A seat at the table: Fostering collaboration between primary care and public health

Primary care and public health: They’ve been aloof allies, like two nations with closely aligned interests but little motivation to relinquish their autonomy. For a long time, the disciplines have independently managed distinct, yet often overlapping, populations.

But it’s no longer reasonable or affordable to keep working in silos. A March 2013 Institute of Medicine report¹ warns the separation between primary care providers (PCPs) and public health professionals impedes their mutual goal of ensuring the health of populations.

“The key task now is to focus on the challenge of sustainable implementation of community-based models of primary care and public health integration.”

What really matters is getting started, it concludes: “Beginning is more important than waiting until all of the requisite components are in place.”

It’s begun.

In search of a common language

The concept of a population’s health is part of the Institute of Health Care Improvement’s Triple Aim: better patient care and improved health for populations at a lower cost. However, “population health” has different meanings for public health and primary care. If there is to be collaboration, there must be clarity and, ultimately, consensus.

In other words, they need a common language. “Public health and primary care use the same words to describe different things,” says Janice L. Genevro, PhD, of AHRQ’s Center for Evidence and Practice Improvement. (See sidebar on next page for more on AHRQ’s involvement.) “In public health, ‘population health’ refers to the larger community. In primary care, it generally refers to the patient panel.”

As a result, each has a different answer to the question, “To whom is your primary responsibility?”

It’s not just semantics; it is the heart of the problem—and the solution.

Historically, services provided by primary care and public health have been siloed, while the served populations may go back and forth between them. To some extent, it made sense, explains Liane Jollon, executive director of Colorado’s San Juan Basin Health Department. Primary care looked at how to best treat the individual. Public health has looked at population health, at communities that are made up of those individuals. She’s now seeing a convergence of the two approaches. “This change is driven by the realization that looking at individuals and looking at whole populations are simply two sides of the same coin.”

Primary care and public health each has a stake in arriving at a common definition—or at the very least, making sure their definitions align. As a convener, a collaborator, a campaigner and a collector of data, public health can advance the conversation.

Jeff Kuhr, PhD, executive director of the Mesa County Health Department, is familiar with the different interpretations of “population,” especially in his role as co-chairman of the Mesa County Health Leadership Consortium, which includes, among others, chief executives of hospitals and primary care practices. For health care providers—be they in primary care practices or hospitals—“populations” refers to those in their own systems, he says. “My message is, ‘What about the people who are not in your system?’ Over time, that’s made an impact on the group.”

A national perspective

At the federal level, AHRQ is advancing integration; it fosters clinical-community linkages to connect health care providers, community organizations and public health agencies to improve patient access to preventive and chronic care services in the community. “So much of what contributes to health happens outside of the 10-minute primary care office visit. Health is much bigger than that, and we want to ensure that primary care and public health efforts are linked,” says Genevro.

When public health and primary care cooperate, patients, clinicians and communities benefit. Patients get more help in changing unhealthy behaviors. Clinicians get help in connecting patients to available community services they

AHRQ: Advancing the conversation

AHRQ began to focus on the linkages between primary care and public health around 2005. In 2008 AHRQ held a summit to bring together primary care and community-based organizations. That’s where its commitment to integration began in earnest. “It was exciting to have a real dialogue about these issues,” says Tess Miller, DrPH, who leads AHRQ’s Prevention/Care Management Portfolio. A subsequent summit (2010) followed; it focused on how linkages between clinical practices and community resources (such as local health departments and community organizations) can enhance the delivery of clinical preventive services.

Based on input from stakeholders at the 2010 summit, AHRQ focused on the measurement of clinical-community relationships, and has produced the Clinical-Community Relationships Measures (CCRM) Atlas, which identifies ways to further define, measure and evaluate programs based on clinical-community relationships for the delivery of clinical preventive services. It provides a measurement framework and listing of existing measures of clinical-community relationships, and is intended to support research and evaluation in the field.
cannot provide themselves. Community programs get connected with the clients for whom their services were designed.\(^2\)

Effective population health management demands collaboration. Myriad factors influence population health, and no single organization can take them on. The commitment shared by primary care and public health—to improve health through preventive care services—may help shape consensus and foster collaboration.

Over the last few years, Genevro has seen a growing recognition of the value of these collaborations. The silos are crumbling, and there are several reasons.

- **The Triple Aim:** Most of the changes happening now have deep roots in the Triple Aim. It’s been expressed in different ways by various organizations, Genevro notes. The National Quality Strategy frames it as “Better Care, Healthy People/Healthy Communities and Affordable Care.”

- **Training:** Instead of considering “one patient at a time,” newly licensed physicians have been taught to think of “population” in ways that go beyond their patient panels.

- **Patient-centered medical home (PCMH) and neighborhood (PCMN):** “The commitment to improving outcomes means these providers take a broader view of the role of the health care system,” Genevro says. Practices going through the PCMH recognition process are encouraged to think more about patients as a group—it’s the first step in gaining a perspective on the clinical needs of a population. The PCMN takes an even broader view, building a bridge to the social determinants of health.

- **Accountable care organizations:** ACOs were envisioned to create accountable communities of practice for the health of entire populations, so it’s a natural corollary to think about resources and programs available in the larger community.

**Public health as convener**

Public health can—and must—convene stakeholders, says Kuhr. The first and most obvious place is at the community level. The Mesa County Health Department takes its role as convener seriously. “Rather than writing grants for specific programs to be run by the health department, we’re giving those projects to local partners and agencies. We’re empowering them,” he says. Doing this also reduces duplication of efforts.

“So many of these organizations have like missions. We’re better off bringing those agencies together to find one common message,” says Kuhr, adding that local and state public health agencies need to get out of the mind frame of program delivery and begin to see themselves as conveners.

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> — Jeff Kuhr, PhD, executive director of the Mesa County Health Department

A good example, he says, is Healthy Mesa County, which provides local agencies the opportunity to achieve greater results through aligned objectives and strategies. The Mesa County Health Department developed the program, but it’s not tied to any agency. “It’s not threatening to any agency, so all can participate. It allows them to align around common messages and offer their own programs that align with that message,” he explains. So there aren’t three different agencies offering smoking cessation programs that compete for clients—or for the attention of providers.

Healthy Mesa County fulfills public health’s traditional role as campaigner, and it marries it to its emerging role as convener. This approach avoids duplication and reduces confusion for clients.
about how to obtain the services they need. It also makes it easier for primary care providers to connect to these programs. They, as much as consumers, need to know what’s available, and where. If primary care providers are to manage patients’ needs and keep them out of the hospital, they need knowledge of and access to all of a community’s resources. And they need access to them over time and across populations.

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—Liane Jollon, RN, executive director, San Juan Basin Health

The second, more complex, aspect of the role of convener is working with health delivery systems, including primary care. “Public health can help providers better understand the role they play in the continuum of care.” Kuhr’s position on the Mesa County Health Leadership Consortium gives him a bully pulpit to promote local public health participation in health care strategy.

He also argues for “skin in the game”—something that’s anathema to many in public health, he says. Mesa County Health Department’s partnership with Marillac Clinic, a community clinic in Mesa County, provides an example.

The collaboration will ultimately increase primary care capacity and provide greater access for the underserved. As Kuhr explains it, Mesa County Health Department has had a family planning and immunization clinic for years, but federal funding is starting to dry up. So Kuhr secured a $1.1 million Colorado Health Foundation grant to expand capacity, creating a foundation for status as a federally qualified health center (FQHC). It partnered with Marillac which, according to the proposal, will move into the health department clinic, assume most of the responsibilities and turn it into a primary care clinic that would ultimately become an FQHC. Construction began in August; the new clinic will have a 10,000-patient capacity.

On a smaller scale, the San Juan Basin Health Department runs a community-based care coordination effort in partnership with Rocky Mountain Health Plans. A nurse navigator coordinates primary care, disease management, behavioral health, substance abuse and other areas, depending on a patient’s needs.

Approaching this from the community, rather than the practice, level has its advantages, Jollon explains. “We can provide information about gaps; that information becomes part of a system-level conversation, which drives the community—including hospitals, medical providers and other social or safety-net programs—to look at what services they need to add.”

Public health can also be a resource for certain outcome-based best practices. “We’re working at making changes—from reducing tobacco use to increasing breast feeding—that improve outcomes. The next step is to offer our skills and knowledge to inform primary care interventions,” says Jollon.

Collaboration and context through data

One of the benefits public health organizations can provide primary care practices is data. Public health officials accumulate the widest array of community resources for social determinants of health, Jollon says. Such assessments can put primary care in context. Primary care is focused on delivery, she says. “Public health is focused on the intersecting pieces.”

Genevro agrees, noting that public health professionals have more skill and experience at conducting such community needs assessments. These assessments could be a gold mine for primary care, especially if they assess resources and capabilities as well as need. But the data must be shared.
All public health agencies in Colorado must produce a community health assessment every five years; these assessments provide the basis for community health improvement plans. “We collect as much data as we can—whatever we can get our hands on—to paint a picture of Mesa County,” Kuhr says. It’s a comprehensive approach. The department overlays each data set on what it already has, allowing it to identify both resources and gaps.

“No data set is a complete picture,” he says. Sometimes, the data was collected with a particular agenda. Sometimes, it’s just a snapshot of one demographic. Whatever the reason, it’s not integrated. “We’re taking all that information and pulling it together to provide a fair, comprehensive look. That’s what a health department does as a non-biased entity—pull it together and create perspective.” Using data this way provides a more complete, balanced and robust picture of the community.

It’s another part of the convener role: “We can find opportunities and use data we collect on behalf of our partner agencies to write grants. When you come to the table, everyone can share information about their own agencies.” For instance, he and his team used that aggregated data to determine Mesa County’s need for an FQHC, which led to the aforementioned partnership with Marillac.

Meanwhile, the San Juan Basin Health Department has a data-sharing agreement with a pediatric practice to monitor childhood obesity. “It’s unique—and it’s small—but we hope to replicate that community-based approach with other organizations,” Jollon says.

Her department is engaged in a community conversation with primary care practices, hospitals, public health and other providers on how to use technology to share information. “If we are going to become data rich, we want to be information rich. Data is still a poorly understood piece, but we’re getting there. It’s a virtuous circle. We sit at the table and talk about data. That drives better technology, which drives better data.”

**Making progress with limited resources**

The vision for true data sharing is there, but making it a reality remains challenging, given the paucity of resources. For example, on the primary care side, someone needs the time and the skills to use the data. At the simplest level, comprehensive public health data helps physicians understand their patient population baselines—the first step toward making measurable improvements. The challenge: making optimal use of the data.

Some primary care practices use practice facilitators, Genevro says. These health care professionals, and others, such as community health workers, can act as “boundary spanners” who help practices in a number of ways, including accessing and optimally using data.

It gets back to having the infrastructure in place—both people and technology. Not every practice does. So who pays for it? Both primary care and public health feel resource-poor. Limited resources and unrealistic expectations—such as a comprehensive 10-minute visit—leave everyone overwhelmed. The question, says AHRQ’s Miller, is how to make these linkages, these collaborations, sustainable. Moreover, she says, both primary care clinicians and public health officials are suffering from change fatigue. A natural response to another demand will be “Not another thing!”

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Everything old is new again

Nevertheless, success stories continue to emerge. Miller and Genevro have witnessed increasing convergence around concepts and language in a core group of committed public health and primary care professionals. The challenge now is to disseminate that shared understanding. They cite “unsung work” happening in pockets around the country; they make particular note of the National Association of County and City Health Officials and the Association of State and Territorial Health Officials. (ASTHO’s Primary Care and Public Health Integration initiative includes summaries of success stories, including several from Colorado, at www.astho.org/Programs/Access/Primary-Care-and-Public-Health-Integration.)

What is occurring is actually re-integration. Until the early 20th century, these silos weren’t in place. Several trends contributed to the segregation of primary care and public health. Perhaps the most significant: the decision to create separate public health schools and medical schools. Public health began to establish itself as a profession independent of medicine. That continued through the 20th century. Now, the pendulum is swinging back.

Miller has been intimately involved with the integration issue for nearly a decade, and she recognizes the progress. “When we first became involved in this issue in 2005, even bringing primary care and public health to the same table was rare,” she says. That’s changed. From the frame-

works and maps developed by organizations like NACCHO and ASTHO to the on-the-ground work going on in Colorado and elsewhere, public health and primary care are coming to the table together.

“I think that’s the takeaway from all of this: We’re all working together to create the highest level of health for all people,” says Jollon. “Collaboratively, we can improve the health of individuals and communities, enhance the health care experience and begin to control costs.”

Kuhr appreciates the progress to date, but he believes much work remains—and it begins with transforming perspectives. “First and foremost, the value of public health needs to be realized,” he says. No single entity is at fault. “It could be our fault in public health because we don’t communicate our value. It could be the fault of a health care system in which providers don’t want to take a serious look at population health outside their own systems. Whatever the reason, we need to build a broader view from both sides.”

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LIANE JOLLON was named the executive director of San Juan Basin Health in August 2013. She previously served as a clinic nurse at SJBH in 2010, subsequently serving as a clinic manager and then Health Services Division director. A native New Yorker with a bachelor's degree from Columbia University, Jollon has worked in local and statewide non-profits in Colorado for the last 14 years. Her experiences range from delivering direct services to board positions and leadership roles. She earned her R.N. degree in 2010.

TESS MILLER is responsible for strategic planning, budget development and execution, and program implementation for the Division of Practice Improvement. She received her doctoral degree in public health and a certificate in health communication from the Bloomberg School of Public Health, Johns Hopkins University.

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JEFF KUHR has served as a local public health agency director in Nebraska and Colorado for the past 11 years. He is the president of the Colorado Association of Local Public Health Officials, a member of the Colorado Public Health Improvement Steering Committee, the co-facilitator of the Mesa County Health Leadership Consortium, and a governor-appointed member of the Colorado State Board of Human Services. He has a Ph.D. in educational psychology and is a Master Certified Health Education Specialist. His 22 years of experience in public health and health promotion provide a unique perspective on the connection between behavioral health, physical health, and population-based prevention strategies.
About Rocky Mountain Health Plans

Founded in Grand Junction, Colo. in 1974, as a locally owned, not-for-profit organization, Rocky Mountain Health Plans provides access to affordable, quality health care enabling its more than 229,000 members across the Western Slope to live longer, healthier lives.

About the Community

Western Colorado is creating an accountable community that uses health IT in a meaningful way, adopts value-based payment models, coordinates care and empowers patients to take charge of their health.

We aspire to ensure the following:

- High-quality health care is affordable and accessible to all.
- Those who purchase health care are assured that care is effective, safe and appropriate.
- Patient care is a team effort, with roles that are well-defined, connected and collaborative.
- Patients have access to the support and information they need to take charge of their health and make their own decisions.
- Payment reform will foster reimbursement models that support accountability for population health and resource use.
- Information technology supports population health, helping providers predict outcomes, prioritize interventions and prevent disease.
- Health data is a community resource used in a secure way to support coordinated care at the population, practice and personal levels.
- Investments in information technology and health system transformation will improve quality of life and economic well-being across the state.
- Health is a community resource that requires leadership, stewardship, individual responsibility, community support and ongoing maintenance.

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