Linking primary care and public health in Minnesota

Why it’s critical to the health of our population

BY JANE KORN, M.D., M.P.H.

The current push for better care, better value and improved population health is providing an impetus to reshape the relationship between primary care and public health in our state. Clearly, achieving the Triple Aim will require a health care system that delivers high-quality, comprehensive primary care to all at a lower per capita cost. But in order to address the growing burden of chronic disease—one of the drivers of rising costs—health care organizations will need to coordinate their work with public health to better enable people to live healthy lives through community-based prevention. Neither the health care system nor the public health sector can do this alone.

A 2012 report issued by the Institute of Medicine (IOM) calls for the integration of primary care and public health, defining integration as “the linkage of programs and activities to promote the overall efficiency and effectiveness to achieve gains in population health.” The IOM proposes a continuum of integration, starting with mutual awareness and cooperation and moving to collaboration and full partnership. Federal agencies including the Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, and Health Resources and Services Administration have begun to embrace this concept and are beginning to take a more coordinated approach to funding their respective programs. We have a National Prevention Strategy that aims to “move the focus on sickness and disease to one based on prevention and wellness.”

In our state, the Minnesota Department of Health and local public health departments have been working with the primary care community to achieve that goal, leveraging opportunities to optimize the quality of clinical care and working to reform payment in a way that encourages integrated care to prevent and manage chronic disease.

Clinics and communities

Minnesota’s Statewide Health Improvement Program (SHIP) is one such example. Funded in 2008 by the state Legislature, SHIP is about creating opportunities for health in communities. SHIP activities focus on active living, healthy eating and smoke-free environments, using strategies that complement the one-patient-at-a-time approach of the clinical setting or disease-management programs offered by health plans. Through SHIP, local public health departments are engaging schools, businesses, transportation agencies, city planners and the health care sector to implement policies, systems and environmental changes that will support improvements in population health. Over the past four years, the work done as a result of SHIP has strengthened ties between local public health departments and primary care. In many areas of the state, these efforts are redefining the relationship between local public health departments and primary care clinics in exciting ways. For example, in Fergus Falls, local public health and Lake Region Healthcare are working together to put prevention guidelines into practice by optimizing workflows for screening patients, counseling them, making referrals and providing follow-up.

Building on the foundation of SHIP, Minnesota’s Community Transformation
Grant (CTG) Program, funded under the Affordable Care Act, expands on the collaborative work being done by clinics and public health. CTG adds an emphasis on reducing health disparities and preventing and managing chronic diseases such as heart disease, diabetes and hypertension. With the CTG funds, we are supporting evidence-based programs in the community such as the Diabetes Prevention Program and smoking-cessation programs that help people manage their risk for chronic disease. Through CTG, primary care practices are working with local public health departments to determine how best to streamline referrals to community services, how to use health information technology to facilitate follow-up, and how to integrate nontraditional providers such as community health workers or community paramedics into a more coordinated system of care. In the Duluth area, for example, local public health is providing resources to area clinics to train staff in motivational interviewing and in practice facilitation.

CTG also has supported Minnesota Community Measurement’s development of a healthy lifestyle measure for primary care that includes BMI, smoking status and hypertension control. This measure will be piloted this spring with selected primary care clinics involved with CTG activities. We hope both the medical and public health sectors will find the data provided by this measure useful for assessing and improving population health.

New payment models
On the payment side, Minnesota was one of six states selected in 2013 to receive a State Innovation Model (SIM) testing grant from the Center for Medicare and Medicaid Innovation. Jointly administered by the Minnesota Department of Human Services (DHS) and Department of Health (MDH), SIM funding will enable testing of new ways of delivering and paying for health care using an accountable health framework based on total cost of care. SIM builds on Minnesota’s experience with health care homes that promote coordinated, team-based, patient and family-centered care. It also makes a substantial investment in health information technology. Grants will be made available to providers in early 2014 to support secure health data exchange across care settings. Later this year, through a competitive grant process, SIM will fund up to 15 Accountable Communities for Health to test new ways of linking medical care, behavioral health care, long-term care, public health, social services and community-based prevention with a goal of developing financially sustainable models to address community health priorities.

The importance of data
Data exchange, data reporting and data analytics have become increasingly important to both primary care and public health. Launched a decade ago, Minnesota’s e-health initiative was created to accelerate the use of health information technology. As of August 2013, 87 percent of clinics, 96 percent of hospitals and 97 percent of local health departments were using electronic health record (EHR) systems and 92 percent of clinics were e-prescribing. We need to continue working to ensure we maximize the potential of EHRs to support clinical decision-making and the exchange of clinical and public health information.

The State Quality Reporting and Management System (SQRMS), which tracks the quality of health services, is yielding data that benefit both the primary care and public health sectors. Among the data being collected are measures of health outcomes, preventive services and management of heart disease, diabetes, asthma and depression. Several public health programs in Minnesota, including state programs for asthma, diabetes, heart disease and cancer, as well as the health care home initiative are using SQRMS data to monitor progress in meeting statewide health-improvement goals around chronic disease prevention and control.

Conclusion
The IOM proposed the following principles to encourage integration of primary care and public health: shared goals for population health, community engagement, aligned leadership, and collaborative use of data and analysis. These principles are embedded in the work now being done in Minnesota. One could say that after decades of drifting apart, we now have the “perfect storm” for bringing public health and primary care into closer alignment to provide high-quality care for all, contain costs and improve the health of all Minnesotans.

Jane Korn is medical director of the Health Promotion and Chronic Disease Division of the Minnesota Department of Health.

REFERENCES