Note: The Public Health Improvement Plan (PHIP) for Maine is the result of discussions and activities that took place from June 1999 through June 2001. Not all participants agree with all findings and recommendations. A significant challenge in publishing a document such as this, is attempting to document the status of the discussion at a specific point in time, when in-fact the discussion continues.

The PHIP describes a vision to be accomplished over the next 10 years and as the status of public health "on the ground" changes, the PHIP will need to be revised and updated. It is our hope that the dialogue that began with Maine Turning Point and resulted in the PHIP will continue. Implementation and undertaking changes described herein, as well as the revised vision that is bound to emerge in the years ahead, is and will always be the responsibility of a wide range of individuals, organizations, and government agencies.

Report from the Work Group on the Integration of Public Health and Clinical Care

Summary Recommendation:

The Workgroup has grouped strategies for improving public health in the context of clinical care into four topical areas summarized by the following statements.

A. The public's health will benefit if physicians provide more local leadership in health promotion and disease prevention.
B. Clinicians' interest and participation in public health activities is likely to increase if payers and policy-makers develop new and enhance existing opportunities, mechanisms, and incentives.
C. Closer linkages among clinicians and public health professionals will enhance population-based programs and individual health care for Maine residents.
D. Clinician training in public health topics is essential to a healthier Maine.

Implementation Steps:

A: The public's health will benefit if physicians provide more local leadership in health promotion and disease prevention.

Strategy: Each Health District should have a part time Medical Officer

B: Clinicians' interest and participation in public health activities is likely to increase if payers and policy-makers develop new and enhance existing opportunities, mechanisms, and incentives.

Strategies:

- Health plans and health systems, as some already do, should work proactively and collaborate with public health colleagues to improve payer reimbursement for effective health promotion and disease prevention services provided in clinical and non-clinical settings.
- Provider payment systems should provide mechanisms and incentives for effective prevention services. Third party financing for all three levels of prevention should be increased.
- A forum on prevention should be convened for providers, payers, and public health advocates to explore issues, identify barriers, and develop strategies to achieve desired outcomes.

C: Closer linkages among clinicians and public health professionals will enhance population-based programs and individual health care for Maine residents.

Strategies:

- Clinical providers and public health professionals should better integrate their activities.
- Existing health outcome and prevention practice information and office systems should be made more readily available.
- Community Oriented Primary Care (COPC) demonstration projects should be developed in Maine.

D: Clinician training in public health topics is essential to a healthier Maine.

Strategies:

- Public health education should be strengthened in current clinical programs
- An educational consortium should be established in Maine to foster public health curriculum development, adoption, and implementation in clinical training programs.

History and Emerging Role of Public Health

Public health was born of the need to address the infectious disease epidemics that were afflicting entire populations. The emerging prevalence of chronic disease and the fading effect of infectious disease during the 1900's, along with increased specialization among clinical care providers, the once intertwined clinical care and population-based aspects of public health have grown apart.[1] In the last decade, however, there has been a growing need for greater integration of clinical care and public health.

Nationally the link between clinical care and public health is widely understood to be essential to the provision of the highest quality health care possible. It is important to note that in Maine, public health nurses, private practice physicians, and a host of other licensed or credentialed health service providers are a significant part of the fabric of public health, especially in rural areas where there are few, if any "official" public health service providers. However, **few of these medical, dental, mental health or other clinicians consider themselves part of the public health system.** The Work Group on Public Health in the Context of Clinical Care (PHnCC) was charged with examining the relationship among clinical and public health professionals in Maine and to then develop recommendations that would improve the public's health in the context of individual clinical care. Group membership included representatives from the following disciplines: dental, physician, nursing and advance practice nursing, chiropractic, academic research, speech therapy, hospital medical administration, physician assistant, and mental health (see Appendix D for participant list).

Work Group Process

The Work Group adopted the World Health Organization's definition of health: "a state of complete well-being, physical, social and mental, not merely the absence of disease or infirmity," and agreed that the Institute of Medicine's (IOM's) definition of public health provided a consistent

[1] Lasker, R., et.al., "Medicine & Public Health: The Power of Collaboration," The New York Academy of Medicine, New York, 1997, pp 7-14.

framework for deliberations. The IOM has stated that, "The substance of public health is organized community efforts aimed at the prevention of disease and promotion of health."

Furthermore, they agreed that it was important to clarify their intended meaning of the term "clinician." In this document, the term "clinician" refers to an individual who provides a health service. The professions that are implied in our use of this term include, at a minimum: nurses, nurse practitioners, physicians, physician assistants, dentists and dental hygienists, providers of mental health services, along with the many other providers of clinical care. The intention is to be inclusive of the widest possible range of individuals involved in clinical care.

Members of the work group reviewed national consensus documents and models (such as COPC) and conducted key informant interviews to determine clinical workforce issues and to recommend strategies for integrating and improving public health in primary care settings.

In August of 2000, Dora Mills and Lisa Letourneau presented the draft Maine Turning Point recommendations to their colleagues on the Maine Medical Association (MMA) Public Health Committee.

The Committee was enthusiastic about the Health District Medical Officer (HDMO) concept and drafted a resolution to endorse and support the Turning Point proposal.

The resolution was approved at the MMA Annual Meeting in September 2000.

The Maine Osteopathic Association endorsed the measure the following month, due in large part to leadership from Stephen Shannon, D.O.

"Public health is not just something that the state does. We need to recognize that providing effective care for our populations of patients and improving preventive care are ways that we contribute to public health, too."

—Lisa Letourneau, M.D.

Strategies for Improving Public Health in the Context of Clinical Care Discussion and Recommendations – Topical Area A

The public's health will benefit if physicians provide more local leadership in health promotion and disease prevention.

Discussion: In Maine, the local communities with the most developed public health collaborations with clinical care providers have or have had a physician in a leadership position in the community as well as among medical, mental, and dental health colleagues. The lack of ongoing dialogue between clinical care providers and traditional public health service providers in Maine communities contributes to the fragmentation of health promotion and disease management services. Furthermore, medical literature strongly supports the fact that physician leadership is one of the key factors in influencing physician behavior change.

Recommendation: The State of Maine should engage a part-time Medical Officer in each of the Health Districts. We are aware that this idea raises concerns for many and touches on some sensitive areas in the community as well as among various clinical disciplines. In our initial conceptual framework, the HDMOs are not intended to direct or otherwise "run" or "be in charge" of the Coalitions in each Health District. The HDMO functions are to operate as an adjunct activity, as directed by the State Health Officer, and as possible at the local level to provide support to the leadership and members of the Health District Coalitions. For additional information on the Health District concept see the report from the Work Group on Infrastructure.

A closer look ~ The proposed role of Health District Medical Officer:

1. Credentials: The Health District Medical Officer (HDMO) would be a physician who is board certified in a primary care specialty (family practice, internal medicine, pediatrics, obstetrics/gynecology), with prior formal training in public health and or a commitment to participating in periodic formal training sessions provided by or approved by the Bureau of Health in collaboration with appropriate private sector partners.
2. Responsibilities:
   - a.) Assist the Bureau of Health in disease surveillance and provide local public health leadership for dealing with emerging infectious diseases;
   - b.) Work with existing organizations that are required to develop guidelines to enhance implementation of prevention measures, to assure local implementation of evidence-based risk-reduction and disease management strategies, and disseminate effective standards of practice as set in concert by the HDMOs, the Bureau of Health, and the Bureau of Medical Services;
   - c.) Provide key linkages between the Health District Coalitions and the local health care delivery system.
3. Level of effort: These positions would be funded at 0.2 FTE (0.4 FTE in Portland area District) through Bureau of Health contracts with Health District Coalitions.

Indicators or Measures of Success:

- Legally authorized and funded

Strategies for Improving Public Health in the Context of Clinical Care Discussion and Recommendations – Topical Area B

Clinicians' interest and participation in public health activities is likely to increase if payers and policy-makers develop new and enhance existing opportunities, mechanisms, and incentives.

Discussion: Nationally, there has been an emerging influence on the provision of primary, secondary, tertiary preventive care in clinical settings resulting from the National Committee on Quality Assurance (NCQA) and its development of the Health Plan Employer Data and Information Set (HEDIS) and set of common data indicators for examining performance of Managed Care Organizations (MCOs). The most recent version of HEDIS requires MCOs to report on more than 50 prevention-oriented indicators, largely secondary and tertiary prevention-related issues.[2] These quality improvement and data collection activities have played an important role in changing clinician practices and increasing the provision of prevention services. However, there are still disappointingly few financial incentives available to providers who achieve high levels of compliance with HEDIS measures. Some payers, such as Medicaid and Anthem Blue Cross have increased reimbursement for certain preventive care services, such as physician counseling time to discuss smoking cessation with pregnant patients. Yet some payers want providers to perform better overall and provide more preventive services, but only pay for acute care services, while not providing incentives or reimbursement for services that results in overall better performance on the practice's population of patients.

---

[2] Healthy People 2010, 7-9

The ability to code for and thus be reimbursed for providing primary, secondary, and tertiary prevention services may be a significant incentive to clinicians. Those third-party payers who have identified this strategy for improving delivery of prevention services should share their data regarding the cost-savings benefit of providing clinically based primary prevention services and the timeline for realizing those savings within the health care system. Data from third-party payers already employing effective strategies could be used to determine adequate clinician reimbursement for these services.

Recommendation: Payers should provide adequate resources and provide reimbursement for prevention services provided in a clinical environment.

Indicators or Measures of Success:

- Increased number of payers who provide reimbursement for preventive medicine billing codes

Discussion: Employers, insurers, and individuals would benefit from universal clinical access to services that promote reduction in health risks ("risk-reduction") services. This would be more likely to occur if ALL third-party payers, not just MCOs, reimbursed clinicians for provision of risk-reduction services.

Recommendation: Professional associations, public health professionals, and clinicians should advocate for third-party payer financing for effective clinical provision risk-reduction services. This exploration should consider both regulatory and competition-based strategies to assure that all Maine citizens have access to health promotion and disease prevention services.

Indicators or Measures of Success:

- Current policies assure financing for clinical provision of risk-reduction services
- Change from current status.

Discussion: Collaboration between managed care plans, agencies that provide public health services and clinicians, is a logical consequence of the health promotion objectives shared by these organizations.[3] Dialogue among these parties is necessary to further their common objectives related to health promotion. Currently, no forum exists to promote ongoing dialogue between all of these parties in Maine. Such a forum would provide an opportunity for providers, payers, and public health advocates to facilitate improved communication, cooperation, and overall relationships.

- Recommendation: Convene a forum for initiating and fostering ongoing dialogue among Maine's clinical care providers, public health professionals, and third-party payers as a means for exploring issues, identifying barriers, and developing strategies to achieve desired outcomes.

[3] Healthy People 2010, 7-9

Indicators or Measures of Success:

- Creation of a forum for initiating and fostering ongoing dialogue among Maine's clinical care providers, public health professionals, and third-party payers.
- Demonstrated improvements in key indicators of preventive care services such as mammography (possibly tracked via HEDIS or BRFSS).
- Incentives for, and improvement in population health outcomes.

Strategies for Improving Public Health in the Context of Clinical Care Discussion and Recommendations – Topical Area C

Closer linkages among clinicians and public health professionals will enhance population-based programs and individual health care for Maine residents.

Discussion: This section attempts to address two areas of concern. One issue is clinician frustration with the small sample sizes and limited feedback on quality of care to patients that is provided by payers. The other issue is the use of various office systems and other tools (some of which are provided by payers, others by federal agencies).

Improved clinician compliance with United States Prevention Task Force (USPTF) recommendations, for example, can be facilitated by physician leadership, education, and by good office systems, such as flow sheets and reminders. Currently we find that third-party payers have provided many clinical practices with office systems and tools that support compliance with USPTF recommendations, while other tools have been developed and distributed by drug manufacturers, federal agencies, or health care delivery systems themselves. These various systems are not necessarily coordinated for seamless implementation or ease of use at the clinical practice level and may lead to duplicate data entry or software compatibility issues.

When payers report back to physicians on HEDIS measures, the payer may choose to emphasize some measures but not others. In addition, when the reports to physicians are plan specific, the data is frequently from too small a sample to be useful to the clinical practice. For example, a practice might be told that they are achieving a 50% rate of dilated eye exams on diabetics covered by insurer "x" – but that 50% may result from a total sample size of six patients.

Recommendation: Maine's clinical care professional associations should:

- More proactively endorse and support implementation of preventive care guidelines and evidence-based, nationally accepted standards for anticipatory guidance.
- Work with payers, state agencies, and non-profit public heath providers to develop and implement office systems that promote the effective delivery of preventive care (e.g. patient care flow sheets) to all provider members.
- Collaborate with third-party payers to enhance clinicians' understanding of how to maximize the utility of the population data that is available to them through the HEDIS reports they already receive.

- Facilitate increased dialogue among clinicians, public health professionals, and third-party payers about ways to potentially pool data among private and government payers to increase the usefulness of HEDIS data to enhance clinical practice.

Indicators or Measures of Success:

- Number of clinicians with office systems in place to assure utilization of preventive care guidelines.
- Increased dialogue among providers and payers regarding measures and reporting.

Discussion: There would be value for clinicians if there were additional data feedback at the individual clinician or practice level in addition to the insurer specific data they currently receive. There would be added value for public health if third-party payer HEDIS data was combined and published by (geographic) Health District. However, there are currently provider contract provisions that prevent payers from sharing clinician-linked data with outside parties.

Recommendation: Maine's third-party payers, clinicians, and public health professionals, working with New England Practice Research Organization (NEPRO), should explore opportunities to increase the availability of existing health outcome and prevention practices data in ways that do not violate patient or provider confidentiality, and to provide financial incentives for providers who reach desired goals for population preventive services and management of chronic illness.

Indicators or Measures of Success:

- Increased communication between third-party payers, clinicians, NEPRO and public health professionals
- Strategies identified to increase availability of existing data without violating patient or provider confidentiality

Discussion: The individual care relationship between clinician and patient is more effective in assuring health and treating disease when the clinician also has an understanding of the population-based issues facing the individual patient. Community Oriented Primary Care (COPC) projects can provide an effective vehicle for supporting population-based care.

Recommendation: Appropriate organizations should secure funding for Community Oriented Primary Care demonstration projects in several Maine communities.

Indicators or Measures of Success:

- Number of COPC demonstration projects designed and funded
- Number of new ideas that promote population health improvement

Strategies for Improving Public Health in the Context of Clinical Care Discussion and Recommendations – Topical Area D

Clinician training in public health topics is essential to a healthier Maine

Discussion: Nationally the link between clinical care and public health is widely understood to be essential to the provision of the highest quality health care possible. However, in Maine, few medical, dental, mental health or other clinicians consider themselves part of the public health system.

Recommendation: Public health advocates, in collaboration with provider organizations and their professional associations should undertake activities designed to enhance clinicians' understanding of their role in the public health system and the importance of clinical participation in public health activities.

Indicators or Measures of Success:

- Public health information and educational programs are offered at the annual meetings of clinical professional associations.
- There is greater availability of public health information/education programs for clinicians.

Discussion: There are two areas of training addressed in this section. The first is continuing education for practicing clinicians in public health topics. The second is education on public heath topics for clinicians in training.

Adequate training on public health issues and population-based care is not consistently integrated into the professional training of clinicians at this time, nor is there adequate and locally accessible public health training for practicing clinicians. The State's public health agencies have an important leadership role in encouraging the development and availability of training appropriate for various clinical disciplines.

Recommendation: An educational consortium should be established in Maine to foster public health curricula development, adoption, and implementation in clinical training programs. Such a consortium would collaboratively develop or adapt from existing national models, a Maine-oriented core public health curricula that could be integrated into health professions training programs using either a discipline specificor inter-disciplinary model.

- Such a program could be developed as a "pilot project" with the goal being to develop educational templates that reflect the health system and social contructs in Maine, which would help insure the proper preparation of the next generation of Maine-trained, and Maine-based, health care professionals.
- This project could focus-on specific areas of public health intervention and prevention strategies related to general primary health care, mental health and oral health.
- As a "pilot project" a public-private consortium could seek federal and/or foundation funding to support the design, development, and initial implementation of the curriculum.

Indicators or Measures of Success:

- More public health topics incorporated into clinician training programs
- Consortium established
- Appropriate organizations develop or adapt Maine-focused training curriculum
- Pilot project initiated and successful

Recommendation: State agencies, in cooperation with clinical professional organizations and Maine-based providers of continuing education for clinicians, should develop and provide opportunities for practicing clinicians to receive supplemental training in public health disciplines.[4]

Indicators or Measures of Success:

- More training is public health topics is available and integrated into clinical curriculae
- CME/CEUs offered at public health events/training/conferences

Clinical Workforce Issues

In Maine, public health nurses, private practice physicians, and a wide variety of other clinical care providers play an important role in public health. In addition to being providers of care for accidents, illness and disease, clinicians have an important role in health promotion and disease prevention through clinical risk reduction strategies, health education, and public leadership on health issues. There are important opportunities for clinicians to have an impact on the health of their entire patient population and their community as a whole (i.e. public health). For example, the primary sources of information about health care issues for most Maine voters are Family/Friends (20.8%) and the Family Doctor (20.5%).[5]

We noted the following issues from the key informant interviews, and although they have not been addressed in this document, they are and remain important considerations for future dialogue:

Clinical Workforce Issues:

- *There are current and projected shortages in a number of clinical professions such as nurses (especially geriatrics), OT/PTs, mental health professionals, dentists, clinicians trained in prevention methods, and people with policy development/analytical/problem-solving skills working in the community;*
- *Currently there is a surplus of mid-level providers.*

1995 Maine Health Care Reform Commission Report: Summary of Recommendations Related to Health Workforce in Maine

1. *The Department of Health and Human Services should convene a workforce forum.*
2. *The Workforce Forum would serve as a clearinghouse of information, creating a single access point for anyone interested in workforce issues.*
3. *Develop an inventory of present health workforce and education programs in the state.*
4. *Develop research and analytic methods for understanding population-based needs on an ongoing basis.*
5. *Consider the usefulness of forming a "federation" of licensing boards to facilitate communication across medical disciplines.*
6. *Provide a foundation for assisting stakeholders to make appropriate decisions about the best use of health care personnel in Maine and the need for health education.*

---

[4] For additional information on public health discipline training needs in Maine see the Report from the Work Group on Workforce and Training.

[5] Data from the Maine Turning Point Community Health & Well-Being Survey, Winter 2000, survey of 605 Maine voters, margin on error 4.0% at the 95% confidence interval.

Implications of Clinician Supply and Demand Changes for Public Health:

- *The shortages of mental health and dental care providers will continue to be important public health problems;*
- *The gaps in training in public health, population-based methods, and prevention limits the effectiveness of clinical providers;*
- *There is a definite need to improve the relationships between providers of clinical and public health services — clinicians may be unsure of what role they can play in improving the health of the entire population beyond serving individual patients' needs.*

In 1995, the Health Care Reform Commission made several recommendations directly related to the healthcare workforce that have implications for addressing public health problems. Key informant interviews suggest that few of the Health Care Reform Commission recommendations have been implemented and many issues remain.

While many participants believe that there would be an important role for centralized health workforce planning that exceeds the current capacity, there does not appear to be a consensus within state government or the private sector with regard to the potential value of undertaking centralized health workforce planning of the nature envisioned in the 1995 Commission report.

One area in which this debate plays out is that of data regarding clinical care providers who are licensed by the state. During the mid-1970's federal funds supported data collection and analysis of 13 clinical professions. The data was collected through surveys that were included in license renewal mailings undertaking by the licensure boards. In the early 1980's the federal funds were withdrawn nationwide. Despite the lack of funding Maine continued to do as much data collection as possible, including 1987 and 1990 surveys of registered nurses and licensed practical nurses.[6]

Currently, the state surveys physicians on a biennial basis, dentists and dental hygienists every four years. For other professions, such as social workers and dietitians, the state is generally limited to collecting and reporting on the number of licensed providers without the benefit of surveys to collect additional details.

The kinds of data that advocates of expanded centralized planning seek, but do not feel is currently available, includes information such as:

- number or proportion of licensed providers who work full-time vs. part-time, vs. inactive (to help identify areas where there may be excess capacity or a need for additional capacity);
- settings in which the providers are employed (private practice, hospital, etc.);
- counties in which providers work (for example, in 1999 there were 56 certified nurse midwives in Maine[7], but we do not know the geographic areas they serve or the number of women they serve);
- number of providers who are graduates of Maine-based training programs vs. those who work in Maine but came here from other places (to help identify where our training programs are helping to meet an existing need and where we might want to expand or develop local training programs to meet needs that are not currently being filled by existing programs);

---

[6] Warren Bartlett, memo dated June 14, 2001.

[7] Maine Health 2000: A Health Planning Resource, Maine DHS Bureau of Health, Section III page 111.

- number of providers, by county or other geographic delineation, who currently accept Medicaid patients, etc.

The Bureau of Health estimates that it costs approximately $50,000 per profession to undertake and analyze the results from surveys that could provide additional data regarding the breadth and scope of activity of members of the surveyed profession.[8] It will be extremely difficult to obtain financial support for expanded surveying and data collection for licensed clinical professionals unless and until a stronger consensus on the need for and value of centralized state workforce planning develops.

Another area that drew attention in the 1995 Commission report and in MTP's key informant interviews was that of the Commission's recommendation regarding a workforce forum. Public Law 1996, Chapter 653, Part C, Section C-3, requires the Bureau of Health to convene a health workforce forum annually. However, the legislature has never provided funds to support such a forum.

The Office of Rural Health has been assigned responsibility for providing the forum and has done so, without the benefit of dedicated funding for this purpose, in the context of the Maine Rural Health Association annual meeting. Several key informants and work group participants acknowledged the Bureau's efforts in this area. They, like the Bureau itself, recognize that important work envisioned in the Commission Report is not currently but could be accomplished if there were dedicated resources available to carry out the full vision upon which this mandate is predicated.

Barriers to Collection of Adequate Workforce Data:

1. Licensing boards are limited in their ability collect data on the clinical workforce;
2. In some quarters there is a perceived lack of leadership from state government with regard to health workforce planning and medically underserved areas (see above regarding lack of consensus);
3. The Bureau of Health has collected data when possible but the legislature does not provide funding that would make it possible for BoH and the licensure boards to collect, analyze, and publish more detailed clinical workforce data on a wider range of professions at regular intervals.

Conclusion: Without better data, it will not be possible to forecast and respond to clinical care workforce needs. If a consensus develops that supports enhancing the state's role in undertaking centralized health workforce planning, expanded data (similar to or even beyond that which is currently undertaken periodically for physicians and dental health providers) would need to be collected for an additional ten to twelve clinical occupations.

D. Recommendation: There should be surveys of the active clinical care workforce and that data should be used to project workforce needs and develop public policy responses as needed.

[8] Warren Bartlett, op cit.

Strategy: Monitor the active clinical workforce composition and use the data to project need.

A Closer Look: In order for this monitoring to be possible, the Bureau of Health would need additional resources (financial and human) in order to coordinate with the Licensing Boards to collect and disseminate a broader range of data to improve knowledge and understanding of the characteristics of those members of the clinical care workforce whose professions are licensed (e.g. working part-time vs. full time, etc.) as well as to develop public policy related to clinical workforce training, retention, and availability.

Indicators or Measures of Success

- Financial support for and collection of a broader range of data
- Availability of that data to public health advocates and others
- More in-depth analysis of workforce issues and development of appropriate policy responses.