

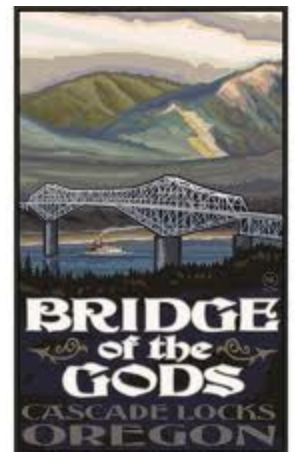
Linking Primary Care With Public Health and Community Resources: Studies to Build the Medical Neighborhood

Oregon Rural Health Conference
October 25, 2012

Melinda Davis, PhD
Paul McGinnis, MPA

Presentation Objectives

- Highlight importance of clinic – public health - community resource linkages
- Share findings from current work
- Apply linkages conceptual framework in a “case”



Why Linkages? IOM Perspectives ¹ ...

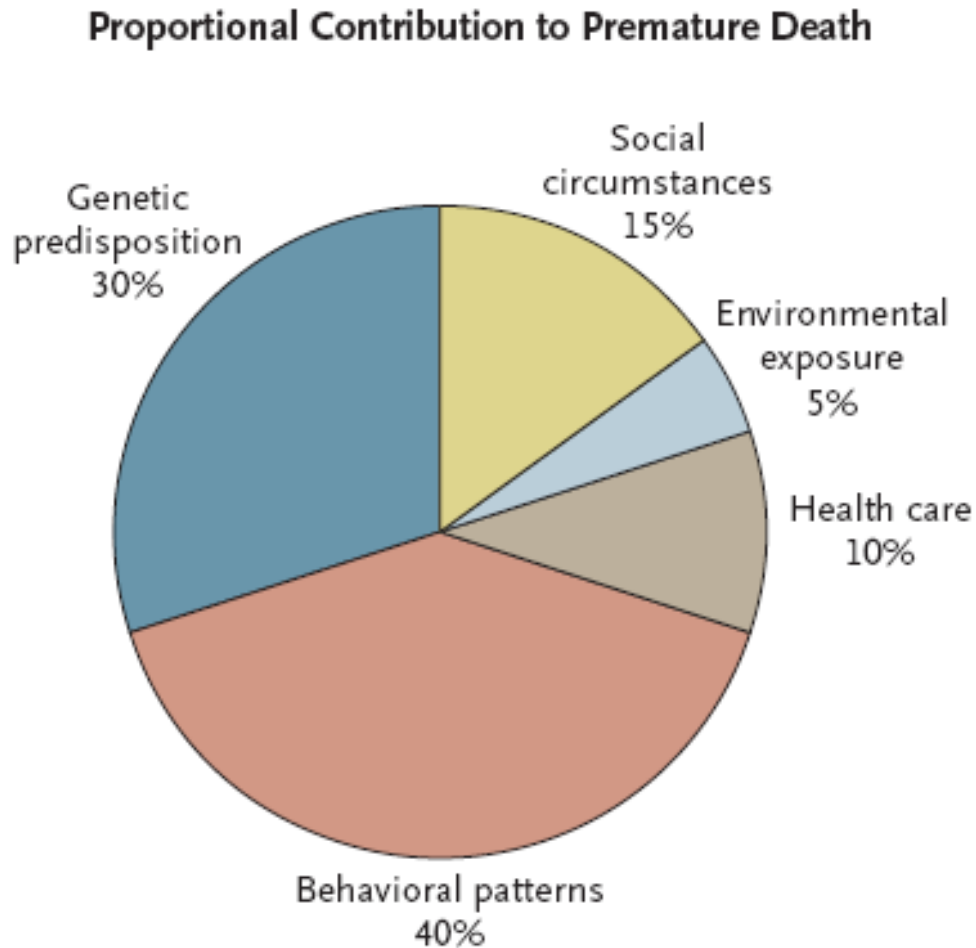
- Multiple actors contribute to population health
 - Social and environmental determinants of health
 - Impact of primary prevention
- Substantial, lasting improvements require concerted efforts
- Integration can enhance capacity of primary care and public health to carry out missions
- Health reform provides opportunity for change

¹ Institute of Medicine, Report Brief, March 2012. Primary Care and Public Health: Exploring Integration to Improve Population Health. see <http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx>

Why Linkages? Clinic Perspectives...

- NCQA and state-based PCPCH measures call for “delivering or **arranging** for 90% of the USPSTF Grade A and B Recommendations and/or Bright Futures periodicity guideline”
- Patients receive only half of the recommended clinical services overall and < 20 % of recommended counseling or education services (McGlynn et al. 2003)
- Delivery of all the USPSTF recommendations would consume 7.4 hours of a clinician’s day (Yarnall et al., 2003).

What factors contribute to premature death??



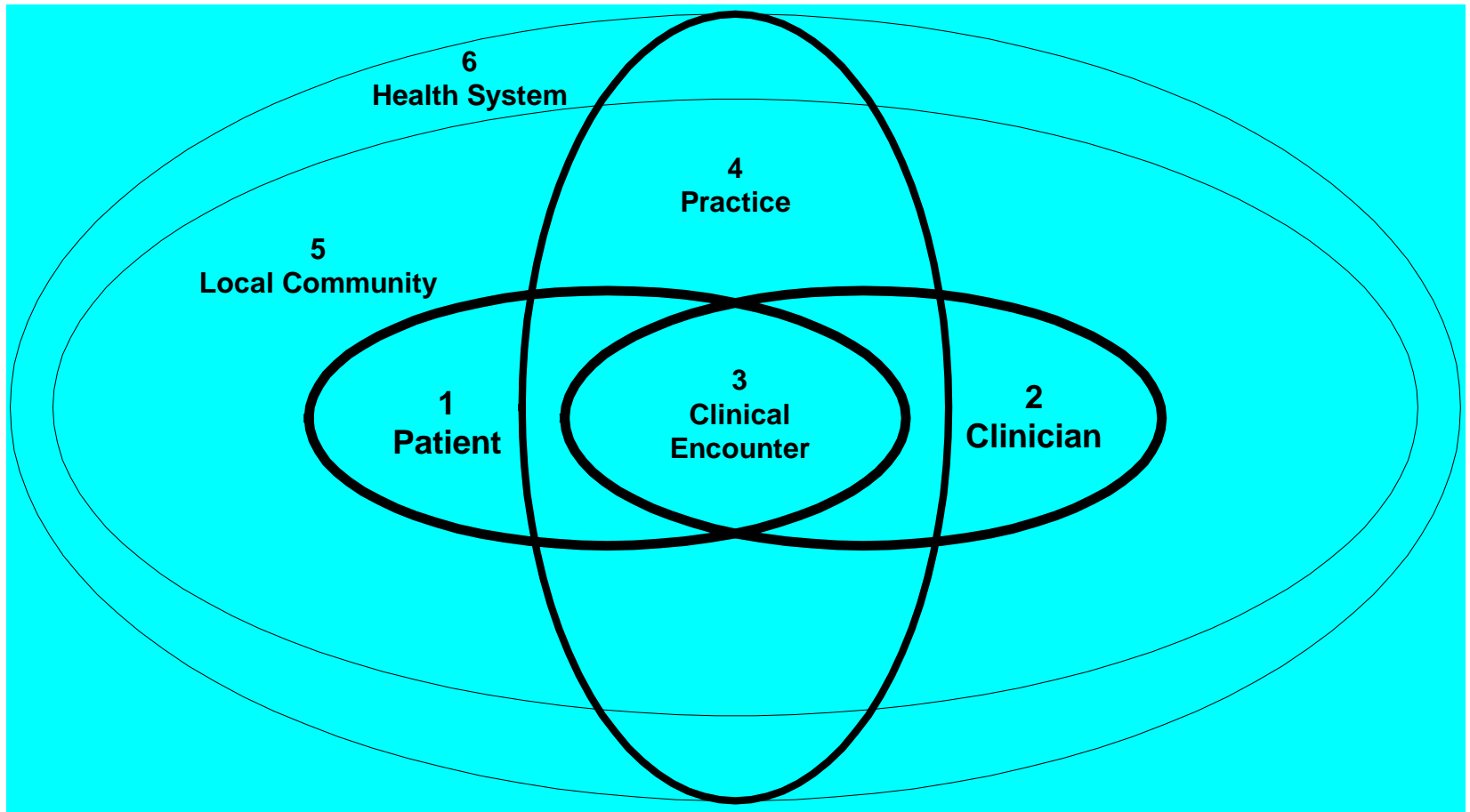
Schroeder. *N Engl J Med* 2007; 357:1221-8.

McGinnis et al. *Health Aff (Millwood)* 2002; 21(2):78-93.

Figure 1. Determinants of Health and Their Contribution to Premature Death.

Adapted from McGinnis et al.¹⁰

Complexity Science and the Ecology of Health Care



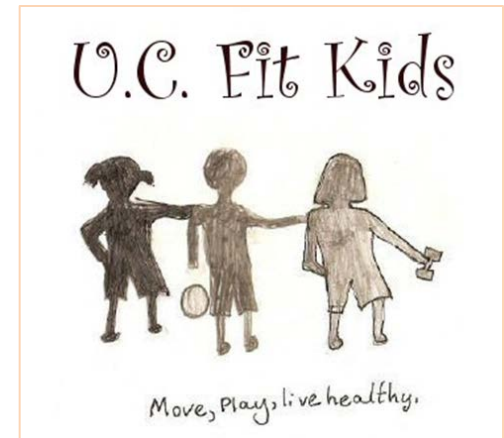
Crabtree BF et al. Understanding practice from the ground up.
The Journal of Family Practice. 2001; 50(10):883 – 887.

ORPRN “Linkage” Research

- **Betty Gray** - Practices, Barriers, and Training Needs of Rural Health Care Practitioners Relevant to the Management of Pediatric Obesity
- **Clemente** - Integrating Primary Care Practices and Community-based Programs to Manage Obesity (AHRQ Task Order #21)
- **Linkages Measures and Framework** - Linking Primary Care & Resources in the Community to Improve Health: Development of Conceptual Framework and Measures (Task Order #9)

Example 1: Betty Gray

- **Funding:** School of Nursing Betty Gray Fund
 - Supplement U.C. (Union County) Fit Kids
 - PI: Nancy Findholt, PhD, RN
- **Research Question:** What are the perceived barriers, resources, and training needs of rural primary care providers regarding childhood obesity?
- **Method:** Interviews with 16 clinicians in rural Eastern Oregon
- **Summary of Findings**
 - 5 categories of barriers: practice, clinician, patient/family, community, and socio-cultural environment
 - Few clinic and community resources
 - Little previous training, but interest



Example 2: Clemente



- **Funding:** AHRQ (Task Order #21)
- **Objective:** To develop a *process* to facilitate sustainable linkages between clinics and communities in the management and treatment of obese patients
- **Methods:** Mixed methods intervention with community partners and clinics
- **Findings**
 - Improved screening (height, BMI)
 - Clinic level improvement in brief counseling documentation
 - 4/6 clinics (66%) initiated a total of 137 referrals
 - Few clinics improved documentation of obesity status or referral
 - Foundation for clinic and community engagement

Example 3: Linkages Measures and Framework

- **Funding:** AHRQ (via Westat contract, Prevention and Care Management Task Order #9)
- **Objective:** Develop conceptual framework for measuring effectiveness of linkages between primary care practices, local health departments, and community organizations
- **Method:** Literature review, expert panel
- **Findings....**

IOM Principles for Successful Integration

- A common goal of improving population health
- Involving the community in defining and addressing its needs
- Aligned leadership that
 - Bridges disciplines, programs and jurisdictions
 - Clarifies roles and insures accountability
 - Develops and supports appropriate incentives
 - Has the capacity to manage change
- Sustainability, via establishing shared infrastructure and building enduring value
- Collaborative use of data and analysis

“The committee finds that the types of interactions between the two sectors are so varied and dependent on local circumstances, such as the availability of resources and differences in health challenges, that it is not possible to prescribe a specific model or template for how integration should look.”

IOM Report (2012)

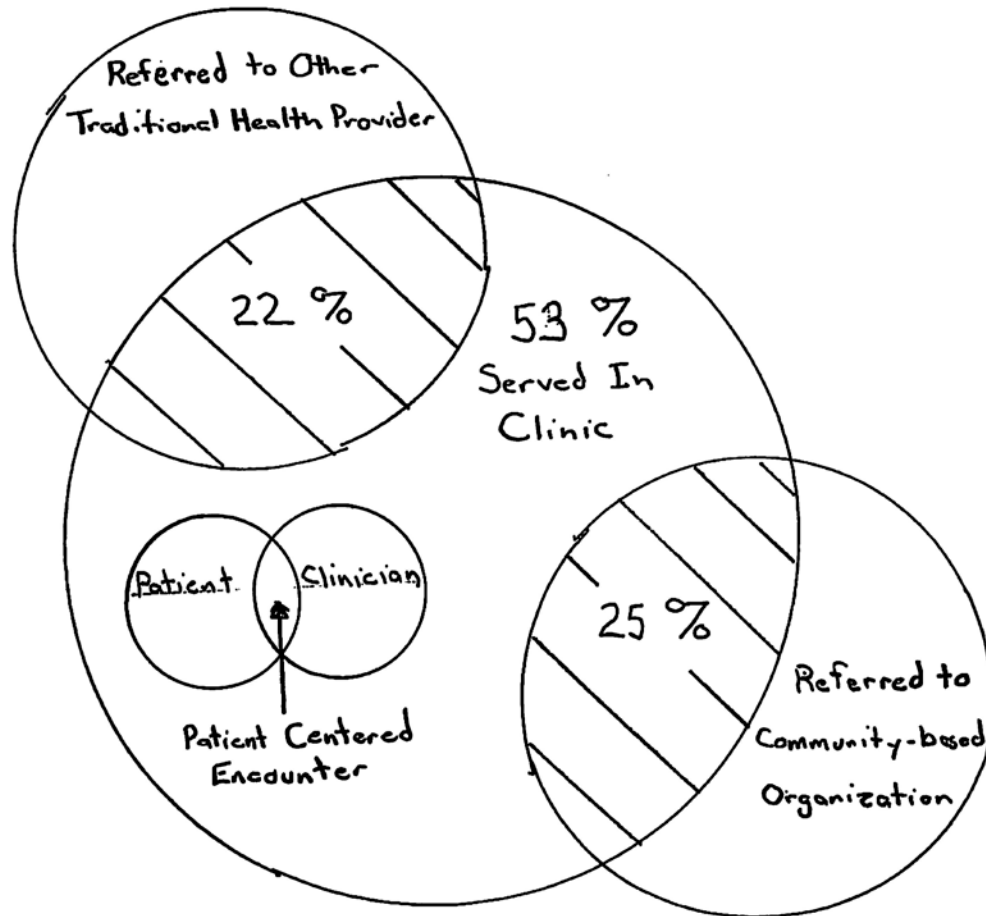
Primary Care and Public Health

So what does this mean for primary
care and my community?

The Referral Decision Tree

- Two steps: 1) Refer or Not? 2) To Whom?
- Referral choice (yes or no) is grounded in 3 variables
 - **Patient Characteristics:** Condition, socio-economics, insurance, demographics, social and psychological needs, “patient readiness”
 - **Clinic / Clinician Characteristics:** Scope of service, support personnel (refer within the clinic), training, and tolerance of “uncertainty.”
 - **Community / Health System:** Medical geography, community resource geography, transportation, and community norms etc..

Settings for Delivery of Grade A and B USPSTF Recommendations



Preventive Services Considered

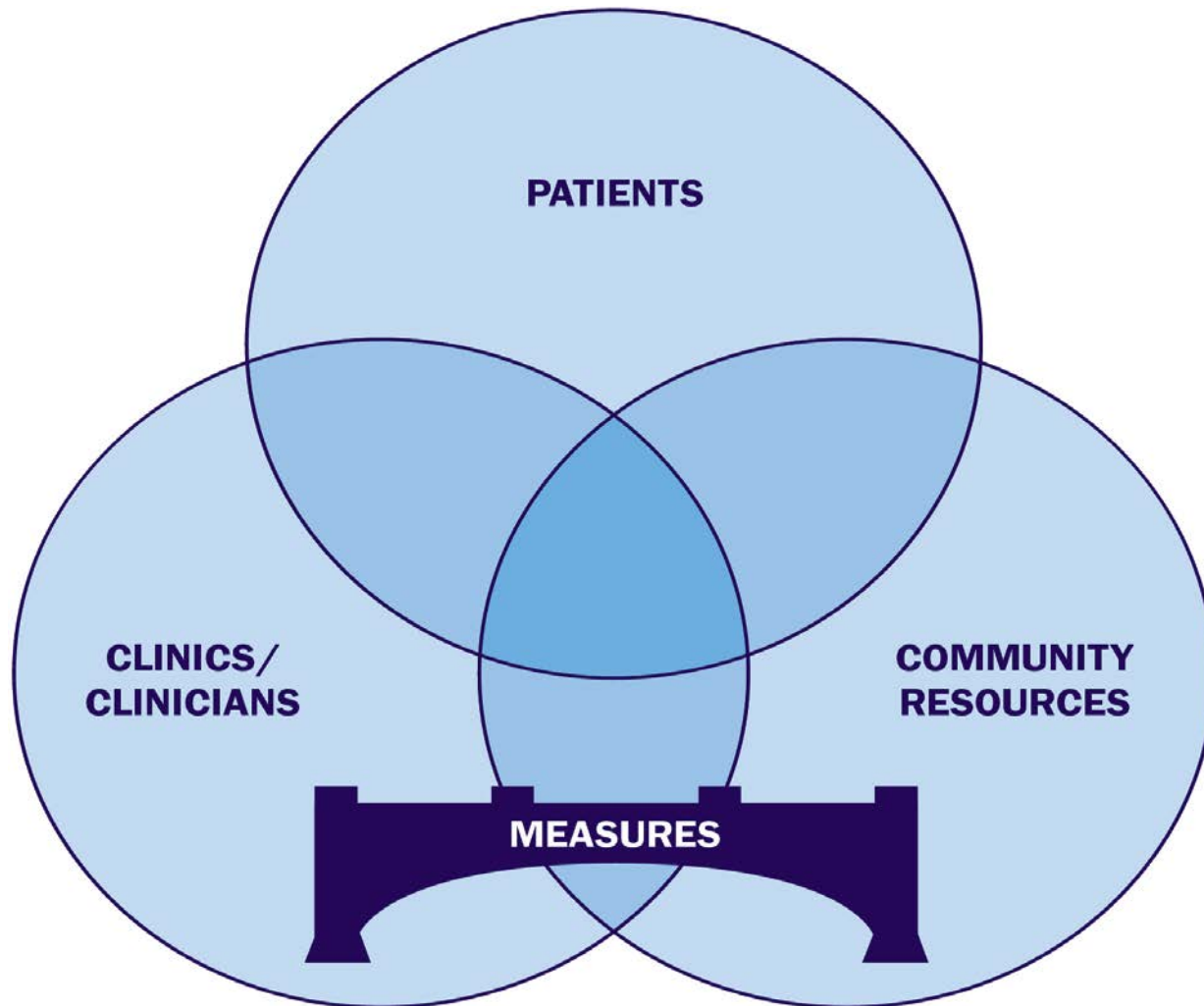
- Alcohol misuse counseling
- Breastfeeding counseling
- Healthy diet counseling
- Obesity Screening and Counseling (> age 6)
- Tobacco use counseling
- Behavioral counseling in primary care to promote physical activity (coming soon!)
- Sexually transmitted infection counseling

A Subset of Care Coordination

- **Care Coordination:** The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health services (McDonald et al., 2010)
- Most activities involve traditional “health providers”
- Differentiation between health organizations and community-based resources:
 - Excluded certified laboratories, pharmacy / pharmaceuticals, hospitals, outpatient ambulatory surgical facilities, sub-specialty clinicians
 - Excluded services requiring the use of diagnostic tool or device that is monitored and certified for safety and accuracy by a state regulatory authority

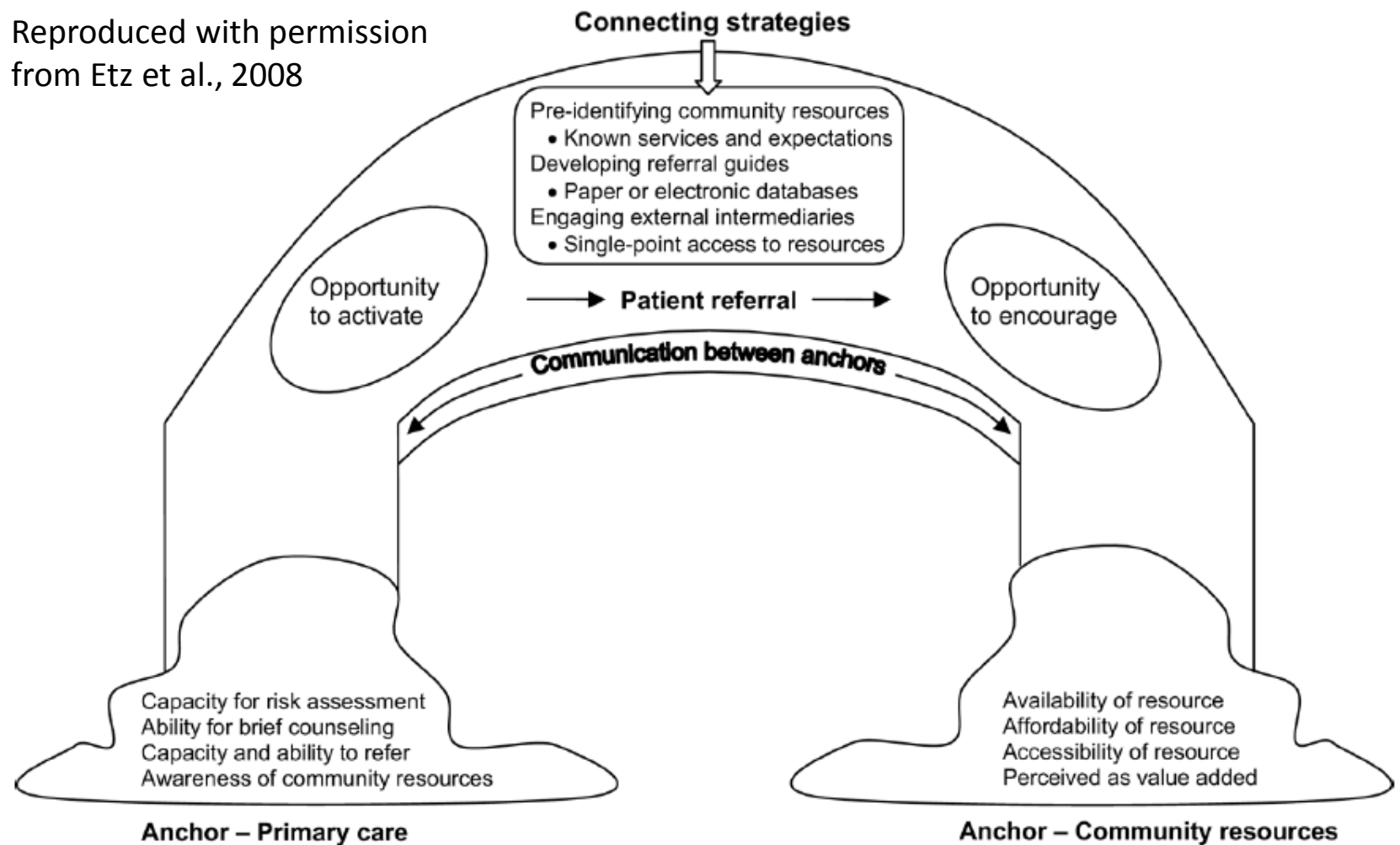


Conceptual Framework Model for Clinic Community Resource Measures

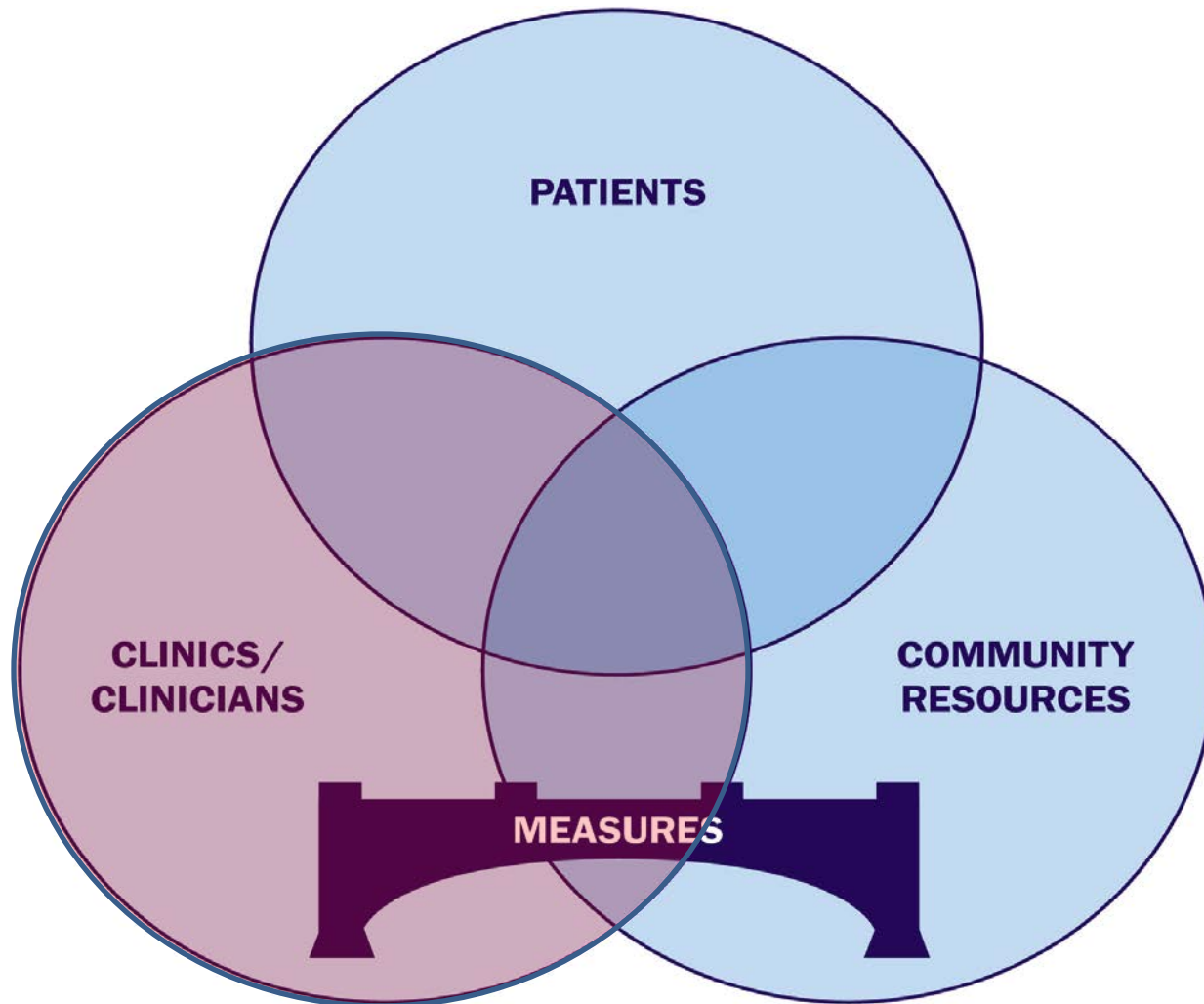


Bridging Primary Care with Community Resources: Model Elements

Reproduced with permission
from Etz et al., 2008



Clinic/Clinician Measures



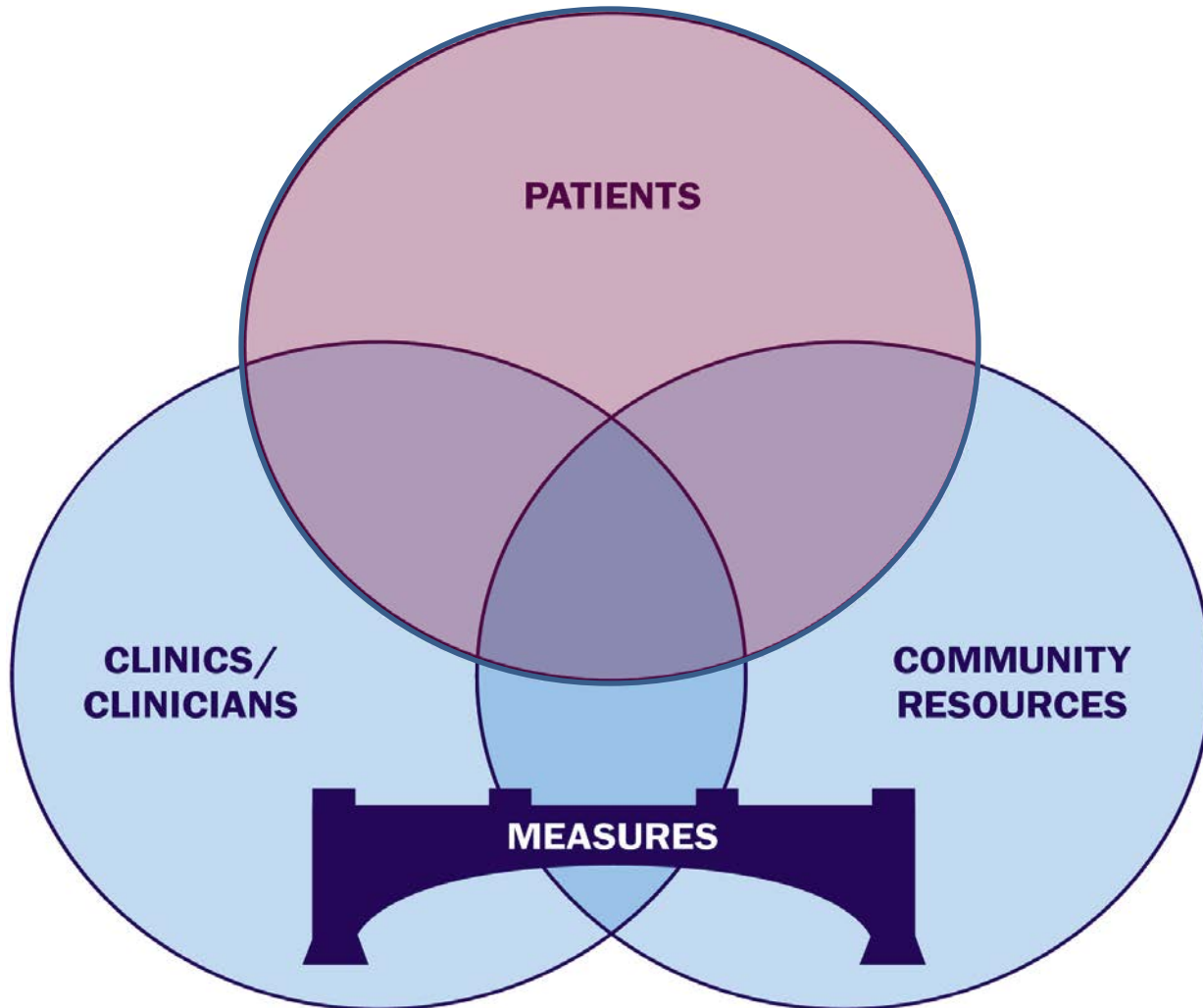
Clinic / Clinician Measures

- Service capacity and training
- Information technology infrastructure
- Delivery system design (scope of professional services included)
- Organizational infrastructure
- Knowledge of and familiarity with community resources

“Knowledge of” Expanded

- The Referral – (Refer or Not, then to whom)
- AIDA Model
 - Awareness
 - Interest
 - Desire
 - Action
- Hesitancy to Refer
 - Unknown organization
 - Not convinced it works
 - Unsure of quality of information

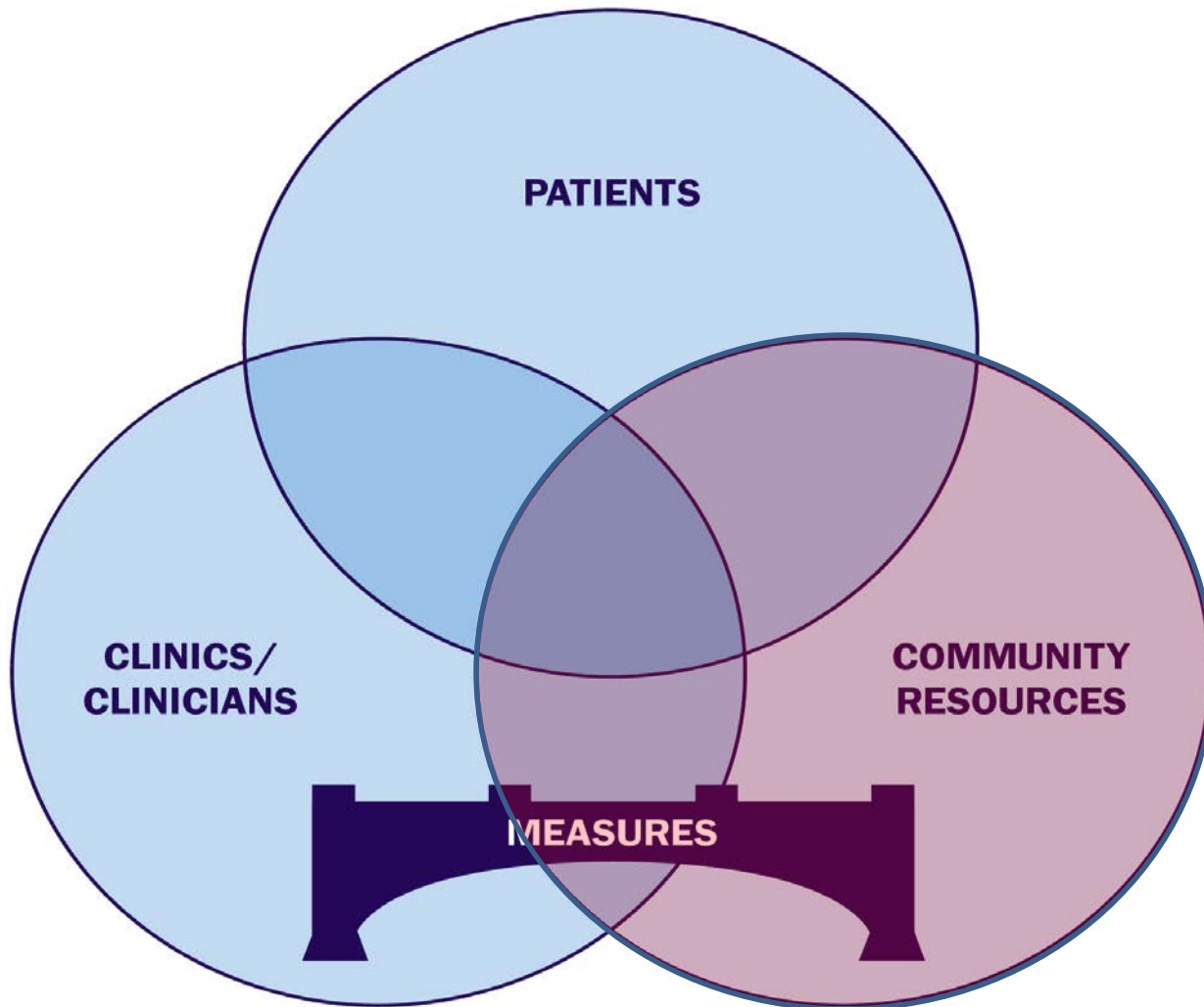
Patient Measures



Patient Measures

- Patient Characteristics – Socio-economic/ demographic / insurance status / family support etc.
- Health literacy
- Capacity for self-management
- Knowledge of and familiarity with community resource
- Readiness / stage for behavioral change

Community Resource Measures

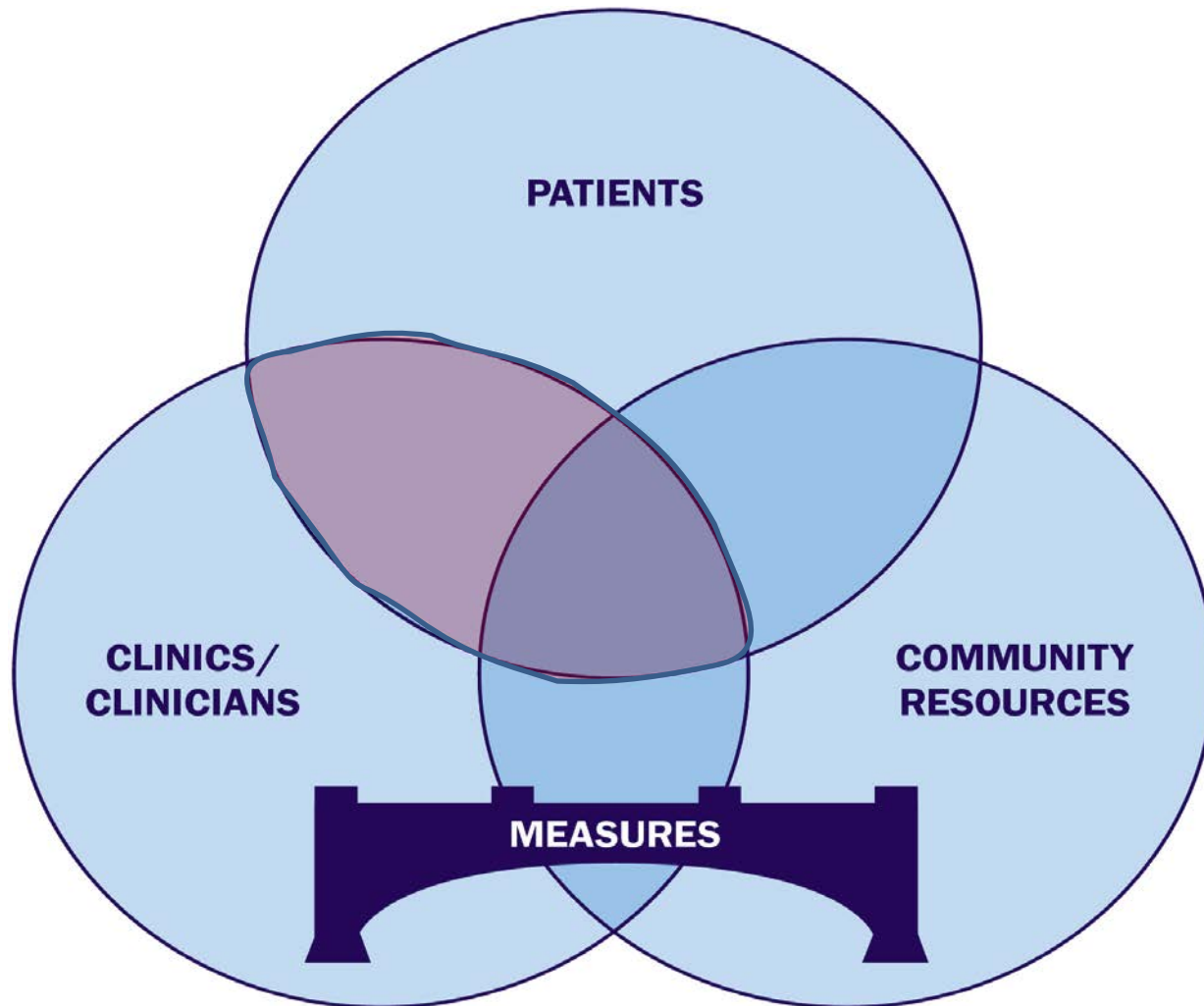


Community Resource Measures

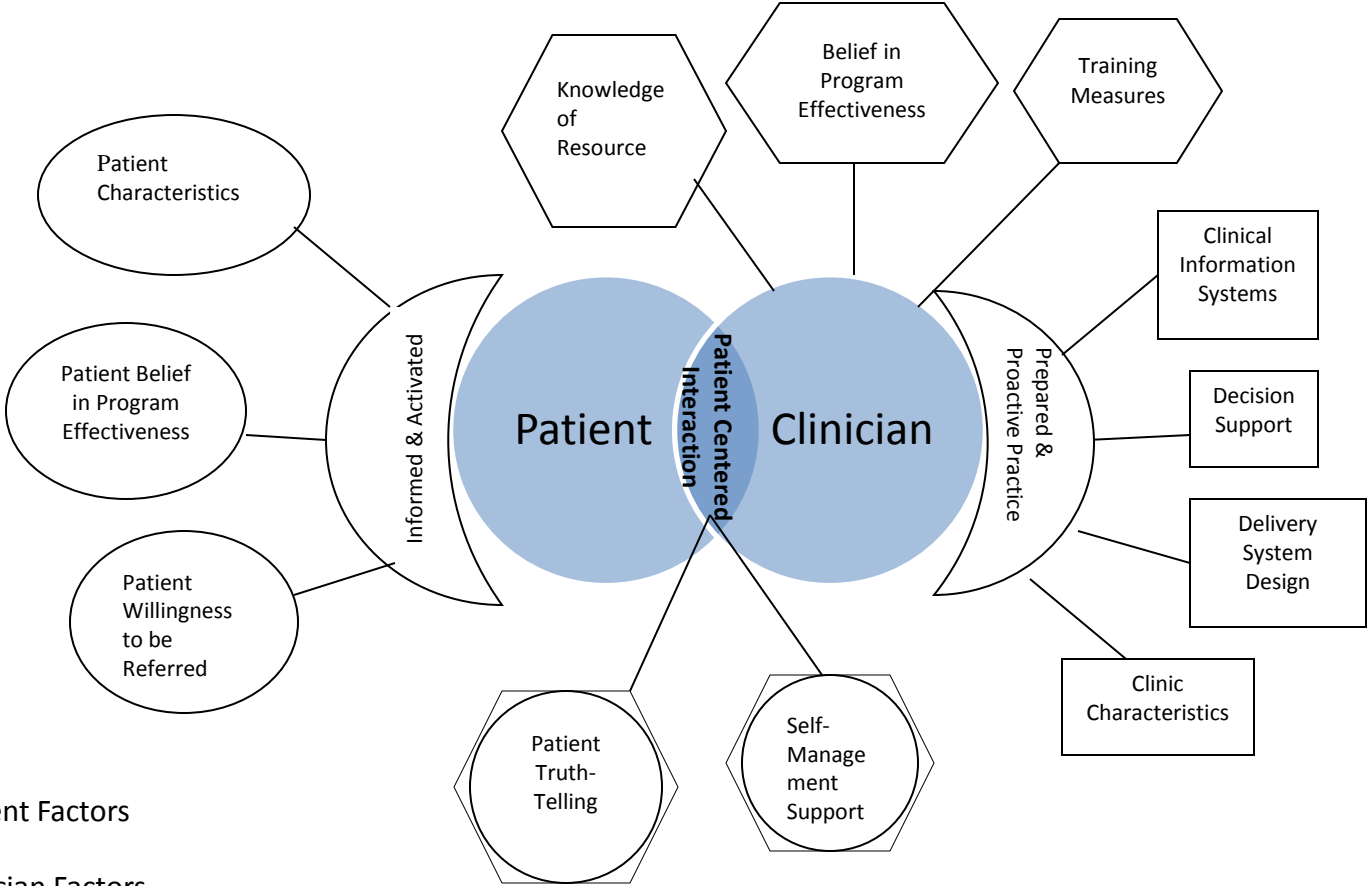
- Service capacity and training
 - Availability
 - Accessibility
 - Quality
 - Continuity
 - Cost
- Information technology infrastructure
- Delivery system design
- Organizational infrastructure

Now the Linkages....



Clinician and Patient within Clinic



Clinician and Patient within the Clinic

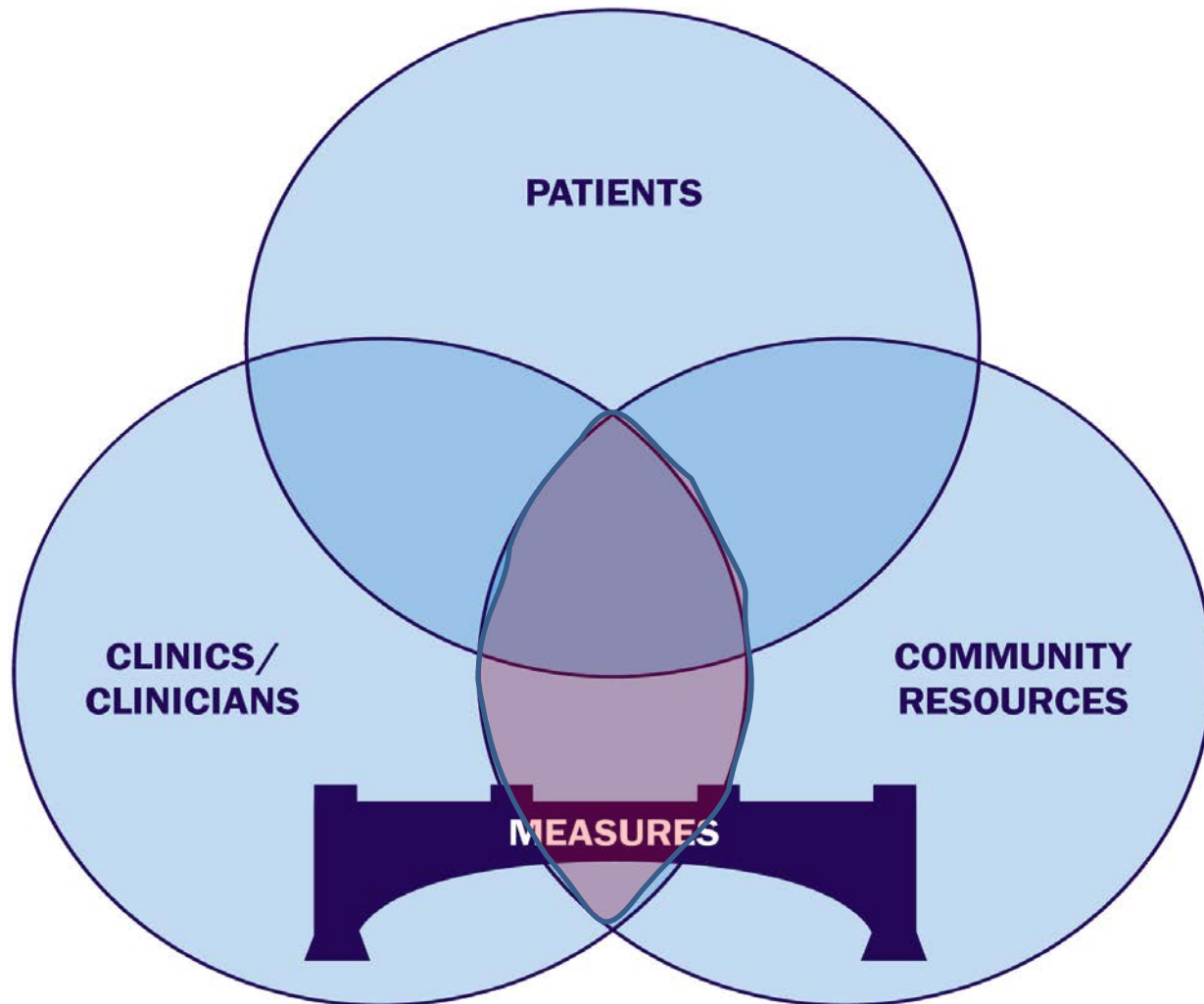


Legend

-  = Patient Factors
-  = Clinician Factors
-  = Clinic Factors

Modified from Chronic Care Model -Wagner

Clinics/Clinicians & Community Resources

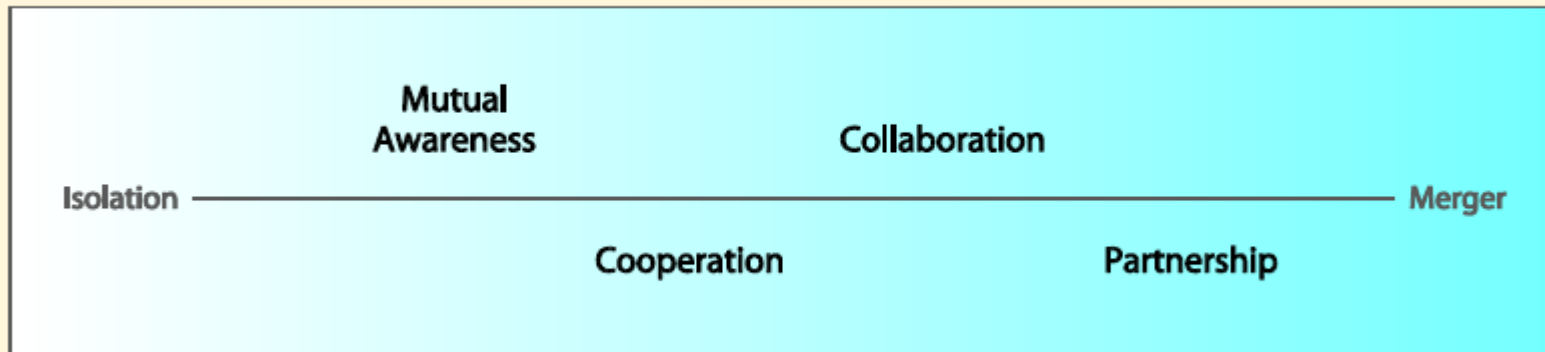


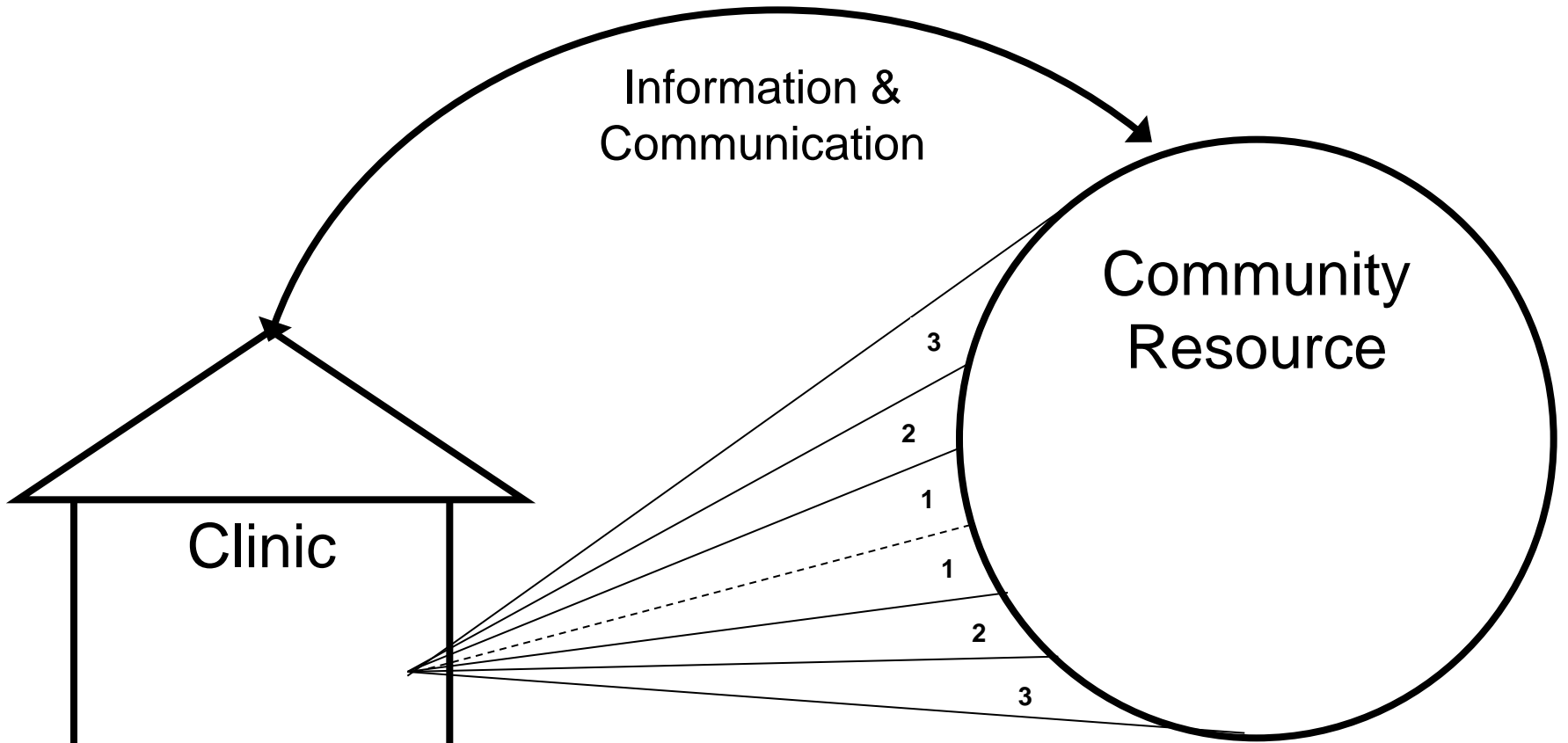
Clinic/Community (Inter-organizational) Relationship - Himmelman

- **Coordinating:** Exchanging information and altering activities for mutual benefit and to achieve a common purpose.
- **Cooperating:** Exchanging information, altering activities, and sharing resources for mutual benefit and to achieve a common purpose. Cooperating requires greater organizational commitments than networking or coordinating and, in some cases, may involve written (perhaps, even legal) agreements.
- **Collaborating:** Exchanging information, altering activities, sharing resources, and enhancing the capacity of another for mutual benefit and to achieve a common purpose. The qualitative difference between collaborating and cooperating in this definition is the willingness of organizations (or individuals) to enhance each other's capacity for mutual benefit and a common purpose.

Clinic/Community (Inter-organizational) Relationship - IOM

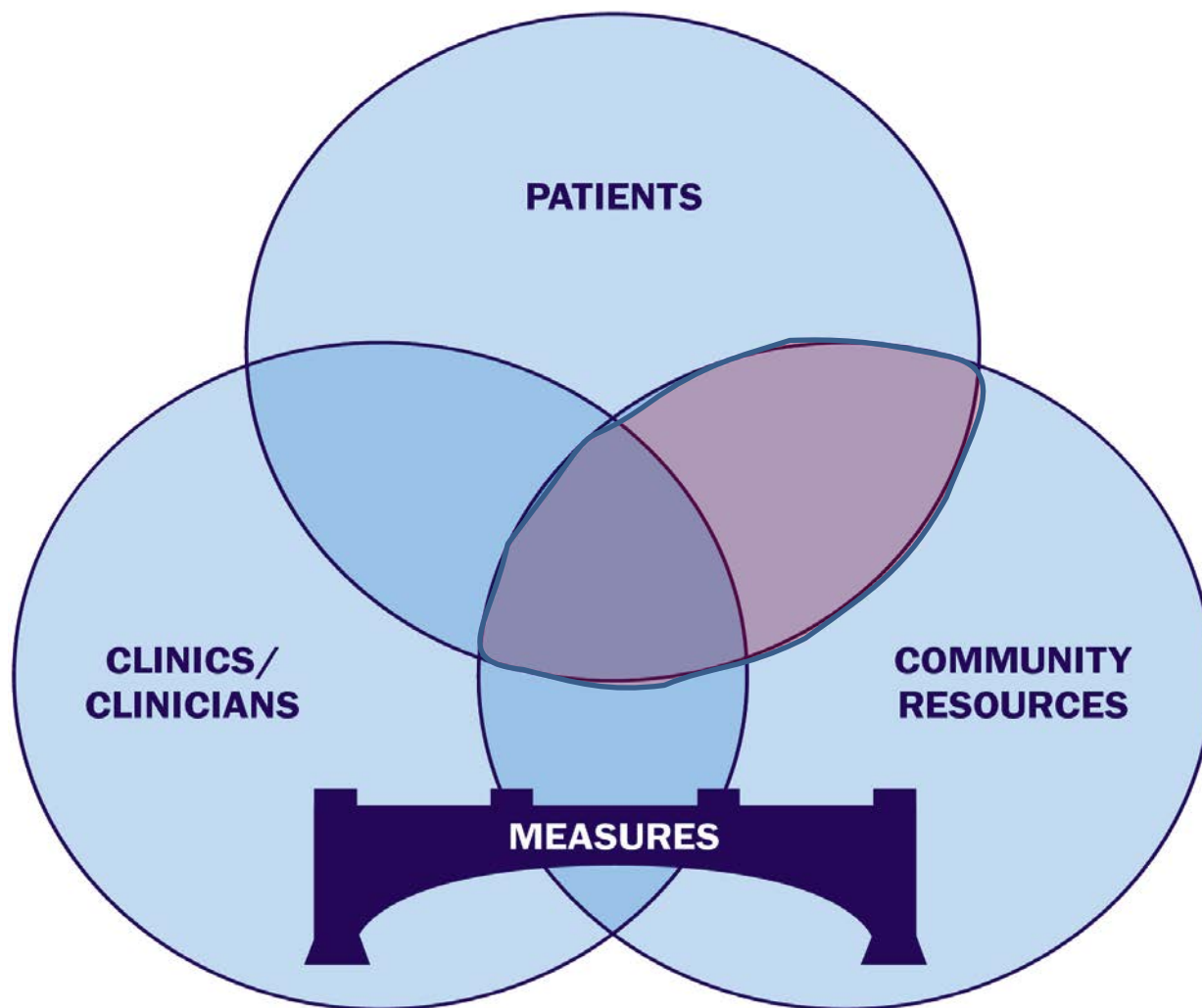
- **Integration:** the linkage of programs and activities to promote overall efficiency and effectiveness and achieve gains in population health.
- Degrees of integration:





Legend
----- = Knowledge of Resource
1= Coordinating
2= Cooperating
3= Collaborating

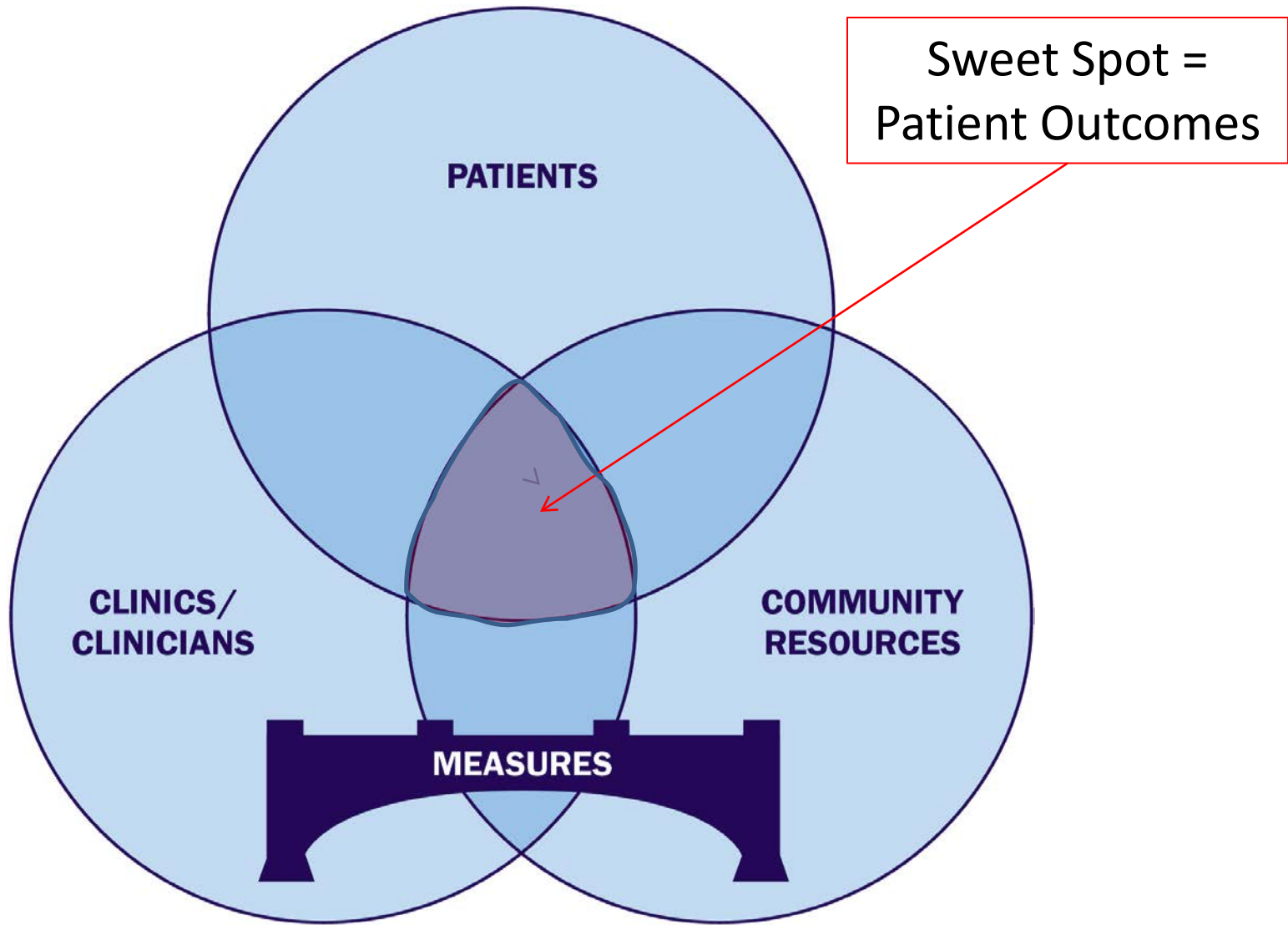
Patients and Community Resources



Patients and Community Resources

- Not much information!





Small Group Exercise



Thank You

Melinda Davis, PhD

Research Scientist - ORPRN

Research Assistant Professor - Dept Fam Med

davismel@ohsu.edu

Paul McGinnis, MPA

Community Health, Quality and Practice

Development Director - ORPRN

mcginnip@ohsu.edu