A new Medicaid system is emerging in North Carolina in which accountable care organizations will aim to improve both the quality and value of health care. We explore how local health departments can apply their expertise in population health to help achieve these goals.

This article uses the culture of health framework developed by the Robert Wood Johnson Foundation to address the critical contributions local health departments can provide in a Medicaid managed care environment. This framework identifies 5 strategies for improving population health: partnerships, innovation, data, connections, and payment reform. Improving population health is one of the stated goals of Medicaid reform in North Carolina.

Partnerships Between Public Health and Health Care

Partnerships between public health and health care will be critical in a Medicaid managed care environment in order to ensure a comprehensive view of factors affecting health outside the scope of traditional clinical care. Health behaviors, physical environment, and socioeconomic factors constitute up to 80% of the outcome equation in many population health models [1]. These nonclinical aspects are even more important when considering the vulnerable populations that are eligible for Medicaid.

One of the fundamental obligations of public health is to perform a community health assessment that evaluates the factors that influence health and quality of life. Tax-exempt hospitals are also required to conduct a community health needs assessment to assure that they have the information they need to prioritize and coordinate their community benefits with other health improvement efforts. Although hospitals and health departments previously pseudo-partnered on assessments, North Carolina recognized the potential synergy for these 2 processes and promoted connectivity through the North Carolina Public Health/Hospital Collaborative to facilitate and advance shared health improvement initiatives through public health and hospital partnerships [2].

There are other public health and health care partnerships that are structured for managed care environments such as population care management programs for children enrolled in Medicaid and pregnant women at elevated risk of complications. These programs are a shared responsibility of regional Community Care of North Carolina networks, local health departments, and local medical practices. Public health nurses and social workers are embedded in pediatric and obstetric/gynecology practices to connect patients and families with needed services and resources outside the scope of clinical care; these services can include transportation, medication management, referrals, home visits, and health education. Health departments provide multiple wraparound services in this domain—with supports like nutrition counseling, immunizations, family planning, breastfeeding consultation, and smoking cessation—while maintaining coordination with the medical home. Traditional medical management programs show limited effectiveness [3-5] given their focus on specific disease conditions and their lack of linkage to preventive or population care.

Medical management combined with population care management is increasingly viewed as a promising intervention and best practice in improving health outcomes [6, 7].

Innovation to Address Drivers of Health

Drivers of health require more than a technical fix; they require adaptive and innovative responses to health on a physical, social, emotional, and fiscal front. Changes of this magnitude require a collective approach. The understanding that health is more than just the absence of illness comes to the forefront of this discussion, particularly as recognition of the importance of social determinants of health collides with payment reform processes. For example, while specific population care management programs may provide much-needed medication through an assistance program or a crib to ensure a safe sleep environment for a new baby, these programs are rarely robust enough to also tackle the greater needs of safe and stable housing, steady and livable income,
or quality education.

Health care reform provides health departments, hospitals, and other community partners an opportunity to build on community health assessment partnerships by collaborating on collective impact approaches. In a collective impact approach, organizations’ individual agendas are set aside in favor of pursuing a shared and aligned agenda around specific outcomes. These specific outcomes are typically broader in scope and are also more likely to move the needle in terms of health and quality of life for a population. This approach allows local health departments to be the social determinant navigator for accountable care organizations.

As hospitals embrace their role in improving community health, there is an opportunity for health departments to be the community “hand” that leads an individual out of the hospital and into an environment that will promote and support clinically relevant behavior changes. These opportunities may include environmental or systems changes like increased access to healthy foods through EBT/SNAP utilization at farmers’ markets or rules and ordinances that maintain tobacco-free public places. Looking at local policy changes through a “health in all policies” lens further supports a patient’s individual medical management and also integrates the population-based approach supported by public health.

New Ways to Use and Share Data, Analytics, and Information Technology

Health care reform provides an opportunity for public health and hospitals to build their partnerships and work in new ways. One avenue is in data and information technology. Local health departments can be the navigators as hospitals enter the world of collective impact. Collective impact involves the establishment of shared goals around specific data indicators, many of which local health departments already track and monitor. Other indicators require the sharing of data from a variety of sources such as hospital systems, education systems, and mental health providers. Medicaid reform with a focus on cost savings and quality of care could facilitate collaboration across sectors, including data sharing.

Additionally, as public health departments and hospitals explore integration of medical and population care management, continuity of electronic medical record systems becomes important for the sharing of patient information, population trends, and linkages of community resources. Ideally, if using the same systems, both the hospital and the county health department have access to the patient’s medical treatment plan and to his or her community coordinated care action plan. Knowledge of both plans by each entity enhances the continuity of care, thereby improving the quality of that care.

Further, hospitals can utilize the talents of local health departments by allowing access to admissions data that can then be mapped using a geographic information system (GIS). With this data, public health departments can map hot spots of chronic disease or other health issues. GIS mapping can then aid in a population-based management approach by targeting culturally specific interventions in neighborhoods or potentially by identifying gaps in services or resources based on the location of clusters. Further, health departments and hospitals can potentially synergize efforts in order to create regional data hubs that can collect the locally specific data critical in addressing prioritized social determinants of health. This is of particular importance as the availability of local morbidity and behavior-related data for counties has whittled away as changes in and reduced funding for the Behavioral Risk Factor Surveillance Survey have been implemented.

Connecting Patients to Social and Community-Based Services

Public health has traditionally focused on a broad array of linkages and referrals to support services for their patients and external clients. This expertise is rooted in our history of care management services, but that orientation has also been influenced by the reality that many social determinants are addressed by other community organizations. Since health departments are principal safety-net providers in many communities and often deal with complex circumstances related to their patients, they are frequently in the position of providing resource connections for these populations. It is a responsibility born of necessity. If patients lack transportation to receive regular medical care or lack food to meet basic nutrition needs, then it is unrealistic to expect improvements in health until these needs are addressed.

Accordingly, health departments have invested in a variety of different assets including interpreters, social workers, outreach and education specialists, community health workers, navigators, prescription assistance aides, and behavioral health counselors. These staffing resources are driven by local needs and community support. In addition to internal capacity, public health departments have also embedded supplemental operations within their departments by including staff from social services, mental health services, federally qualified health centers, free clinics, and other human services agencies. These quasi-formal systems are extensive and are consistent with academic characterizations of an integrated delivery system as “a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population” [8]. These components are precursors to accountable care or managed care structures, and further harnessing the inherent benefit of these delivery systems will provide mutual benefits to populations, managed care organizations, and public health.

Emerging Payment Models to Incentivize and Sustain Initiatives

Both the Patient Protection and Affordable Care Act of 2010 and the Medicare Access and Children’s Health
Insurance Program Reauthorization Act of 2015 have reinvigorated the focus on value and quality in health care payment. Value and quality in health care outcomes require a holistic view of the patient and their environment. As previously illustrated, local health departments—with their presence in all 100 North Carolina counties and their focus on integrated systems and services—are uniquely positioned to provide this view, as well as the community-based interventions necessary to assure a healthier population. How then, are these services financially supported in Medicaid reform?

There is emerging work around risk-adjusting payments, which involves paying more for patients deemed to be at higher risk for adverse outcomes. This work supports the proposition that medical providers like health departments should be paid more to treat patients with greater needs, such as patients living in poverty, those with lower educational status, or individuals who face transportation or language barriers. However, paying more to treat patients with greater needs seems like a baby step when what is needed is a lunar jump. To truly address these health-impeding, complex issues requires investment upstream to improve social determinants of health. In fact, it is possible that these risk-adjusted models are slowing the transition to a more comprehensive solution. Where is the incentive to help people lead healthier lives if payment is greater for those who lead less healthy lives?

Relatedly, compelling research being done by ReThink Health’s dynamics model shows that, for long-term savings in lives and costs, the most effective strategy is a reform that addresses health care quality and coverage as well as investments in population-based strategies to ensure healthier living. Specifically, they found that when added to quality and coverage, population health interventions would save 90% more lives and reduce costs by 30% after 10 years. At 25 years, those numbers improve, with population health interventions saving 140% more lives and reducing costs by 62% [9]. Fully funding tobacco, diabetes, and other chronic disease prevention programs, for example, and then (and here’s our lunar jump) reinvesting initial savings generated from reform back into the system yields the kind of results about which every health system reformer dreams.

Fortunately, North Carolina’s proposed Medicaid reform plan includes this concept of reinvesting savings in the form of a delivery system reform incentive payment (DSRIP). While limited in scope, DSRIP does allow local health departments to start the work necessary to demonstrate that an investment in population health saves lives and money.

Conclusion

A commitment to the broader model of population health that addresses the social determinants of health, paired with innovative investments generated by Medicaid reform efficiencies, will improve the quality and value of health care in North Carolina. Capitalizing on and fully funding the population health infrastructure already in place through our local health departments is an effective strategy to accomplish Medicaid managed care organizations’ goals of improving health and reducing costs.

Colleen M. Bridge, PhD, MPH director, Orange County Health Department, Hillsborough, North Carolina; adjunct clinical professor, Department of Maternal and Child Health; adjunct assistant professor, Department of Health Policy and Management; Gillings School of Global Public Health, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.

Steven E. Smith, MPA director, Henderson County Health Department, Hendersonville, North Carolina.

Stacie Turpin Saunders, MPH director, Alamance County Health Department, Burlington, North Carolina.

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