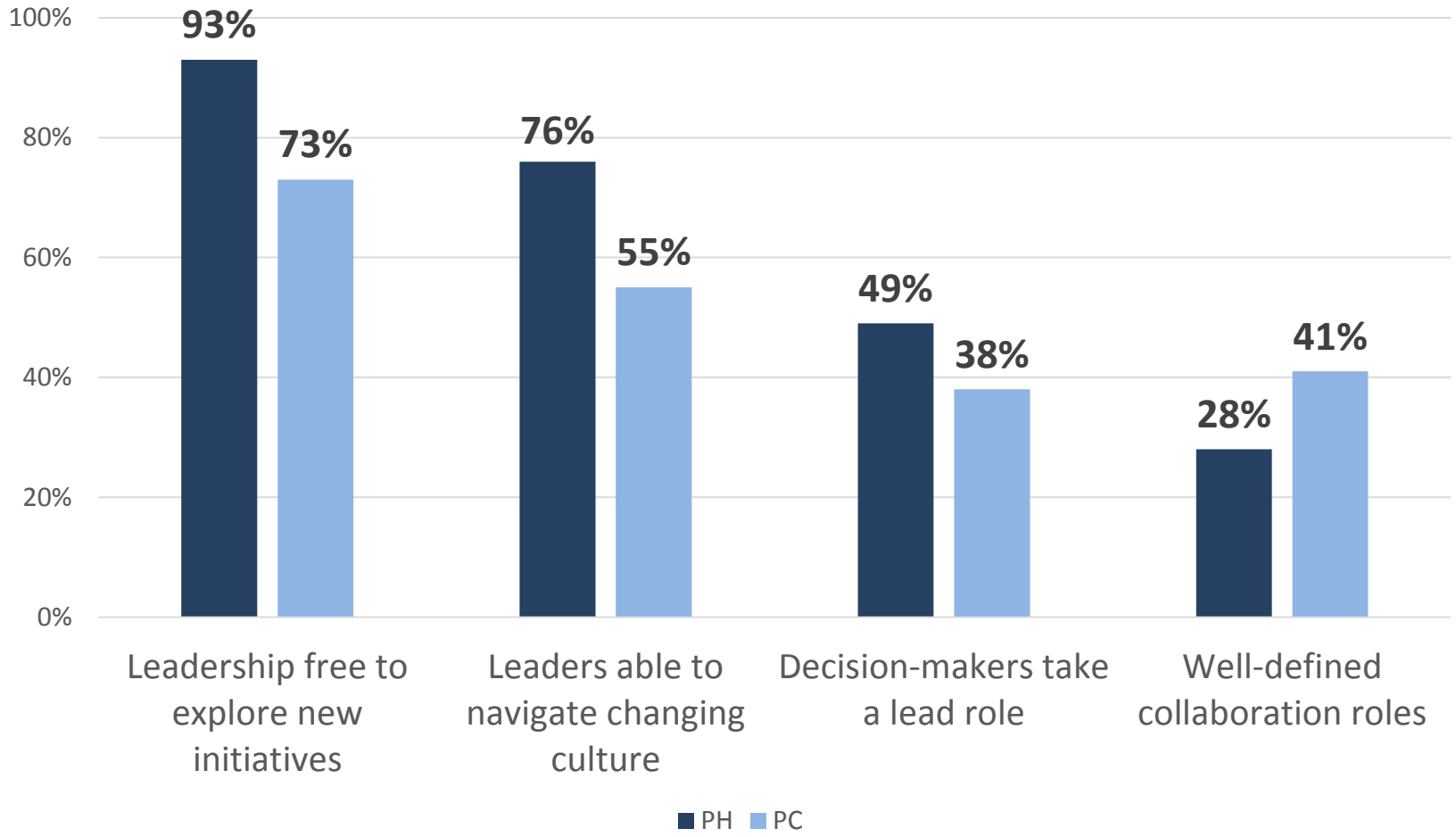
## Partnership Related Barriers




## Systems Related Barriers



# Results: Leadership

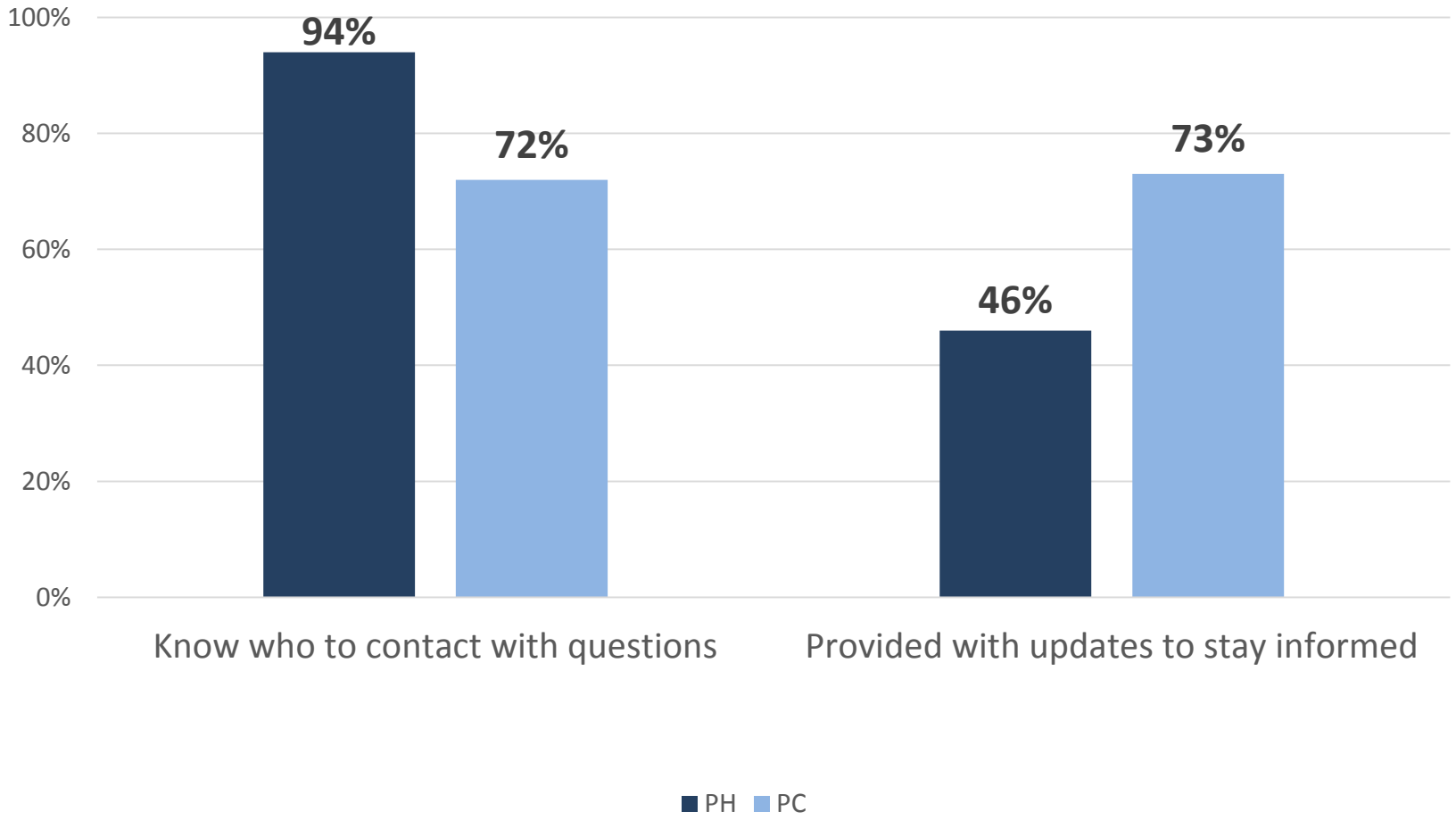


# Key Barrier: Leadership

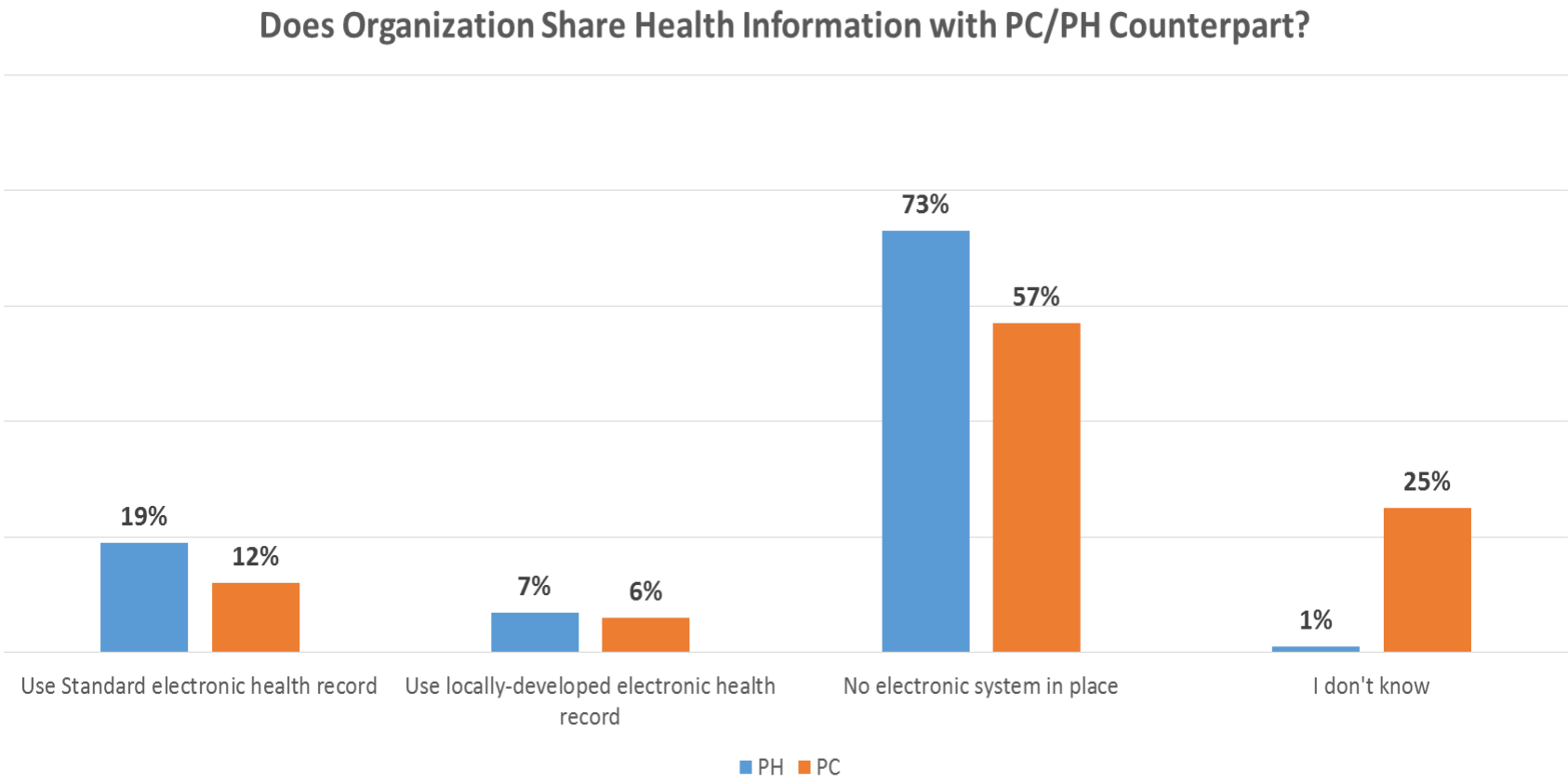
*I think it's really about leadership, if there's effective leadership in organizations on either side that has the vision to try to define what collaboration should look like and then if resources in terms of manpower and funding flow accordingly then I think that's what can make it work.*

(WI Primary Care)

# Results: Communication



# Results: Lack of Data Sharing

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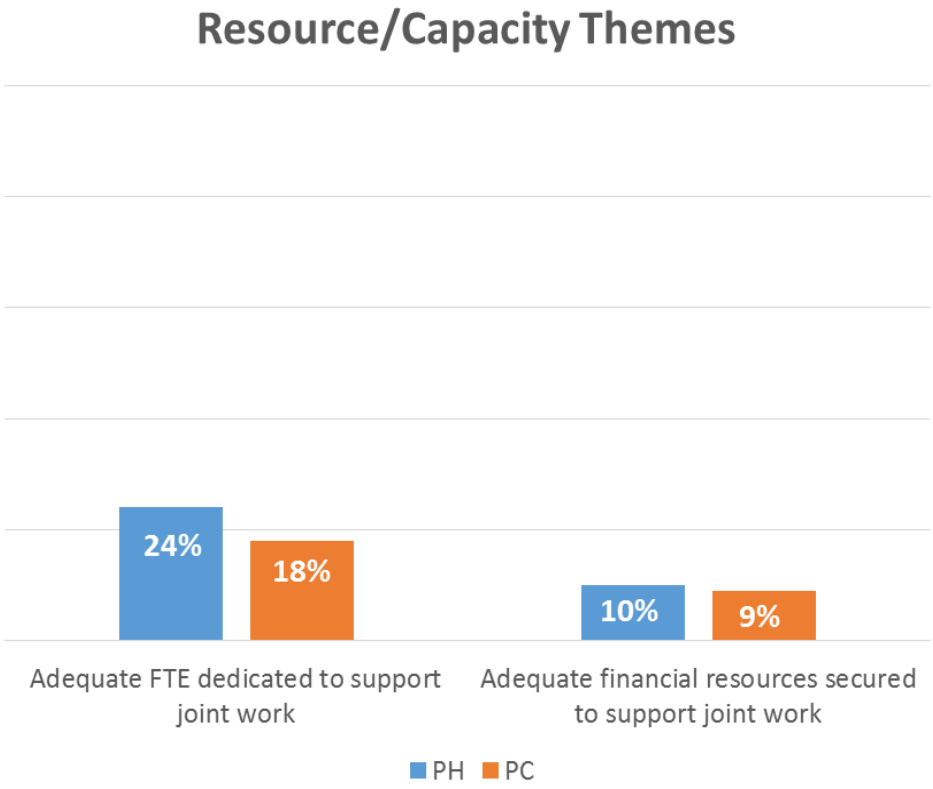
# Results: Resources & Capacity




*Well, I think probably just the one of resource availability is probably the biggest one. There's not abundance internally, and I know on their side there's typically not either, but when it comes to our ability to maybe get engaged in things, that's probably the biggest, just competing priorities.*

(WI Primary Care)

# Different Priorities?

| Reason(s) for Working Together | PH | PC |
|---|---|---|
| Improve population health in community | 95% | 79% |
| Engage more stakeholders | 81% | 31% |
| Improve individual patient care | 79% | 59% |
| Meet specific program requirements or mandates | 60% | 38% |
| Extend population/demographic reach | 53% | 36% |
| Build more credibility in community | 50% | 18% |
| Share costs & maximize resources | 44% | 29% |

*I think we miss the joint strategic planning to say, "Look, here's the goal for our County, and here's our workforce and here are the other resources. We're gonna work together." And I think that that's where we miss some opportunities.*

(CO Public Health)

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# Results: Lack Mutual Understanding

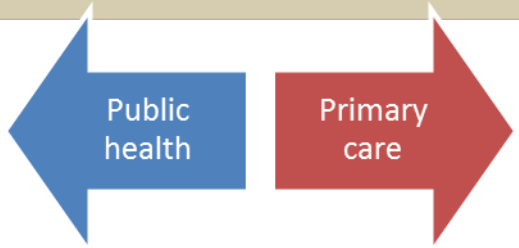
*I think sometimes the Public Health people don't always quite understand the realities of Primary Care. You know, they are sitting off in a Public Health department, well let's do this and let's have the doctors screen for this and do that and do this and do this and do this. You know, primary doctors are all ready to quit because they have too much to do. (laughing) Do you know what I mean?*

(MN Primary Care)

*I think frankly I don't believe public health understands generally at the local level what its role with primary care is outside these very discreet programs like immunizations where it's really clear. What's local public health supposed to be doing?*

(WA Public Health)

# Key Barriers Summary




## Partnership

- Communication
- Data sharing
- Lack of capacity
- Lack of prior partnership
- Lack of shared priorities
- Not understanding each other
- Leadership

## System

- Constant change
- Funding environment
- Geographic
- Primary care context
- Resources
- Need for systems change
- Leadership

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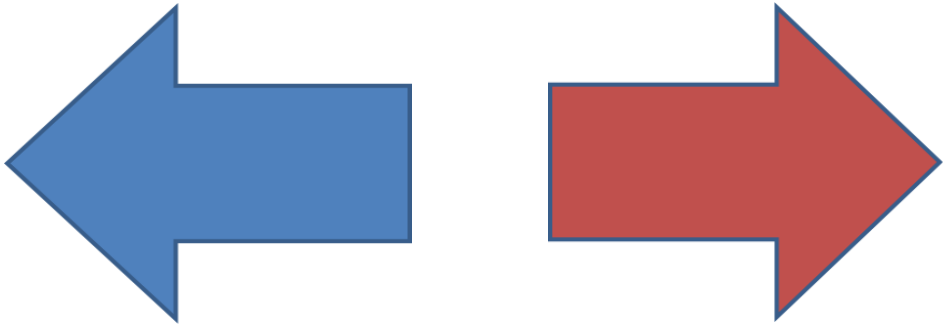
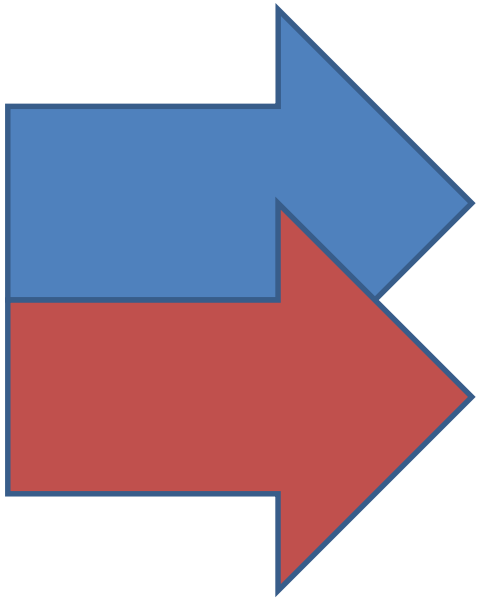
# Taking Action



# Taking Action



# Taking Action: Foundational capacity

Energizing characteristics

- Connect on key programs with existing resources to build relationships & understanding
- Support PH as “neutral convener”, regional focus
- Support mission & priorities of PC
- Develop IT & communication capacity
- Leader commitment

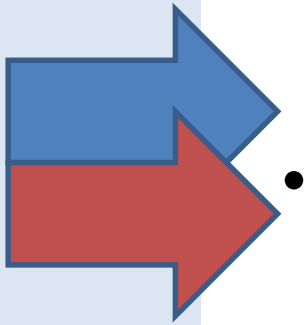
Foundational characteristics

# Taking Action: Energizing capacity

| | | |
|---|---|---|
| Energizing characteristics | | • Aligned goals and activities (strategic planning/community assessment)<br>• Engage in joint program/project opportunities to build relationship & understanding<br>• Frequent [bilateral] communication<br>• Share resources/staffing<br>• Innovation/EBP projects |
| | | |
| | Foundational characteristics | |

# Taking Action: Next Steps

- Engage stakeholders



- Do findings "fit" experiences?
- Is current state OK?
- What would encourage more collaboration for mutual benefit?
- How might results inform future?
- What is needed to further working together?

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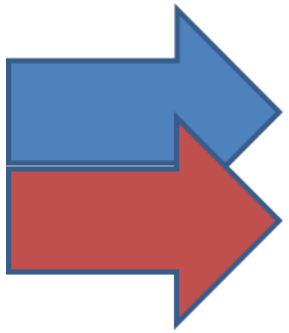
# Taking Action: Stakeholder perceptions

- Need consistency with people/partners
- Align health goals with partners
- Joint grant proposals
- Joint work on CHA/CHIP
- Regional approaches
- Dedicated funding/incentives/cost sharing models
- Tool Kit of ideas



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# Limitations

- Difficulty in engaging primary care respondents from a wider breadth of local health jurisdictions
- Interviews focused on local jurisdictions where investigators knew at least some collaboration existed; may have missed additional issues that would have been raised in jurisdictions with little or no collaborative work
- Interview times were limited; may have missed important modifiable barriers

# Implications for Policy, Practice, & Research

- Evidence-building for overcoming barriers (foundational and energizing)
- Evidence-building about the return on investment of greater integration and more collaboration
- Policy, incentives (funding) supporting more collaboration & integrating activities
- Attending to primary care and public health contexts and limitations
- Continued development of information technologies and information sharing
- Leader development for collaboration