NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

[RESEARCH BRIEF]
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Partnerships between Local Health Departments and Community Health Centers in Pursuit of the Triple Aim

Introduction

In 2012, the Institute of Medicine (IOM) published a report calling for increased integration of primary care and public health to improve population health. In that report, the IOM noted that "substantial opportunities exist to understand models of successful and sustainable integration taking place in local communities and diffuse that knowledge." This research brief and the project it summarizes represent an effort by the National Association of County and City Health Officials (NACCHO) to contribute to that understanding and sharing of information. This research brief provides information on current collaborations between local health departments (LHDs) and community health centers (CHCs) to inform community, state, and national initiatives to promote further collaboration in pursuit of Triple Aim goals.

Background

LHDs and CHCs provide a critically important safety net that protects and serves low-income and disadvantaged community members by offering important health-related services at low or no cost. CHCs, including Federally Qualified Health Centers (FQHCs) and FQHC look-alikes, provide preventive and primary healthcare to nearly one in 15 people, regardless of a person's ability to pay, and have demonstrated high-quality care and improved patient outcomes.[1] CHCs and LHDs often play complementary roles in their communities; CHCs focus on clinical care and LHDs focus on population-level health and prevention, while sometimes also delivering direct healthcare services.[2]

In addition to helping improve population health, integrating public health and primary care can address other key health system goals. In an influential article in 2008, Donald Berwick and his colleagues defined the Triple Aim as "improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations."[3] These goals were later incorporated into the National Quality Strategy that was mandated by the Patient Protection and Affordable Care Act.[4]

While the original article introducing the concept of the Triple Aim made only passing mention of public health and no direct reference to CHCs, the authors underscored the importance of pursuing the Triple Aim in a way that ensured equity across populations.[3] More recently, Dr. Edward Ehlinger, president of the Association of State and Territorial Health Officials, has more deliberately emphasized equity by proposing a "Triple Aim of Health Equity."[5] Given that CHCs provide care to a large portion of the low-income population and LHDs focus on population health and prevention, involving these entities in Triple Aim activities is critical to ensuring equity. Working together, possibly in partnership with a Medicaid managed care provider,[6] LHDs and CHCs may be able to play the role of integrator in the Triple Aim by involving individuals and families in their own care; redesigning primary care so it is better integrated and less physician-focused; and organizing the delivery of health services for the low-income population as a whole.[3]

Collaboration between LHDs and CHCs can help improve the quality of care for low-income individuals and ensure that the care is delivered in an efficient manner that takes advantage of each organization's strengths. The importance of collaboration and integration is reflected in the Centers for Medicaid and Medicare Services (CMS) Quality Strategy, which includes the integration of public health and primary care as one of its goals.[7]

LHDs and CHCs can collaborate in a variety of ways. LHDs can help individuals in need and link them to CHCs for care. CHCs, in turn, can provide referrals to no- or low-cost prevention programs run by LHDs. LHDs and CHCs can also work with hospitals and other providers to coordinate community-wide interventions that address the needs of all individuals with or at risk of chronic conditions such as diabetes or high-blood pressure.

Methodology

NACCHO conducted the LHD-CHC Collaboration study to better understand current collaborations between LHDs and CHCs in pursuit of Triple Aim goals. The sample for the study was drawn from the NACCHO Forces of Change survey, a periodic survey

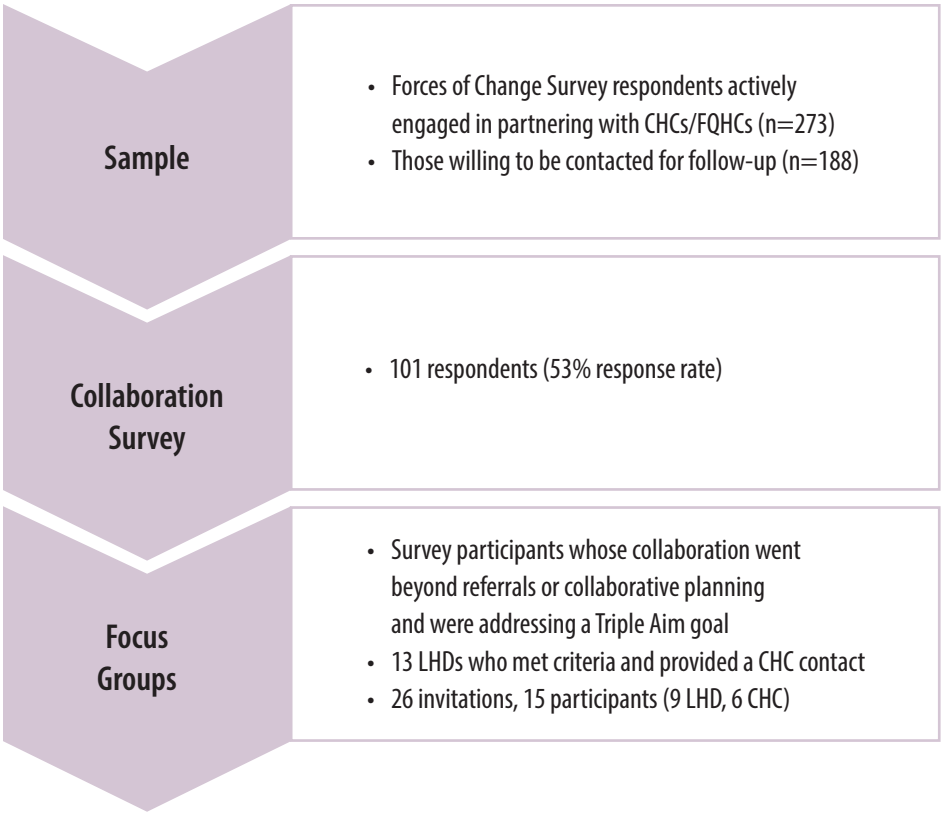
of a representative sample of LHDs.[8] In order to qualify for inclusion in the LHD-CHC Collaboration study, a survey respondent had to indicate the following:

- His or her health department was "actively engaged" in partnering with a community health center or FQHC to address primary care priorities (41%);[8] and
- He or she was willing to be contacted by e-mail for follow-up related to their survey responses.

The 188 LHDs that met these criteria were sent the LHD-CHC Collaboration survey.* The survey asked the respondent to describe collaborative activities (e.g., referrals, community planning, co-location), characterize the relationship on a scale from networking to collaborating, and provide contact information for their partner.

NACCHO asked survey respondents and their CHC partners to participate in a focus group if they were engaged in collaboration that (1) went beyond a referral relationship, community planning, or joint participation in community coalitions; and (2) included activities that were clearly linked to the Triple Aim (Figure 1).

FIGURE 1. LHD-CHC COLLABORATION STUDY SAMPLE AND DATA COLLECTION METHODS



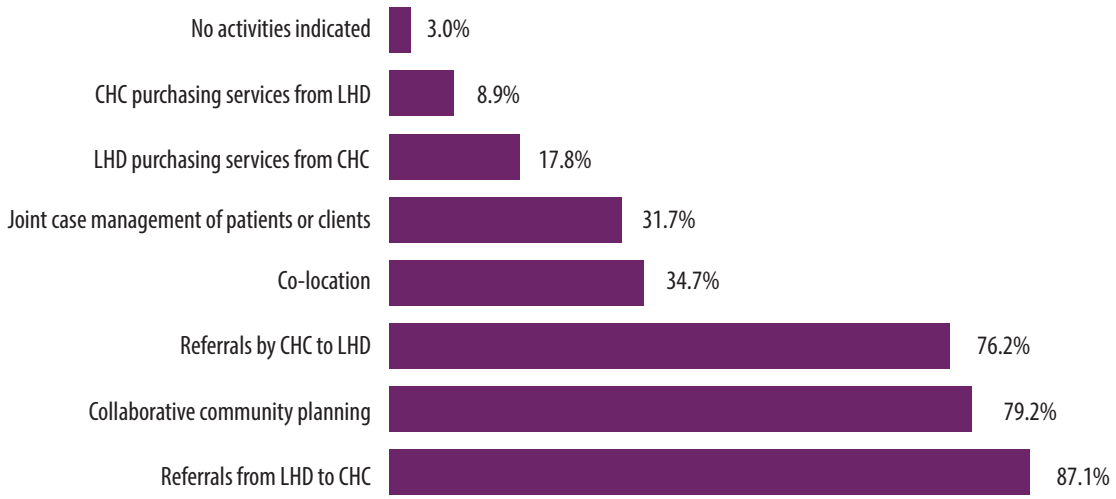
** One large health department indicated in an e-mail that they had multiple health department locations engaged in collaborations with a number of different CHCs that operated in the city. Because of the city's size and special circumstances, they were asked to identify a small number of their most developed collaborations and provide responses about those. The city identified three collaborations that were included in the survey, making the total sample size 190.*

Findings

Extent of collaboration

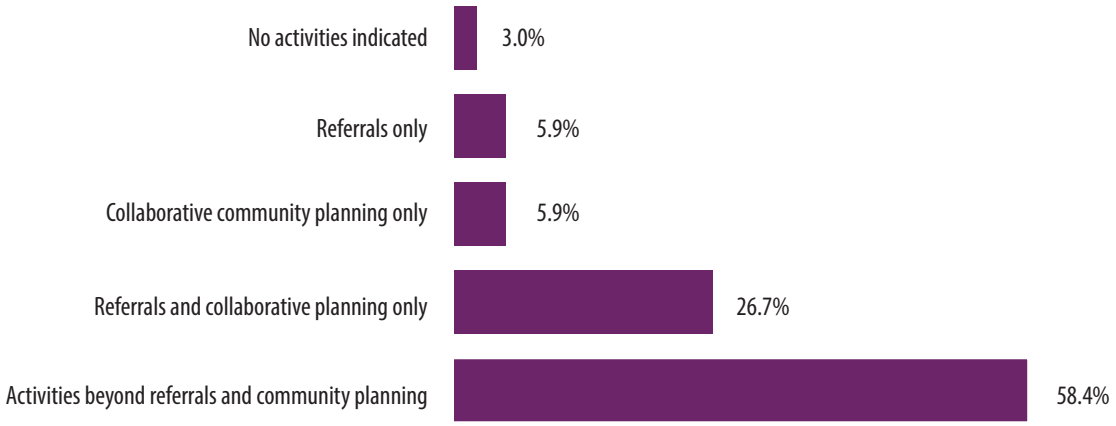
Survey results showed that the most common type of collaboration was for LHDs to refer clients to CHCs (87%), followed by collaborative community planning (79%), and referrals by CHCs to LHDs (76%). Co-location (35%) and joint case management of patients or clients (32%) were much less common, though around a third of LHD-CHC partnerships involved these activities. Even less common was the purchasing of services; LHDs were somewhat more likely to purchase services from CHCs (18%), while only 9% of CHCs reported purchasing services from LHDs (Figure 2).

FIGURE 2. WHAT COLLABORATION ACTIVITIES DID THE LHD AND CHC ENGAGE IN? (N=101)



Many of the partnerships involved various combinations of activities. While referrals and community planning are important activities, they alone do not indicate engaged collaboration in which partners are working together to pursue goals. Most of the collaborations involved activities beyond referrals and planning, but 42% did not (Figure 3).

FIGURE 3. ENGAGEMENT IN DIFFERENT TYPES AND COMBINATIONS OF COLLABORATIVE ACTIVITIES (N=101)



Focus Group Comments

Motivation for Collaboration

"Now that IOM is talking about the minimum package, and health departments are experiencing some pretty draconian budget situations and budget cuts to some of the safety-net services that we've historically provided, we may not have the capacity to [provide the same services]. I think we need to look at the resources and regulations governing community health centers so they can effectively pick up that safety-net role."

"We don't have the resources, we don't have the people. The only way to truly make a difference is to collaborate to ultimately make our communities healthier."

Facilitators to Collaboration Leadership Ties

"Our organizations have a reciprocal relationship. Our Executive Director here at the public health department serves on the board of the community health center and [the community health center has] some staff that serve on our working groups or boards."

"There was a change in leadership, and the new CEO of our community clinic gets public health [. . .] and is reaching out to us and we're reaching back."

Successful Collaboration Encourages More Collaboration

"We started with diabetes. We found that [working together] helped to decrease the patient's A1c's [and] helped them to have better control. So now we're working on helping control blood pressure and teaching classes. Once you have the trust and have the collaboration, then you can build on it and introduce different things."

Motivation for Collaboration

NACCHO asked focus group participants multiple questions about their experiences with collaboration around the Triple Aim. The most commonly cited reason for collaboration between LHDs and CHCs was cost concerns and the desire to maintain services in the face of LHD budget constraints. Because LHDs and CHCs have a shared mission of serving low-income and underserved groups, collaboration is an important way to address limited resources (see Motivation for Collaboration section in sidebar).

Promoting Collaboration

Participants in the focus groups reported on a variety of factors that promote collaboration, including ties between high-level leadership and shared board or advisory group membership. One LHD respondent reported that a change in leadership opened up opportunities for collaboration (see Leadership Ties section in sidebar).

Some communities reported that providing an opportunity for staff to learn about the other organization's work helped facilitate collaboration. Inviting a variety of staff from one organization to another's open house can generate ideas about how CHCs and LHDs can work together to serve their common clients. Collaboration around community assessments can open up further avenues for other collaboration, especially if the assessment looks at opportunities for working together to address the needs the assessment identifies.

Focus group participants also described how successful collaborations create opportunities for more collaboration. As CHCs and LHDs learn more about each other's operations, strengths, and needs, they can begin to see how they can work together to address more of the community's needs (see Successful Collaboration section in sidebar).

Challenges to Collaborating

Strengthening collaboration between LHDs and CHCs is not without challenges. Ironically, one of the biggest challenges is a result of the same forces that are encouraging collaboration. As NACCHO members are well aware, LHDs have been under tremendous budget pressure since the financial crisis and recession, resulting in significant staff reductions.[9] LHD staff may have concerns about job security and can be wary of efforts to collaborate out of concern that CHCs will take over LHD responsibilities and LHDs will lose even more jobs. Participants reported that in order to ensure buy-in, leaders should clearly inform staff about the goals of collaboration, the opportunities it brings, and how it may be necessary for ensuring that vital services continue in a community. Collaboration can help an LHD improve its budgetary standing by sharing the burden of a costly service, and can create opportunities for additional grant funding (see Potential Financial Benefits section in sidebar).

Discussion

Just over 40% of LHDs reported having been actively engaged in partnering with a CHC in the Forces of Change Survey. When surveyed for the research described in this brief, 58% of this group of collaborating LHDs reported having been engaged in activities that went beyond referrals or planning. This suggests there is a tremendous untapped opportunity for increased collaboration that actively seeks to address community needs through increased partnerships between LHDs and CHCs.

LHDs already engaged in collaboration expressed a strong interest in building upon their work, and there remains a large pool of LHDs who are not yet collaborating with CHCs. As noted in the beginning of this brief, given the essential role that these entities play in the community safety net and in promoting population health, collaboration between them can make a tremendous contribution to achievement of the Triple Aim.

When focus group participants were asked what could be done to encourage collaboration, they suggested that there was a need for each organization to learn more about the other so leadership and staff could begin to identify opportunities for collaboration and so any misconceptions could be challenged (see Building Understanding section in sidebar).

Participants suggested that state primary care associations that represent the interests of CHCs, national associations such as NACCHO and the National Association of Community Health Centers, and federal agencies such as the Bureau for Primary Health Care and the Centers for Disease Control can help educate both LHD and CHC staff about each other, promote the benefits of collaborating, and share best practices in collaboration.

Participants also said the federal agencies can promote collaboration through encouraging or mandating partner representation on boards and advisory groups, and by requiring reporting on collaborations in funding applications. One LHD participant in the focus group who has served on federal grant review panels noted that she has noticed that it is already becoming common for grants from the Health Resources and Services Administration (HRSA) to encourage collaboration with LHDs (see Funding Opportunities section in sidebar). The fact that key federal agencies are promoting collaboration creates opportunities for LHDs and CHCs to find ways to better serve their communities and common client base.

Conclusion

NACCHO is committed to continuing to support and encourage collaboration between LHDs and CHCs. NACCHO will use the research presented in this brief to develop a tool to help LHDs reach out to CHCs and work together to identify opportunities to collaboratively pursue Triple Aim goals in their communities. In coming months, the draft tool will be tested and shared with LHDs and other stakeholders to ensure it supports efforts to increase collaboration in pursuit of the Triple Aim and greater health equity.

Potential Financial Benefits of Collaboration

"Family planning has never been a program that covered all of its expenses so we lost a great deal of money. Even though we continue to lose money, we are not losing as much as when we were doing it ourselves; the same is true for the breast and cervical cancer program. We still provide the case management but they [the CHC] perform the direct clinical services."

"In any type of grant-writing situation, if you've got a collaborative or collaboration that is established, that collaboration makes that grant a whole lot stronger when people are looking at it in terms of funding."

Building Understanding

"I think it starts first by understanding what the requirements of an FQHC are [. . .]. Then you can go in and talk to the CEO and educate them about what public health is and what [LHDs] can do and how they can help an FQHC meet some of their requirements. The two missions are very similar in terms of typically being safety-net providers and providers of services to people who have no other option."

Funding Opportunities that Promote Collaboration

"I have noticed that many of the HRSA grants are requiring some type of partnership with local health departments. Having been a HRSA grant reviewer, you can really see when people write grants whether or not they really have a partnership with the health department."

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FOR MORE INFORMATION, PLEASE CONTACT:

Tiffany J. Huang, MPH
Program Analyst, Performance Improvement
202-507-4207
thuang@naccho.org

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1100 17th St, NW, 7th Floor Washington, DC 20036

P 202-783-5550 F 202-783-1583

www.naccho.org