

# PUBLIC HEALTH IMPROVEMENT PARTNERSHIP

## AGENDA FOR CHANGE

### Public Health Partnering with the Healthcare System Workgroup Report

May 12, 2012

In 2011, the Public Health Improvement Partnership, under direction of the Secretary of Health, adopted the *Agenda for Change*; a roadmap for redirecting the work of public health to better respond to the changing needs of preventable illness and disease in our state. Three workgroups were established to identify goals, strategies and action plans. The role of this workgroup was to evaluate and provide ideas and input about how public health can be more effective in partnering with the healthcare system to improve access to care, and clinical-and community-based preventive services in Washington State.

There are many compelling reasons why public health must renew strong partnerships with the health care system, including:

- 1) the dramatic emergence of a new set of preventable health illnesses (obesity, diabetes, heart disease),
- 2) the rising and unsustainable costs of clinical health care,
- 3) the dismal US health rankings compared to other developed countries,
- 4) evidence that overall population health will improve most by preventing chronic disease, and
- 5) knowledge that we will have a bigger impact creating better healthier lives and economic vitality if we partner with health care leaders, community leaders, and the health care delivery system to stem the tide of preventable illness.

Health care reform, alone, will not solve the problem. Restructuring payments, increasing the number of people with insurance and changing incentives are all important health reform strategies, but each is only one part of a larger picture. That larger picture is where a public health perspective can make an important contribution.

Over the past century, public health measures had a tremendous impact on the health of people by providing strategies for prevention and early detection of diseases like tuberculosis, syphilis and measles. The tools in the public health toolbox included raising awareness through community education, engaging leaders in setting policies to prevent

disease transmission and providing information to health care providers about the most effective practices based on the latest research.

As the US disease burden has shifted from infectious disease at the turn of the last century, to chronic disease at the beginning of the 21<sup>st</sup> century, there are important implications for the relationship between traditional 'public health' work and clinical preventive services provided in individually-focused healthcare. Our best opportunity to achieve prevention goals, reducing the cost and impact of chronic disease, will come from effectively combining the knowledge that emerges from population-based studies of the public's health with the potential for patient education and intervention in clinical preventive services. It is critical that public health identify best practices and new strategies in partnership with health care leaders, community leaders, and the health care delivery system so that all available resources are working together to stem the tide of preventable illness. If we do this well, all Washington citizens will live better, and lead more productive and healthier lives.

This workgroup's members (roster page XX) have considered how public health can best partner with other health care entities, in order to support a prevention agenda for the future. They have asked 'What does the field of public health contribute to the topic under consideration? They have considered the importance of individual access to health services and specified the various ways that access barriers keep people from getting needed health services. They have considered how public health can help build a stronger health care system, and can promote better mental health. They have developed a vision of a less divided system of both public health and the healthcare delivery system working to prevent, detect, manage and treat many of today's chronic diseases such as diabetes and heart disease.

Now is the time for public health to use the tools from the past; raising awareness through community education, engaging leaders in setting policies to prevent disease transmission and providing evidence based information to health care providers, but to adapt these to address the problems of today.

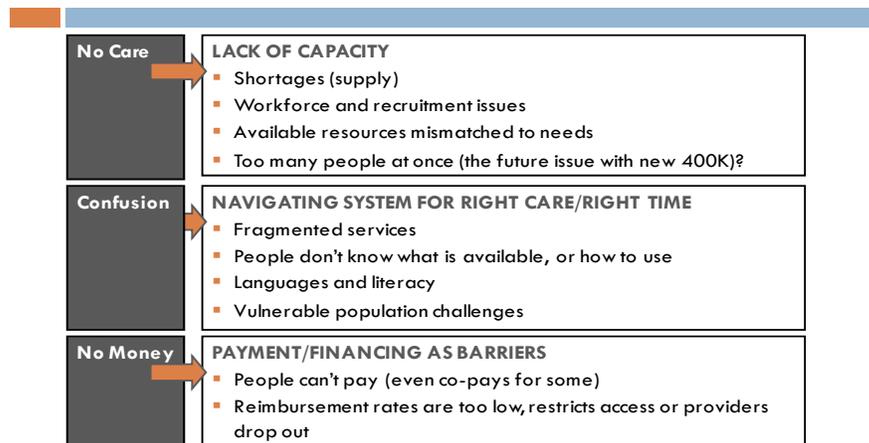
## Access to Health Care

On September 12, 2011, the work group began its discussion by talking about what goes wrong in the current system that prevents people from getting the health care they need, when they need it, broadly summarized as challenges with access to care. These challenges are actually a combination of problems. They heard a presentation by Bonnie Burlingham from the Washington State Hospital Association on the Rural Health Care Strategic plan, describing disparities between rural and urban risk factors, health outcomes and access to care. The goal of the Strategic Plan is an integrated rural healthcare system in Washington and improved community health.

The workgroup recognizes that three fundamental problems limit access to care: (i) lack of provider capacity, (ii) confusion about how to access care, and (iii) inability to pay. They are

experienced to some degree in every community in Washington, and may look different in rural or urban settings. The situation may also be more acute from one community to the next. The challenges to access translate into greater illness burden when people (especially vulnerable populations) do not get needed care – including preventive services. The illness burden stretches beyond the individual, to the family and the broader community in terms of poor health, lost work and greater cost for more expensive treatment and miss-used resources.

## Access to care challenges



**Lack of provider capacity** refers to the lack of needed care by primary care providers, specialty providers, mental health providers and other specialty providers in some areas and after hours. Lack of capacity is manifested as the lack of providers accepting Medicaid/Medicare patients, limited access to appointments for new patients (compounded when five percent of the population use 50% of the services and resources), no after hours care in rural areas (drives people to emergency rooms) and the overuse and ineffective use of hospital emergency rooms. These capacity issues prevent people from seeking prevention, early intervention, and primary care services resulting in costly inefficient treatment.

**Confusion about how to access needed health care** includes a lack of information about where to get services, the fragmentation of services, language and cultural barriers, and fear of deportation. These confusion issues result in vulnerable populations not seeking early care and receiving primary care at hospital ERs.

**Inability to pay** refers to a lack of health insurance, inability to pay co-pays or deductibles, no prescription coverage, and refers to providers choosing to leave poor or rural areas because of low reimbursement rates, or other financial reasons.

While solving all of these problems is beyond the scope of the workgroup, the workgroup members believe public health can play a very important role in helping communities

address them. The core work of public health is to make sure that every member of our community has the best opportunity to live as long and as healthy as possible. We ensure this by mobilizing our many partners, judiciously using available resources, and applying scientifically proven methods to attack the leading causes of preventable death and illness. Public health is a very broad discipline which is grounded in ten essential services and measured against national public health standards for voluntary accreditation. Within these are three clearly defined ways the public health system in Washington can and should help with the access to care problem described by the workgroup.

The primary ways public health can help are to:

- **Provide information** to local leaders and others about local health care capacity, how people are using the system to obtain care, the financial barriers, and the health status of the community. The workgroup heard repeatedly that community leaders want to improve the ability for people within their communities to obtain needed care but did not have the information to understand the problem and therefore were unable to effectively develop strategies for improvement. The state agencies and the public health system can provide information on health care provider capacity by specialty, community health status, hospital usage and evidence based improvement options. Public health can provide much of this background information and can monitor outcomes over time.
- **Provide local leadership** to help communities convene to understand and address community health challenges together. The workgroup described the desire for public health to bring together community leaders to understand and act on the community's health problems. They heard that the many entities involved in providing health care and preventive services don't talk to each other and if they do talk it's fragmented and usually only about an individual case. Public health has the desire and expertise to carry out the role of bringing the parties together who want to have a role to play in improving the community's health, and these can include health care providers, community centers, schools, law enforcement, faith groups and others. By talking together, health care providers and community leaders can also better understand changes to the health care system that will stem from federal health care reform. Having a better understanding of health care needs and issues in the community can help people find innovative ways of providing services such as telemedicine or mobile 'rail car clinics' in rural areas. No single provider or group can do this alone – but it takes people sharing ideas to bring about community level change.
- **Promote adoption of clinical preventive services.** Clinical preventive services consist of screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, or provide people with the information they need to make good decisions about their health. Consistent use of evidence-based preventive services throughout the health care system can improve quality of care. Public health can help disseminate information about the most effective clinical preventive services, showing which services reduce death and disability, and are cost-effective or even cost-saving.

While preventive services are traditionally delivered in clinical settings, some can be delivered within communities, work sites, schools, residential treatment centers, or homes. Clinical preventive services can also be supported and reinforced by community-based prevention, policies, and programs. And, community programs can also play a role in promoting the use of clinical preventive service and assisting patients in overcoming barriers (e.g., transportation, child care, patient navigation issues).

Workgroup members recognize that now is the time for public health to more effectively and strategically partner with the health care system to improve access to quality, affordable, and integrated health care and clinical preventives services.

The workgroup offers the following objectives, strategies and possible action items for public health to undertake in partnership with community and health care leaders to improve access to health care in Washington. It is expected that some of the action items can be acted on in the short term while others will require further exploration and assessment.

## Objective 1: Information

### 1.1 Strategy for Information

**Provide information about the capacity of the health care delivery system within community so that local participants can develop plans to close gaps.**

*Possible action:*

- Provide information to local health departments and their communities about the number and type of providers in their area so that there is better information to identify gaps in service, and help people obtain services
- Assess the capacity for primary care services available within the community
- Provide data to communities to monitor the availability of healthcare services in terms of adequacy, sufficiency and quality
- Assess the availability of clinical and preventative services for Medicaid and Medicare clients, and for vulnerable populations such as the homeless, the indigent, or those with behavioral health issues within communities
- Assess the availability of clinical and preventative services within communities
- Assess the availability of specialty clinical services such as obstetrics, pediatrics, and behavioral health within communities
- Provide the healthcare delivery system with data to support patient safety goals
- Share health care credentialing and licensing data to identify opportunities for patient safety improvement

## 1.2 Strategy for information

**Provide information about how people use the health care system (utilization data) in their communities so that inefficient use can be identified, and providers can help people navigate the system effectively and efficiently.**

*Possible action:*

- Summarize and share existing sources of data about geographic variation in access to and use of health care resources including the Behavioral Risk Factor Surveillance System (BRFSS), Office of Financial Management - Blue Ribbon Commission Report, Puget Sound Health Alliance (PSHA), and the Dartmouth Health Atlas of Health Care
- Explore network capacity within the community
- Assess after hours capacity available within a community other than the ER
- Explore what existing use data is available within the community and share. For example, what hospital emergency room use data is publicly available?
- Explore what existing use data is available from the insurance plans

## 1.3 Strategy for information

**Provide information about funding barriers so that health care partners delineate where payment is a problem.**

*Possible action:*

- Identify populations who lack access to health care. The process to specify barriers can include an assessment survey, analysis of secondary data such as ER and insurance status data.

## 1.4 Strategy for information

**Provides information about the health status of the community including behavioral health, access to care, quality, outcomes, and gaps so that community leaders, health care providers and other decision makers can make informed decisions about how to meet local need.**

*Possible action:*

- Provide population-based information such as rates of disease, access to health, behavioral health status, and other health factors available through the Public Health Improvement Partnership, the County Health Rankings, and other sources.

## 1.5 Strategy for information

**Public health partner with hospitals and health care providers to implement electronic health records systems called Health Information Exchanges (HIE).**

*HIE reduces the cost for the Department of Health to maintain secure and confidential connections with providers and local health jurisdictions. The HIE will improve rapid confidential reporting of communicable disease, collection and reporting of hospital data, expand surveillance of non infectious conditions, and to link to emergency department use data.*

*Possible action:*

- Establish relationships with partners including the operator of the HIE, One Health Port, the Washington Health Care Authority, and participants in the HIE (e.g., hospitals, providers), and share with local health jurisdictions as facilities within the jurisdictions implement the HIE.

## Objective 2: Leadership

### 2.1 Strategies for Leadership

**Public health convenes people with a shared interest in health outcomes so that meaningful community health assessments can be developed. This includes connecting hospitals, consumers, behavioral health, primary care, specialty care, and dental care services.**

- Partner with nonprofit and district hospitals and other provider groups in the development of community health needs assessments and community benefits implementation strategy reports.  
*The purpose of the community health assessment is to learn about the health status of the population. Community health assessments describe the health status of the population, identify areas for health improvement, determine factors that contribute to health issues, and identify assets and resources that can be mobilized to address population health improvement.*
- Publish reports about the health of local communities (such as county profiles) for broad dissemination and easy access (such as a web portal)
- Identify how other states developed collaborative community health needs assessments with their partners including hospitals, provider groups, community clinics, public health, and provided for public participation and share this information.

### 2.2 Strategy for leadership

**Public health convenes diverse audiences to share information about the health of the community so that there is a common understanding of health issues prevalent.**

- Convene community forums where public health, clinicians, hospitals, boards of health and other partners to identify problems (including social determinants of health) and potential solutions.
- Expand presentations to local boards of health, community groups, tribal boards and others.
- Share community health needs assessment with local boards of health, and other forums.

## Objective 3: Education

### 3.1 Strategies to Promote Adoption of Clinical Prevention Strategies

**Advocate for provider use of evidence-based clinical prevention services (population based and proven to be both effective and cost saving) endorsed by the National Commission on Prevention Priorities Services (National Quality Strategy).**

*Possible action:*

- Share information on effective clinical preventive services such as screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, or provide people with the information needed to make good decisions about health
- Share information with community leaders and others the clinical preventive services agenda for community-level efforts to reduce chronic diseases such as heart disease, cancer, stroke, alcoholism, drug abuse, mental health issues and diabetes
- Disseminate this information to primary providers and others on a regular basis and evaluate for successful messaging

### 3.2 Strategies to Promote Adoption of Clinical Prevention Strategies

**Promote the adoption of primary care medical homes to recognize the benefits of increased access to health care, continuity of care, and patient-centered care.**

*Possible action:*

- Public health share information with providers and other health care leaders about primary care medical homes and how this option improves quality of care and patient safety, reduces fragmentation of services and has the potential for increased reimbursement as a Primary Care Medical Home.

<p><b>Strategies and action items</b></p>	<p>Enter a <b>1</b> for the most important action item under the strategy</p>
<p><b>1.1</b> Strategy for Information Provide information about the capacity of the health care delivery system within the community so that local participants can develop plans to close gaps.</p>	
<p><b>1.1a</b> Provide data on number and type of providers by area</p>	<p><b>3 (8yes)</b></p>
<p><b>1.1b</b> Assess the capacity for primary care services available</p>	<p><b>1 (6 y, 2 n)</b></p>
<p><b>1.1c</b> Provide data to monitor the availability of healthcare services in terms of adequacy, sufficiency and quality</p>	<p><b>1 (7Y, 3 N)</b></p>
<p><b>1.1d</b> Assess the availability of clinical and preventative services for Medicaid and Medicare clients, and for vulnerable populations</p>	<p><b>4 (8Y, 1N)</b></p>
<p><b>1.1e</b> Assess the availability of clinical and preventative services within communities</p>	<p><b>1 (7 Y, 1 N)</b></p>
<p><b>1.1f</b> Assess the availability of specialty clinical services such as obstetrics, pediatrics, and behavioral health</p>	<p><b>(7Y, 2 N)</b></p>
<p><b>1.1g</b> Provide the healthcare delivery system with data to support patient safety goals</p>	<p><b>(6 y, 4N)</b></p>
<p><b>1.1h</b> Share health care credentialing and licensing data to improve patient safety</p>	<p><b>(6y,3n)</b></p>
<p><b>1.2</b> Strategy for information Provide information about how people use the health care system (utilization data) in their communities so that inefficient use can be identified, and providers can help people navigate the system effectively and efficiently.</p>	
<p><b>1.2a</b> Summarize and share existing sources of data about geographic variation in access to and use of health care resources including the Behavioral Risk Factor Surveillance System (BRFSS), Office of Financial Management - Blue Ribbon Commission Report, Puget Sound Health Alliance (PSHA), and the Dartmouth Health Atlas of Health Care</p>	<p><b>2 (8y, 1n)</b></p>
<p><b>1.2b</b> Explore network capacity within the community</p>	<p><b>2 (4y,5n)</b></p>

<p style="text-align: center;"><b>Strategies and action items</b></p>	<p>Enter a <b>1</b> for the most important action item under the strategy</p>
<p><b>1.2c</b> Assess after hours capacity available within a community other than the ER</p>	<p><b>2 (5Y, 4N)</b></p>
<p><b>1.2d</b> Explore existing use data available within the community and share. (ER use data?)</p>	<p><b>2 (5y, 4n)</b></p>
<p><b>1.2e</b> Explore what existing use data is available from the insurance plans</p>	<p><b>(6Y, 3N)</b></p>
<p><b>1.3</b> Strategy for information Provide information about funding barriers so that health care partners delineate where payment is a problem</p>	
<p><b>1.3a</b> Identify populations who lack access to health care. The process to specify barriers can include an assessment survey, analysis of secondary data such as ER and insurance status data</p>	<p><b>5 (9Y)</b></p>
<p><b>1.4</b> Strategy for information Provides information about the health status of the community including behavioral health, access to care, quality, outcomes, and gaps so that community leaders, health care providers and other decision makers can make informed decisions about how to meet local need.</p>	
<p><b>1.4a</b> Provide population-based information such as rates of disease, access to health, behavioral health status, and other health factors available through the Public Health Improvement Partnership, the County Health Rankings, and other sources</p>	<p><b>7 (9Y)</b></p>
<p><b>1.5</b> Strategy for information Public health partner with hospitals and health care providers to implement electronic health records systems called Health Information Exchanges (HIE).</p>	
<p><b>1.5a</b> Establish relationships with partners including the operator of the HIE, One Health Port, the Washington Health Care Authority, and participants in the HIE (e.g., hospitals, providers), and share with local health jurisdictions as facilities within the jurisdictions implement the HIE</p>	<p><b>4 (5y, 3n)</b></p>

<p><b>Strategies and action items</b></p>	<p>Enter a <b>1</b> for the most important action item under the strategy</p>
<p><b>2.1</b> Strategy for Leadership Public health convenes people with a shared interest in health outcomes so that meaningful community health assessments can be developed. This includes connecting hospitals, consumers, behavioral health, primary care, specialty care, and dental care services.</p>	
<p><b>2.1a</b> Partner with nonprofit and district hospitals and other provider groups in the development of community health needs assessments and community benefits implementation strategy reports.</p>	<p><b>6 (8y, 1n)</b></p>
<p><b>2.1b</b> Publish reports about the health of local communities (such as county profiles) for broad dissemination and easy access (such as a web portal)</p>	<p><b>3 (9y)</b></p>
<p><b>2.1c</b> Identify how other states developed collaborative community health needs assessments with their partners including hospitals, provider groups, community clinics, public health, and provided for public participation</p>	<p><b>1 (7y, 2n)</b></p>
<p><b>2.2</b> Strategy for leadership Public health convenes diverse audiences to share information about the health of the community so that there is a common understanding of health issues prevalent</p>	
<p><b>2.2a</b> Convene community forums where public health, clinicians, hospitals, boards of health and other partners to identify problems (including social determinants of health) and potential solutions</p>	<p><b>8 (8y)</b></p>
<p><b>2.2b</b> Expand presentations to local boards of health, community groups, tribal boards and others.</p>	<p><b>(8Y, 1 n)</b></p>
<p><b>2.2c</b> Share community health needs assessment with local boards of health, and other forums.</p>	<p><b>1 (8y, 1n)</b></p>
<p><b>3.1</b> Strategies to Promote Adoption of Clinical Prevention Strategies Advocate for provider use of evidence-based clinical prevention services (population based and proven to be both effective and cost saving) endorsed by the National Commission on Prevention Priorities Services (NQS).</p>	

<p><b>Strategies and action items</b></p>	<p>Enter a <b>1</b> for the most important action item under the strategy</p>
<p><b>3.1</b> Strategies to Promote Adoption of Clinical Prevention Strategies Advocate for provider use of evidence-based clinical prevention services (population based and proven to be both effective and cost saving) endorsed by the National Commission on Prevention Priorities Services (National Quality Strategy)</p>	
<p><b>3.1a</b> Share information on effective clinical preventive services such as screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, or provide people with the information needed to make good decisions about health</p>	<p><b>4 (7y,2n)</b></p>
<p><b>3.1b</b> Share information with community leaders and others the clinical preventive services agenda for community-level efforts to reduce chronic diseases such as heart disease, cancer, stroke, alcoholism, drug abuse, mental health issues and diabetes</p>	<p><b>5 (9y)</b></p>
<p><b>3.1c</b> Disseminate this information to primary providers and others on a regular basis and evaluate for successful messaging</p>	<p><b>(8y)</b></p>
<p><b>3.2</b> Strategies to Promote Adoption of Medical Homes Promote the adoption of primary care medical homes to recognize the benefits of increased access to health care, continuity of care, and patient-centered care.</p>	
<p><b>3.2a</b> Public health share information with providers and other health care leaders about primary care medical homes and how this option improves quality of care and patient safety, reduces fragmentation of services and has the potential for increased reimbursement as a Primary Care Medical Home</p>	<p><b>4 (7y, 3n)</b></p>

## Appendix

<b>Key Indicators</b>	<b>Years</b>	<b>WA State</b>	<b>National Average</b>	<b>Target</b>
Percent of adults age 18 or older who report having a personal doctor or healthcare provider.	<b>2009-2010</b>	<b>78%</b>	<b>80%</b>	
Percent of adults age 18 or older who report needing to see a doctor within the past year but could not due to cost	<b>2009-2010</b>	<b>13%</b>	<b>15%</b>	
Percent of women age 21 or older who report receiving a Pap smear test within the past 3 years	<b>2010</b>	<b>76%</b>	<b>79%</b>	
Additional years a 20 year-old is expected to live in good, very good, or excellent health	<b>2008-2009</b>	<b>52 years</b>	<b>48 years</b>	

**Data source:**

(DOH) Behavioral Risk Factor Surveillance System

(National) CDC, Behavioral Risk Factor Surveillance System

# PUBLIC HEALTH IMPROVEMENT PARTNERSHIP

## Public Health Partnering with the Healthcare System Subgroup

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