EDITORIALS

Connecting Care Through the Clinic and Community for a Healthier America

Healthy People, the nation's roadmap and compass, affirms

> [that] the health of the individual is almost inseparable from the health of the larger community and that the health of every community in every State and territory determines the overall health status of the Nation.[1(p551)]

Yet, to date, our society has not yet optimally aligned the individual and community forces that can best foster health for all. For too long, fragmentation has ruled the day. In particular, the nation's health care systems have focused predominantly on sick care, plagued by episodic and uncoordinated delivery, multiple paper-based clinical records, rising costs without related quality improvement, and reimbursement systems that reward volume and not value. Moreover, a suboptimal focus on prevention, without engagement of and integration with the broader public health community, has added to the fragmentation. As a result, patients and populations alike have not consistently reached their full health potential.

Fortunately, a new day has dawned. The Affordable Care Act (ACA),[2] the health reform law of 2010, offers the promise of greater insurance coverage for millions. It also knits together the themes of care coordination and health promotion for both the clinic and the community.[3] Many provisions offer opportunities for health care providers to partner with public health agencies and community organizations for the benefit of their patients. Hence, the various components of the ACA provide an unprecedented opportunity to overcome fragmentation and integrate primary care and public health. Doing so recognizes that health arises not simply from a visit to a doctor's office, but also, more broadly, from where people live, labor, learn, play, and pray.[3] Indeed, the overarching goals of Healthy People 2020 emphasize a life span approach to health promotion and a society in which the healthy choice represents the easier choice.

The current joint issue of the *American Journal of Public Health*® and the *American Journal of Preventive Medicine* highlights these critical themes of connection and integration. The issue features new bridges between clinical care and community prevention, two worlds that have spun for too long in separate orbits.[4] The US Department of Health and Human Services (HHS) supports many of these national efforts to make quality and prevention come alive for patients and society at large.

We can begin by reaffirming explicitly the basic, yet profound, concept of patient centeredness. For example, the HHS Centers for Medicare & Medicaid Services (CMS) is promoting new models for patient centeredness through the 2012 launch of accountable care organizations (ACOs). In the ACO Medicare Shared Savings Program (MSSP), networks of physicians, hospitals, and other providers join voluntarily to improve care coordination for defined panels of Medicare beneficiaries; upon reaching desired quality standards with demonstrated cost reductions, the networks can engage in shared savings. Related ACO models unveiled in 2012 through the Center for Medicare and Medicaid Innovation (CMMI) include (1) the Pioneer ACO model, whereby 32 organizations from across the country, already experienced with coordinated care delivery models, can test new and innovative strategies; and (2) the ACO Advanced Payment Model, which allows eligible ACOs to receive an advance on expected shared savings to offset investment costs. The success of ACOs will hinge upon better care both in the clinic and in the broader community, resulting in improved health outcomes for populations.

The heightened emphasis on patient-centered medical homes also promotes a team approach for optimal care of patients. Such an approach assures whole patient orientation, follows evidence-based guidelines, and implements continuous quality improvement. In this area, the HHS Health Resources and Services Administration has committed to have more than 25% of its federally qualified health centers and community health centers soon achieve recognition as National Committee for Quality Assurance–recognized medical homes. CMMI is supporting several pilot programs for medical homes as well. In this way, primary care can help promote public health goals.

Notably, primary care providers serve as the foundation for the team approach for patient centeredness, promoting a strong emphasis on prevention advanced by the ACA. Beginning in 2011, primary care physicians and other health professionals have helped 25.7 million Medicare beneficiaries

receive new preventive benefits such as free annual wellness visits and screening and counseling services without cost sharing. In recognition of these and other efforts, starting that same year Medicare has provided an additional 10% payment for primary care services provided by primary care physicians—physicians in specific primary specialties with primary care services accounting for 60% or more of their Medicare revenues—or major surgical procedures for primary care providers and surgeons in designated health professional shortage areas.

HHS has also advanced care coordination and integration in other ways. For example, the recently launched HHS Partnership for Patients engages providers to reduce both hospital-acquired conditions as well as 30-day hospital readmission rates. Reaching the latter goal of 20% reduction over the next three years means that communities must improve areas such as screening, immunization, and cardiovascular disease prevention. Also, the 2012 CMS Health Care Innovation Challenge will dedicate nearly a billion dollars of new grants for proposals that will improve care, improve quality, and lower costs—themes that offer additional opportunities for partnering with public health agencies and other groups committed to improving the health of populations. Meanwhile, efforts have begun to align financial incentives that will move volume-based purchasing systems to value-based ones.

Achieving integration also requires that providers widen their perspectives beyond the clinic to the community. A concerted effort to train future providers, using public health detailing[5] and other means, can begin this journey. Medical schools and public health schools are broadening curriculum-based efforts to send this message, building on work that has been decades in the making.[6,7]

Such enlightened providers can fully leverage the meaningful use of health information technology.[8] Widespread adoption of Electronic Health Records (EHRs) and health information exchange should improve health care quality for patients and increase provider coordination while reducing unnecessary health care costs that come from duplicated tests or preventable drug errors. The Medicare and Medicaid EHR Incentive Programs, created to encourage widespread adoption of EHRs, have already led to more than 43 000 eligible professionals and hospitals receiving more than $3.1 billion in payments through January 2012. Population-level data from these records can facilitate identification of patterns of illness and of delivery of services to communities with the greatest disease burden.

In short, viewing the community as the unit of care represents the public health vision for the future. New resources and commitments from the ACA are making this vision possible. The new federal National Prevention Strategy, arising from the foundations of Healthy People, has set four pillars for action: creating, sustaining, and recognizing communities that promote health and wellness through prevention; ensuring that prevention-focused health care and community prevention efforts are available, integrated, and mutually reinforcing; supporting people in making healthy choices; and eliminating disparities and improving the quality of life for all Americans.

Moreover, a dedicated Prevention and Public Health Fund now devotes mandatory new resources to community prevention over the next 10 years. To date, the Fund has supported new efforts in tobacco control, obesity prevention, integration of primary care and behavioral health, public health infrastructure in health departments, and other key areas. Also, from the Fund, the Centers for Disease Control and Prevention have recently awarded more than $100 million in new Community Transformation grants to implement evidence-based approaches to address major public health challenges and reduce health disparities.[9] Such efforts can promote health across the life span, from youth[10] to old age, and advance life-saving prevention measures[11] in community as well as in clinical settings.

Ultimately, these combined efforts should advance health care quality, giving people what they need and want. National quality benchmarks will track key prevention outcomes that depend upon actions and activities both in the clinic and in the community setting. For example, ACOs will use 33 quality measures (in four domains of evaluation), such as blood pressure control; screening for weight, depression, and cancer; and other measures. Similarly, quality measures for patient-centered medical homes include outcomes that reflect a prevention emphasis, requiring health care institutions to work more closely with local groups and public health agencies to improve the community's health.[5]

And while several decades of work have advanced our understanding of quality for health care in the clinic, newer efforts are also beginning to address quality for public health in the community—defined as "building better systems to give all people what they need to reach their full potential for health."[12] Public health quality focuses on the concept of population-centeredness and should meet the aims of being equitable, proactive, health-promoting, risk-reducing, vigilant, transparent, effective, and efficient.[12] The initiation of voluntary public health department accreditation this year represents one tangible sign of progress in this regard.[13]

Who should be accountable for the transformative changes proposed here?[14] Everyone can share in the responsibility. Patients, providers, payers, employers, researchers, public health officials, policymakers, advocates, and the general public can commit to integrating policy and practice. Now is the time, paraphrasing Scutchfield et al.,[4] to seize the moment and acknowledge that ultimately we are all interdependent and interconnected. We envision a day when, in addition to accountable care organizations, we will recognize accountable communities, demonstrating progress for patients and populations alike. Connecting care through the clinic and the community will not only help the patients we see but also those we will never see. And with this commitment, we can uphold the promise of Healthy People for generations to come. ■

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A Call for Action on Primary Care and Public Health Integration

The fields of primary care and public health in the United States have for the last century generally functioned independently of each other. This is not optimal; our current health challenges require improved efforts to work together in an integrated fashion to address the root causes of illness and prevent additional cases of disease, and to make the default choice a healthy one.[1] Effective support of healthy behaviors will require coordination of the work of clinicians, particularly primary care clinicians, with public health agencies, schools, businesses, and community groups to better utilize community resources. In such an integrated system, primary care and public health work together to support individuals, families, patients and their caregivers, and to improve the health of individuals and populations (i.e., a true health system).[2]

How will health care in the United States evolve to become part of such a health system? On March 28, 2012, the Institute of Medicine (IOM) released the report, "Primary Care and Public Health: Exploring Integration to Improve Population Health,"[3] in which the Committee on Integrating Primary Care and Public Health review promising models of primary care and public health integration, often with shared accountability for improved community and population health outcomes. From their review of numerous examples, the IOM committee developed a set of principles that they deem essential for successful integration of primary care and public health:

1. a shared goal of population health improvement;
2. community engagement in defining and addressing population health needs;
3. aligned leadership;
4. sustainability, including shared infrastructure; and
5. sharing and collaborative use of data and analysis.

The IOM report notes that integration can start with any of these principles and that starting is more important than waiting until all are in place.

This special issue complements the recent IOM study. Four agencies of the US Department of Health and Human Services (DHHS)—the Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), and the National Institute on Minority Health and Health Disparities (NIMHD) of the National Institutes of Health (NIH)—sponsored this special issue to showcase and support additional efforts in this critical area. A guest editor from each agency worked with editors and reviewers from the *American Journal of Public Health*® (*AJPH*) and the *American Journal of Preventive Medicine* (*AJPM*) to select papers from among more than 125 submitted manuscripts. The articles included in this issue—a first-time joint publication by *AJPH* and *AJPM*—highlight how these two sectors intersect and the work ahead to achieve true integration.

The time is ripe for such integration. As mentioned in the IOM report and cited in the accompanying editorial in this issue by HHS Assistant Secretary for Health Howard Koh and Acting Centers for Medicare and Medicaid Services Administrator