STATE COMMUNITY HEALTH SERVICES ADVISORY COMMITTEE (SCHSAC) SMALL GROUP DISCUSSION SUMMARY

Selected study results from the Primary Care-Public Health Study* were shared at the March 2016 Minnesota State Community Health Services Advisory Committee (SCHSAC) meeting. Local Health Director Renee Frauendienst highlighted findings** from the on-line survey of local public health officials and primary care leaders. Approximately, 52 people, representing 38 community health boards, participated in the 20 minute discussion. Local elected officials and local health directors met in small groups, organized by region of the state. Facilitators from the state health department led these individual table discussions and took detailed notes.

Notes were compiled by investigators for review and summary. The following key points emerged. Overall, throughout the discussion – it seemed difficult for people to just talk about primary care. Discussions invariably seemed to touch on health system, hospitals, and primary care.

Discussion Question #1: How well do these findings "fit" with what you've seen in your community, in your capacity as an elected official or public health official?

Key Connection Points:
Connection points between PH and PC typically program- or project-focused; for example C&TC, IPI visits, shared flu/immunization clinics, school-based clinics, advisory committees, SIM, SHIP, Emergency preparedness, CHNA, CHA/CHIP. These specific programs are entrees to making connections between PH and PC.

Some CHBs are expanding the collaboration, for example the Healthcare Collaborative Project (Scott) meets monthly, has a focus on reducing barriers to mental health support and treatment. Is in the process of applying for grant funding together. Felt that SHIP helped them expand their vision beyond individual patients—are now implementing SDOH screening at clinics.

Role and Value of Public Health:
Study findings resonate—particularly the importance of building trust and relationships. PH can bring expertise to the table—with regard to building partnerships, community engagement, data and use of data for prioritizing.

Public health as the neutral convener was mentioned across many groups. Given the multiple clinics and health systems in a given geographic area, public health can help bridge their work and reduce an element of competition. For example, CHAs are not viewed as competition and some clinics see a need to expand what they do.

Signs emerging that PC recognizes that health is affected by factors outside clinic walls. Starting to see the value that PH can bring to the table.

Yet—it is critical that PH is doing work to support PC mission and priorities—in those instances they will work with public health.

Changes in PC/Health Care:

Some hospitals are hiring community liaisons, yet they have a broad scope of responsibility far beyond population health, so often devote little time to population health in practice. Also may lack skills in community engagement or for convening groups.

Collaboration can be difficult in areas where there are health systems that serve a wide area and multiple hospitals—they may or may not be oriented towards individual communities. Some commented that as these systems get bigger, the hierarchy has changed, and it isn't as easy to "walk in" and talk with someone.

Clinics and systems are definitely in flux—high turnover in clinics—so it can be a challenge to get new people on board with long-term, historical relationships. Need frequent contact to continue to sustain those relationships.

Role of Reimbursement Models:

Recognition that as long as reimbursement follows a fee-for-service model, which is still very dominant, it is difficult to engage clinics and health systems in population health activities. Reimbursement for population health activities is essential---since healthier populations mean less patients and less revenue, for hospitals and clinics.

Although payment reform is lagging, there are some examples where health systems are paying for public health nurses ("integrated positions"), although primary care views them as staff focused on case management as opposed to broader population health work.

Hope that through productive collaborations, which yield better outcomes, that payment models will then follow and support such joint work. Very painful process.

Discussion Question #2: How do you see better coordination between PH and PC impacting costs related to care/insurance/taxes/healthier communities?

Broader Prevention Focus to Health Care:

Bringing a PH prevention focus to PC can result in many benefits and lowered costs—particularly with reducing the number of emergency room visits and reducing hospital readmissions. These are topics of great interest to health care, both PC and hospitals, so helps them see value in the role of PH. For example, many people show up to emergency rooms with severe oral health issues, which is very expensive. Prevention at the clinic levels could reduce these visits.

Role of SHIP clinical linkages strategies—does this make sense to address and consider at a larger, regional level?

Health Care Homes, Community Paramedics, and Asthma Legislation could play an important role in promoting this approach.

Some combined agencies (Health and Human Services) facing increased urgency to respond to the mental health crisis and "frequent fliers" who show up in the ER. Affects the overall department budget, so starting to place MH social workers in emergency rooms. Using this crisis to elevate this issue, educate and raise awareness about the MH crisis team in the community.

Family Home Visiting programs, run either by PH or PC, both work on helping women and younger children. Opportunities to more fully collaborate on the health of pregnant women. Perspective of local elected official is that this really does save money, as substantial tax dollars typically go to out-of-home placement costs. Those can be avoided by early work with families.

Major barrier is the time needed to collaborate—PH needs infrastructure capacity and resources to better coordinate with health care. Requires sustainable funding to do this well.

Handling Influx of Newly-Insured:

The Affordable Care Act (ACA) means more people are insured and wanting access to health care, but the system hasn't necessarily grown to meet capacity. Also a role in helping the newly-insured navigate the health care system.

More collaborative work could help identify who is doing what and reduce duplication between the two sectors.

Community Engagement:

A new development is the sense that PC is seeking out advice from PH earlier in a project, for example at the planning stage, as how to best engage communities—instead of waiting until after when things don't go well. It seems that this clinic/hospital learned the value of public health the "hard way," realizing too late in previous work that public health has an important perspective and skill set to offer. This level of consultation is only possible when there is a strong foundation of trust and communication—which ultimately leads to more effectively and efficiently working with communities to improve health.

The focus on community engagement as a part of accreditation, SHIP, MIIC, has helped PH work more with PC in their communities.

Payment Reform/Reimbursement Continues to Hinder:

Payment models continue to lag behind where some of the partnerships exist; in addition, they are designed largely for acute care, yet the health care needs are very focused on chronic disease.

Could money saved due to ER visit cost reduction be transferred to PH for work on population-based prevention or has it already been shifted to Urgent Care clinics?

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*STUDY DETAILS

Public health directors and primary care leaders were identified for all 241 local jurisdictions in Minnesota, Colorado, Washington and Wisconsin. Forty key informant interviews (20 pairs, five pairs per state) were conducted using a standard protocol. Eighty percent of local health directors (n=193) completed an online survey. A parallel survey was administered to one or more primary care leaders. Overall, 31% of primary care leaders (n=128) completed the survey, representing 50% of jurisdictions studied.

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**BACKGROUND SLIDES

Public Health-Primary Care Collaboration Study

March 2016

MDH Minnesota Department of Health HEALTH PARTNERSHIPS DIVISION

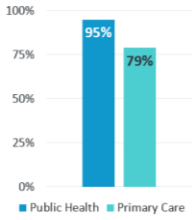
Minnesota Public Health RESEARCH TO ACTION NETWORK

Public Health-Primary Care Collaboration Study

- Partnership between public health and primary care practice-based research networks across four states: MN, CO, WA, and WI
- Conducted interviews with 20 pairs of public health and primary care respondents at local jurisdiction level
- Online survey across all local jurisdictions

Shared Vision

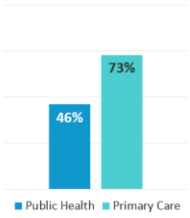
Both public health and primary care report that working together will improve population health in the community



Mutual Trust and Respect

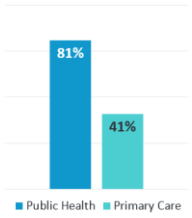
Communication

Provided with updates by counterpart to stay informed about public health or primary care activities in the community.



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



Discussion Questions

- How well do these findings "fit" with what you've seen in your community, in your capacity as an elected official or public health official?
- How do you see better coordination between PH and PC impacting costs related to care/ insurance/ taxes/healthier communities?

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Acknowledgements

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