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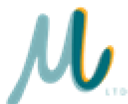

15 years of
Improving Health. Informing Policy

STRENGTHENING PUBLIC HEALTH THROUGH PRIMARY CARE AND PUBLIC HEALTH COLLABORATION

Resources for Action

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Lesson	Desired Action	Resources and examples
1. Progress is possible with a focus on improving the public's health: a shared language and alignment on goals is essential.	Offering collaborative learning opportunities for public health and primary care.	The Northwest Public Health and Primary Care Leadership Institute works to develop shared competencies across public health and primary care disciplines, as well as to develop relationships between future leaders in these fields. Read Washington State's integration profile. • In 2021, HRSA issued a funding opportunity to advance the public health workforce through Leadership Institutes--modeled after the Northwest Public Health and Primary Care Leaderhsip Institute--across each of the 10 Regional Public Health Training Centers in the U.S.
2. State government is a necessary champion.	Defining public health services and appropriation at the state-level	In Washington, Foundational Public Health Services (FPHS) are defined in statute, and state government champions funding FPHS through annual or biannual appropriations. Sustainable funding for public health through predictable state appropriations has freed resources for local health departments to engage in collaboration with primary care.
3. Partnerships with community-based organizations are crucial but community-based organizations do not substitute for local governmental public health.	Developing a business case for public health partnerships with community-based organizations and primary care	In North Carolina, public health leaders work to demonstrate the value of local public health, positioning themselves as ideal partners in collaboration *alongside* primary care and community-based organizations. Resources include: • North Carolina Institute of Medicine Foundations of Health and Opportunity report. • Practical guidance for implementation of office-based opioid treatment through primary care at local health departments. • NACCHO Exchange: rural academic health department model

4. Payment reform is essential to enabling change: state control over Medicaid dollars is a powerful lever.	Using Medicaid funding as a base for innovation	Medicaid section 1115 demonstration projects allow flexibilities in Medicaid spending. Two examples using section 1115 to integrate public health and primary care: • The North Carolina Healthy Opportunities Pilots • Washington's Medicaid Transformation Project. States have flexibility in delivering Medicaid services, including with federal Medicaid managed care authorities and through mechanisms such as: section 1932 state plan amendments, section 1915(b) program waivers, and section 1115 demonstration waivers.
	Strengthening primary care and public health through commercial insurance reform	State health insurance commissioners have authority to regulate the commercial insurance industry to strengthen primary care and public health: • Rhode Island's health insurance commissioner has unique statutory authority to place requirements on commercial payers in the state. • Through the Affordability Standards, commercial insurers in Rhode Island are required to invest in the Patient-Centered Medical Home (PCMH) model and the state's health information exchange.
5. Data systems are core to informing and aligning focus.	Creating and sustaining interoperable data platforms	North Carolina has developed an integrated data platform, NCCARE360, that allows for coordination among health care, human services, and community organizations. This platform is a public-private partnership between NCDHHS and the Foundation for Health Leadership and Innovation. Read North Carolina's integration profile.
6. Relationships are vital, and they must be established before a crisis occurs.	Developing formal relationships	In Oregon, coordinated care organizations (CCOs) are governed by multidisciplinary community advisory councils with a focus on primary care. Though not mandatory, many CCOs include local public health on their advisory councils.
	Developing informal relationships	Counties in Oregon have had success building informal relationships between local public health and health system leaders through casual dinners. Read Oregon's integration profile.
7. Structural integration can strengthen alignment.	Co-locating primary care and public health and/or sharing administrative or other resources	Structural integration can include co-location of services, shared administrative resources, and shared leadership. • A 2010 collaborative report by the National Association of Community Health Centers (NACHC) and the National Association of County and City Health Officials

		(NACCHO) contains practical guidance for partnerships between Federally Qualified Health Centers (FQHCs) and local health departments. This report provides specific resources on how to implement co-location agreements, referral arrangements, and purchase of service arrangements. Washington and Oregon have trialed co-location of local health departments and FQHCs with variable success. Sharing resources improved relationships between the two sectors, but ultimately sustainability was a challenge. Read integration profiles from Oregon and Washington.
8. Leadership matters: a visionary leader is critical, but so is a sustainability plan.	Championing innovative collaboration models	North Carolina: as NCDHHS Secretary, Dr. Mandy Cohen worked to improve the health of residents through systems change and multilayered Medicaid payment reform Read North Carolina's integration profile. Rhode Island: as health insurance commissioner, Chris Koller designed and implemented policy to engage commercial payers, instituting requirements for investment in primary care and public health. Read Rhode Island's integration profile.
	Embedding integration initiatives within coordinating entities	Coordinating bodies have been formally established in North Carolina and Rhode Island: • In North Carolina, the Foundation for Health Leadership and Innovation (FHLI) and Community Care of North Carolina are non-profit organizations focused on identifying and supporting opportunities for collaboration between public health, primary care, and the community. • In Rhode Island, the Care Transformation Collaborative (CTC-RI) is a nonprofit organization aimed at supporting primary care in the state through investment in the PCMH model. CTC-RI began with the implementation of the Affordability Standards, which required commercial payers to invest in the PCMH model. Today, CTC-RI utilizes the Community Care/Health Team model to address complex social and medical needs.