Minnesota Department of Health

Minnesota Public Health RESEARCH TO ACTION NETWORK

October, 2016

PUBLIC HEALTH-PRIMARY CARE COLLABORATION: THINK TANK SUMMARY

The Primary Care-Public Health Study* hosted a Think Tank in Minnesota to convene stakeholders interested in discussing ways to support primary care-public health collaboration. The purpose of the full-day meeting was to build on study findings and the expertise of Dr. Lloyd Michener, Duke University, drawing on strategies outlined in the Practical Playbook.** This invitation-only event included leaders, educators and practitioners from local public health departments, primary care clinics, the Minnesota Department of Health, the University of Minnesota, Mayo Medical School, health plans, the Minnesota Council of Health Plans and the Institute for Clinical Systems Improvement (ICSI). Dr. Michener served as the on-site expert consultant for the day.

SETTING THE STAGE

Study Findings (Study Staff): Staff shared selected key findings from the study

Practical Playbook 101 (Dr. Michener): Dr. Michener provided an overview of the Practical Playbook and examples of how strategies from the Playbook have been used to advance primary care-public health collaboration. He also had some great stories about community-based approaches to collaborating effectively.

Model Framework Discussion

One of the main results of the study to date has been the creation of a new model framework, which can both describe the current status of collaboration, and be used as a self-assessment tool. The new contribution of this framework to partnership/collaboration literature is the concept of a multi-dimensional set of factors, which have been split into: foundational and energizing.

Energizing Characteristics: Weaker ↔ Stronger

High Energy/Low Foundation • Come together for specific clients or projects, or to address a crisis • MOUs, contracts, and other formal structures • Leadership directs work • Lack shared vision, mutual trust, respect, and value	**High Energy/High Foundation** • Work together is ongoing • Shared vision, mutual trust, respect, and value • Formal structures in place • Shared data and information • Adequate staffing or financial commitment
Low Energy/Low Foundation • Rarely come together around projects or clients • Inadequate staffing or financial commitment • Few formal structures support working together • Lack shared vision, mutual trust, respect, and value	**Low Energy/High Foundation** • Shared vision, mutual trust, respect, and value • Supportive leadership • Few formal structures in place • Inadequate staffing or financial commitment

Foundational Characteristics: Weaker ↔ Stronger

Participants liked the model in general, but felt it didn't fully reflect the dynamic aspect of these partnerships—wondering if they move between quadrants naturally as work ebbs and flows, or by specific topic. A key conversation focused on how to sustain partnerships and maintain energy, which was viewed as critical to keep the work going.

Participants were divided into three groups, with the goal of distributing different stakeholder perspectives within each small group. Each group had a facilitator/note-taker and focused on relating key strategies from the Practical Playbook to advancing collaborations that may fit within each quadrant of the model. Dr. Michener and study staff "floated" between the three small groups. As discussion evolved, it became clear that identifying strategies that would increase foundational and energizing characteristics might be more useful than targeting specific quadrants, since all the quadrants could benefit from working on both dimensions. Below are examples from the small group discussions—please note that in some instances Playbook strategies could be placed in multiple places—but one "spot" was selected to best represent the diversity of ideas.

Practical Playbook Strategy Categories	**Foundational Characteristics**		
	Align Leadership	**Build Trust and Respect**	**Create a Shared Vision**
Organize & Prepare	Identify areas of synergy—what can be done better together? Why should we work together? Engage the community--CHA as potential tool.	Come together for dinner or drinks—both one-on-one and in community forums	Decision-makers need to be present at the table to identify a vision for the work.
Plan & Prioritize	Where do you want your project to be in 2-3 years?	Put self-interest on the table-consider other opinions when prioritizing	Create a written vision statement, logic model and work plan, as appropriate.
Implement	Create ongoing communication channels & find the best way to communicate—is it email, meetings, combination of many approaches?	Follow-through with what you said you'd do	"Brand" the work—create an identify for the collaboration
Monitor & Evaluate	Identify who's missing and how to fill those gaps	Account for the interests of all parties—look for areas of alignment and disagreement	Does the work fulfill the vision?
Sustain	Ongoing communication channels so leadership can stay connected	Celebrate achievements and give partners visibility; look for early wins and appreciate them	Tangible measures: return on investment; what needs to be done organizationally to sustain?
Overarching Tenets	Aligned leadership is broader than program scope and requires an ability to clarify roles, ensure accountability, and the capacity to initiate and manage change.	There are key factors in building group dynamics: establishing group norms, learning member perspectives, identifying common language to foster communication and test approaches until you arrive at a good fit	You will need to use consensus to arrive at a shared vision and goals. What does health mean to all stakeholders?

Practical Playbook Strategy Categories	Energizing Characteristics			
	Dedicate Funding/ FTE	**Share and Use Data**	**Specific Project Focus**	**Create Formal Structures**
Organize & Prepare	Identify staffing and financial needs. What will staff actually do?	Make EHR data available in the context of population health; is a formal data use agreement needed? What are the barriers to data sharing?	Consider low-hanging fruit as first potential projects—what points of synergy already exist that partners would be motivated to tackle? E.g. Mental health?	Consider best mechanism to support work: memorandum of understanding, contract, etc.
Plan & Prioritize	What are the barriers to sharing resources? What is needed to create a sustainable partnership?	Look for interesting patterns, issues and gaps (maps and spatial modeling can help). Identify the hot spots.	Identify key roles/responsibilities for project implementation. Look at models, such as Health Care Homes, to provide guidance	What is the governance structure that is needed? Policies, procedures, protocols necessary to support the work?
Implement	Jointly-funded FTE to support collaboration	Engage all stakeholders when sharing data—look at it together!	Make sure implementation follows fits and supports the business case. Set deadlines!	Execute the most appropriate formal mechanisms and borrow templates from successful partnerships.
Monitor & Evaluate	Is the current structure and staffing sufficient to doing effective work?	Are the sources the right ones? Do they have enough rigor?	Determine the questions you'd like to ask for evaluation purposes at the beginning of your project	Reassess project goals and objectives—and whether these are reflected in formal documentation
Sustain	Is there funding for each component of the work?	Share outcomes and data—what have you accomplished?	Evaluate program outcomes, assess unmet needs.	Institutionalize agreements that will carry-on beyond the individuals at the table
Overarching Tenets	Key question relates to who is going to pay for the shifting paradigm. Who are the payers?	Increasing shared data capacity may require organizational change from multiple partners	Legacy projects lead to sustainability, for example immunization registries	For most projects, formal agreements are necessary to sustain and support the work.

MAKING CONNECTIONS: LARGE GROUP CONSENSUS

Group members convened to discuss key points raised in the small groups and work to connect that back to the quadrant. Beyond the tangible points raised to promote foundational and energizing characteristics, a broader conversation emerged that built on those fundamentals and raised issues or questions for the group. Some key points:

- How can we build collaboration and partnership between public health and primary care into training programs for both professions? Should there be "primers" developed to help support such work?
- This work requires inclusion of community leaders beyond public health and primary care, particularly if we are to truly address social determinants of health and promote health equity
- Work remains to fully articulate and define what is meant by "population," and how that definition might mean different things to stakeholders.
- A disconnect remains between who has the power and authority, which is largely tied to current funding and reimbursement models. Public health needs to reach out with something to offer.
- The Community Health Needs Assessment (CHNA) and Community Health Assessment (CHA) mechanisms are critical points of collaboration. How can we leverage that work most effectively?
- Where is the community in this? What would happen if communities expected such collaboration and public health/primary care were accountable to them for such work?
- How do we handle competition between systems? Is there a role for public health as the neutral convener?

MAKING CONNECTIONS: LOOKING FORWARD

Dr. Michener wrapped up the discussion with three questions: what are concrete steps that can be taken? What will you do differently as a result of the discussion? And what else might you like to learn, including beyond the Minnesota context?

- Educational opportunity for those responsible for training programs
- Incorporate these concepts into CHA/CHIP guidance
- During grant review process, actively look for these elements and whether proposals are adequately considering how to build and sustain partnerships
- Community Readiness Assessments
- Is there an advantage to co-location of public health and primary care? What might it look like?
- What is the role of state health departments? Are there incentives that could be provided to encourage collaboration? What support can be provided to local public health?
- Desire for compilation of lessons learned from partnerships: what works, what doesn't and what can we learn from others?
- How can we increase mutual understanding between these sectors? Still considerable lack of understanding between the sectors—need to raise awareness that both public health and primary care are struggling with current workloads.
- Data and measurement: are there new, more flexible data systems that could better support local needs? How do we ensure we're measuring what's most important?

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THINK TANK PARTICIPANTS

Pete Giesen, Olmsted County Public Health; Karen Moritz, Brown County Public Health; Gretchen Musicant, Minneapolis Department of Public Health; Lorna Schmidt, Minnesota Local Public Health Association; Shailey Prasad, North Memorial Family Medicine; Julia Draxton, Centracare Clinic, Stearns County, MN; Onelis Quirindongo, Mayo Clinic; Brenda Brown, Olmsted Medical Group; Meaghan Ridler, Olmsted County Integration Specialist; Nancy Baker, University of MN Family Physicians; Aaron Leppin, Mayo Health Services Research & WellConnect; Julia Dreier, MN Council of Health Plans; JoAnn Foreman, Institute for Clinical Systems Innovation; DeDee Varner, HealthPartners; Carol Bauer, Phyllis Brashler, Debra Burns, Kathleen Conboy, Chelsie Huntley, Bonnie LaPlante, Diane Rydrych, Cherylee Sherry, Karen Soderburg and Sarah Small, all Minnesota Department of Health. Meeting Facilitator: Becky Sechrist, MDH. Study Staff: Kim Gearin, Beth Gyllstrom & Rebekah Pratt.

*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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**PRACTICAL PLAYBOOK

The Practical Playbook works to facilitate primary care and public health collaboration to achieve population health improvement and reduce health care costs. It supports increased collaboration by guiding users through the stages of building partnerships. The Playbook is available free online and in print version and provides helpful resources, lessons learned from existing partnerships, and guidance from experts. The Practical Playbook was developed by Duke University Community & Family Medicine, with support from the de Beaumont Foundation, The Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). More information is available at: https://www.practicalplaybook.org/