

PUBLIC HEALTH IMPROVEMENT PARTNERSHIP

SEPTEMBER 12, 2011

PUBLIC HEALTH PARTNERING WITH THE HEALTHCARE WORKGROUP

PARTICIPANTS

<i>Co-Chairs</i>	Joan Brewster (Grays Harbor); Karen Jensen (DOH)
<i>Staff</i>	Jane Lee, Simana Dimitrova (DOH)
<i>Members</i>	Bonnie Burlingham (WSHA); Jason Zaccaria (Benton-Franklin); Kristen West (CHOICE/Regence); Marsha Crane (Tribal Representative); Mary Looker (CMHC); Peter House (UW-SPHCM); Rachel Quinn (PHSKC); Regina Delahunt (Whatcom); Shelly Prizzo (St. Elizabeth's Hospital); Anne Shields, Mike Lee, Gregg Grunenfelder, Daisye Orr, Tracy Mikesell (DOH)

MEETING NOTES

WELCOME AND INTRODUCTIONS

Joan Brewster and Karen Jensen

Joan and Karen introduced themselves and welcomed participants to the first meeting of this workgroup. Joan asked each participant to briefly introduce themselves.

AGENDA FOR CHANGE ORIENTATION

Gregg Grunenfelder, Agenda for Change Workgroup Co-Chair

Gregg provided a brief overview of the Reshaping Public Health's effort which led to the creation of the *Agenda for Change* in 2010. The Agenda focuses on the changing environment of public health and outlines a shared set of principles and decision considerations for policy, program and funding decisions. He also touched on changing disease trends, health care reform, and opportunities for the future.

To move the Agenda from a broad description of what the governmental public health system should focus on in the future, a new workgroup of the PHIP was appointed. The scope of the work is to build on the Reshaping Public Health efforts over the next 2 to 5 years. The workgroup will guide the process, continually scan the environment, oversee and review the output of the sub-workgroups, identify themes, key issues and gaps and integrate all these elements into an action plan for Washington's governmental public health system.

The three newly created sub-workgroups under the Agenda for Change Workgroup will focus on each area outlined in the *Agenda for Change*. Sub-group participants will contribute content expertise, consider topics broadly rather than based on funding streams and consider how to use existing resources more effectively.



The Agenda for Change workgroup will publish two reports in the next 18 months – an Interim Action Plan in mid 2012 and the 2012 Public Health Improvement Plan.

Karen introduced the scope of this work group: explore how the public health system can interface with the healthcare delivery system to improve the health of people in Washington State. The difference in this work from previous efforts is that focus is on how the governmental public health system can identify ways to partner more effectively with diminishing resources, and how public health can be more responsive with the clinical system. Diversity was sought to complete this work. The best way to do this work is explore targeted topics for discussion including other contribution in addition to the meetings.

In the next 6 to 9 months, this work will focus on the following 4 major topics:

- How does public health work to improve access to quality, affordable and integrated healthcare that incorporates routine clinical preventive services and is available in rural and urban communities?
- How do we strengthen relationships between public health and the healthcare system to improve access to clinical and community preventive services?
- How do we work together to promote good mental health, reduce substance abuse, improve access to behavioral health services, therapeutic care, and substance abuse/addictive services?
- How do we provide responsive oversight of healthy professionals and institutions to support access to care and to help ensure patient safety?

AGENDA FOR CHANGE ORIENTATION

Bonnie Burlingham, WSHA

Bonnie presented an overview of the Rural Health Care Strategic Plan. The first edition came out in 2009, and is currently being revised. The Rural Strategic Plan was created in response to requests from the Washington State Association members for future planning support, from the Federal Office of Rural Health Policy and from the Office of Financial Management. The end goal in this effort is an integrated rural healthcare system in Washington and improvement community health.

The presentation covered data on state's demographics, access to care and health coverage. The vision for the rural healthcare system is structured around:

- Ensure those needing care get the right care at the right time in the right place
- Provide personal and population health services (including oral and mental health care) responsive to documented community needs
- Provide a medical home for all people in the local community
- Deliver planned access to the full continuum of care through regional systems that formally link primary and specialty services
- Leadership comes from communities and providers working together

The alignment of efforts between the Rural Strategic Plan and *Agenda for Change* will help identify a common rural health agenda, provide common vocabulary and tools for consistent communication and help determine how it is possible to make the best use of current and future resources to improve the health of Washington's residents.

The presentation highlighted differences between urban and rural communities that significantly affect future access to care discussions in Washington.

TOPIC 1: DISCUSSION

Joan Brewster

How does public health work to improve access to quality, affordable and integrated healthcare that incorporates routine clinical preventive services and is available in rural and urban communities?

- What barriers limit access to healthcare in your community?

Kristen West: Clear gap exists between urban disparities models and rural ones. Let's keep the pressure on both populations.

Mary Looker: People who used to have payment source, now they don't and are in need of care. ER will become the point of care again unless changes are implemented. There is inadequate workforce and capacity to serve.

Rachel Quinn: In King County there are many socially complex barriers to health care including language, transportation, legal status, homelessness, unstable lives/homes, and cognitive impairments.

Regina Delahunt: Number of practices accepting Medicaid/Medicare is decreasing

Peter House: Financing and political problems; government is seen as 'under attack', sometimes its hard to move forward.

Shelly Pricco: Physical access. Suburban and rural areas have difficulty providing services when large urban areas are 20 minutes away. Good for some but hard for others unable to access urban areas.

Ann Shields: We are operating in a time of severely limited resources. High cost, high need, 5/50 population (5% of the population uses 50% of the cost). Eighty percent of the population (using for example healthy homes) uses 20% of the health care dollar.

Kristen West: Not enough primary care providers in the region. This capacity needs developing. Scope of practice issues.

Regina Delahunt: Access to specialty care such dental or behavioral health services are very difficult.

Marcia Crane: Among tribes more people are uninsured. It is not true that tribes get free health care; tribes get a set number of dollars for tribal member health care. There are misconceptions about the annual health agreements that actually reimburse at rates below vets or prisons.

Jason Zaccaria: Hard to get information out to migrant worker populations. A few FQHC will provide care but knowing where to find care is difficult. Rachel - This is true in urban areas too.

Bonnie Burlinham: There are retention issues across the state as doctors and healthcare administrators are aging. Little succession planning for retiring leaders.

Joan Brewster: There are many broken parts in today's health care system and much desire to make it better. However, there are many barriers to change and few incentives that would change business models and medical practice so that the system improves.

- What positive things are happening in the communities? What is an example of what is working well?

Regina Delahunt: Whatcom Alliance for Healthcare Access (WAHA) is poised to reinvent (reform) the healthcare system in Whatcom County. This effort is 10 years old and includes all players involved in the county healthcare, including providers, business, foundations, etc. WAHA is in the process of reevaluating each member's role. The group is looking at technology, governance, funding. Phase 1 complete. Phase two will focus in implementation. In 2012 a pilot project will be launched. Goal is for ACO to be in place and functioning by 2014. Whatcom County Health Department is a neutral and key player providing assessment data and as a voice for prevention and health promotion in the system. The local hospital is an active leader. Regina will forward a summary to the group.

Kristen West: Slower effort than Whatcom since they are 5 counties. They have not yet agreed to a regional health implementation collaborative. Prioritizing what they want to work on but will include everything from the 5/50 to prevention. How do we integrate primary care and criminal justice and behavioral health care? Local, regional pilot through Choice. Local health departments of all 5 counties very engaged.

- Can we identify some measures and goals?

Rachel Quinn: Collecting internal data and get external contractor data, but no measures or goals set. Using FQHC clinical measures.

Anne Shields: Handed down a lot of measures at high need end. Medicare started covering weight management. Prevention, more flexibility.

Marsha Crane: Most tribes have state of the art data management system, report to RPMS, GPRA systems. Goals include tobacco cessation, flu and other immunization (quality improvements)

Joan Brewster: Where independent medical practices are predominate, it can be difficult to coordinate resources, but there are great advantages that could be realized – shared electronic records and data systems, for example.

Regina Delahunt: Yes, huge issues, ability to share and use data. Their experience with the ACO shows how difficult it is to get systems in place with goals.



Mike Lee: Delivery systems have historically focused on revenues not on health outcomes. More money is made fixing instead of 'preventing' problems. No incentives to prevent. Perhaps Medicare is searching for ways to prevent expensive stuff? Maybe it's time for public health to offer more. How can we suggest changing the structure to make a difference? This is more likely to happen in large urban areas where more money is involved.

WRAP UP

Joan Brewster and Karen Jensen

Additional comments welcome by e-mail by October 14th.

NEXT STEPS

Meet: November 7 (9 am-noon at the DOH offices in Kent)