Exploring Local Integration of Primary Care and Public Health: A Multi-State, Practice-Based Research Study

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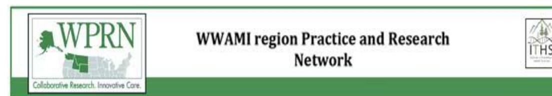

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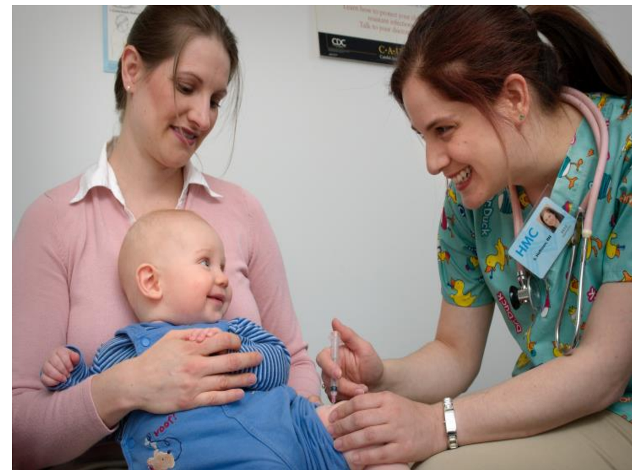
Research Questions

- How does the degree of integration between PC and PH vary across local jurisdictions?
- What factors facilitate or inhibit integration, and how can PC and PH leverage those factors to increase integration?
- Does the degree of integration differ based on health topic (immunizations, tobacco use, physical activity)?
- Do areas of greater integration have better health outcomes?



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Qualitative Component

- In early 2014, each state conducted at least 5 pairs of key informant interviews that engaged a public health director and primary care representative from the same jurisdiction.
- Participants selected to represent a variety of primary care and public health organizational structures and geographic variation across the four states.
- Qualitative results were used to answer research questions, as well as to develop the quantitative surveys.
- In 2016, the primary care and public health practitioners who served as key informants will be invited to participate in focus groups to review, refine and validate findings.

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Survey Development

- Qualitative interview results contributed to emerging framework of how primary care and public health work together locally.
- Survey questions drawn from existing tools, within health and other disciplines, and organized within the emerging collaboration framework.
- Co-Investigators & PBRN members reviewed full list of potential questions within the domain/construct framework and provided initial feedback, wording and definition suggestions, and identified gaps in question content.

Survey Development

- Study Advisory Committee (SAC) members reviewed the questions and rated them (Vovici survey) with respect to:
  - ✓ How well the question fit within the domain/construct
  - ✓ Level of importance of each question to measuring degree of integration
- Median "Relevance" and "Retention" scores were calculated for each question.
- Five questions were dropped based on the SAC rating, due to low relevance and importance.

Survey: Pilot Testing

- Both versions of the survey were pilot-tested with primary care and public health representatives from the four states in December 2014/January 2015. Five public health and three primary care representatives pilot-tested the instruments.

- In addition to completing the actual survey, pilot-testers were asked to respond to provide feedback on clarity and comprehensiveness.

- Average time to complete the survey: 10.5 minutes (range 10-15 minutes)

- Small wording/clarification changes and logic changes were made based on the pilot-test, but no additional questions were removed.

Final Surveys

38 total questions in each survey version.

<u>Survey Constructs and Related Questions</u>:
Vision/Mission=2
Organizational Structure=4
Aligned Leadership=3
Partnership Characteristics=5
Sustainability=5
Shared Data/Analysis=2
Innovation Characteristics=3
Building the Partnership=4
Communication=3
**Plus: 6 seeded contextual variables

Survey Recruitment

- Public health co-investigators from the four participating states identified potential respondents from each of their local jurisdictions. One local health director was identified for each jurisdiction.

- Primary care co-investigators then worked to identify potential primary care respondents within the public health jurisdictions. Given the varying levels of interaction (e.g. clinic, system) within jurisdictions and concern about response rates, 2-3 potential primary care respondents were identified for each jurisdiction.

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Survey Recruitment

- Standard survey recruitment templates were created by MN lead investigators and provided to each state. Seeded data, including population size, percent poverty, percent self-pay and percent non-white were included in the template to ensure use of a single, standard data source across participating states.

- State-specific co-investigators added in data related to organizational structure and jurisdiction type (public health) and recruitment approach (primary care).

Survey Administration

- A standard survey administration protocol was developed, refined with the SAC and distributed to partner states.
- Eight unique surveys were created in REDCap. Surveys fielded during April-June 2015.
- Rolling survey administration approach, with one pre-survey email from key champion within each state, followed by email with unique survey link and three follow-up email reminders.
- Targeted follow-up was done by individual states with non-respondents, as needed.

Public Health Survey Results

- Overall response rate=78% (n=123)
- Some response rate variation between states (range=67-86%)
- Public health respondents were instructed to answer the survey questions with respect to one primary care practice that is "typical" of practices with whom their LHD relates.

Response Profile

	Respondents n=123	Non-Respondents n=56
Organizational Structure		
Stand-Alone Health	58.5%	63.6%
Combined--with human services	41.5%	36.4%
Jurisdiction Type		
Single County	59%	73%
Multi-County	38%	24%
City/County	2%	3%
City	1%	0%
Population Size		
Less than 50,000	64.2%	66.7%
50,000-100,000	13.8%	15.1%
Greater than 100,000	22.0%	18.2%
Poverty Percentage (mean=13.5%)		
10.99 % or less	30.9%	39.4%
11-14.99 %	35.0%	39.4%
15% or more	34.1%	21.2%

Respondent Profile

	%
Estimated Number of Free-Standing Primary Care Practices in jurisdiction:	
-1-4 Practices	45.5%
-5-19 Practices	34.2%
-20+ Practices	20.3%
Working Relationship with Primary Care Practices in jurisdiction:	
-Fairly consistent across all practices	28.9%
-Work more closely with some, but generally have same approach	45.5%
-Varies widely among practices	25.6%
Level of Autonomy within LHD to partner with primary care:	
-Full autonomy to initiate and/or maintain relationship	87.8%
-Limited autonomy (need to clear relationship with higher authority)	12.2%
-No autonomy to initiate or build relationship with primary care	0%

Aligned Leadership

	Strongly Agree/ Agree	Neutral	Disagree/ Strongly Disagree	I don't know
Believe organization's opinions and recommendations are respected by primary care clinic	77.7%	14.9%	5.8%	1.6%
Decision-makers from both organizations committed to and supportive of working relationship	70.0%	20.8%	7.5%	1.7%
Decision-makers from both organizations take a lead role to direct the collaborative work	51.7%	32.5%	13.3%	2.5%

Building the Partnership & Communication

	Know who to contact in PC with questions	Relationship of mutual trust exists between LHD and PC	Communication between PH and PC occurs formally and informally
Agree	94%	81%	87%
Neutral	4%	15%	7%
Disagree	2%	4%	6%

100%
80%
60%
40%
20%
0%

Agree Neutral Disagree

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Motivation to Work Together

Reasons for Working with Primary Care (Could check all that apply)	%
Improve population health in community	95.1%
Improve individual patient care	80.5%
Engage more stakeholders	79.7%
To meet specific program requirements or mandates	59.4%
Extend population/demographic reach	53.7%
Build more credibility in community	47.2%
Share costs and maximize resources	41.5%

Degree of Working Together

100%
80%
60%
40%
20%
0%

Category	Percent
Not working together at all	0%
Starting to work together, but not consistently	17%
Have some projects or focus areas of joint work	43%
Work together frequently, particularly targeting high need communities	26%
Consistently work together on variety of health needs & topics	14%

Conclusions

- Majority of respondents report that they have similar working relationships across practices in their jurisdictions.
- Several factors related to aligned leadership and building the partnership appear to be present for the majority of respondents.
- Most common reason cited for working with primary care is to improve population health, but variety in the other options checked.
- Large variation in degree to which public health and primary care work together across local jurisdictions.
- Most respondents report working on a few joint projects, but that they aren't consistently working together.

Limitations

- Although no consistent differences between respondents and non-respondents were observed on the jurisdictional variables of interest, it is possible that there are capacity differences present that influenced the ability to complete the survey.
- These results only present the public health perspective. It is too soon to fully place the jurisdictions on a continuum without including the primary care perspective.
- There were differences in response rate by state, however the goal is not to present state-specific results and the state-specific rates were sufficient.

Practice Perspective

- Good to know where we are right now—it is important to know the current status.
- Most local jurisdictions aren't very far along, so while we can learn from the high achievers, we need to focus energy on those not as far along.
- Looking ahead it will be important to know the extent to which PC and PH respondents understand how and why they work together.
- This multi-state approach is relevant to other states and local jurisdictions.

Next Steps

- Primary Care analysis
- Paired dyad analysis (Public Health and Primary Care)
- Place local jurisdictions on the continuum of integration (IOM)
- Mixed methods analysis
- Further refinement of emerging model framework, incorporating results from the mixed methods analysis
- Validation of all results with focus groups comprised of key stakeholders and key informants

Questions?

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