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Identifying Barriers to Collaboration Between Primary Care and Public Health: Experiences at the Local Level

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Abstract

Objectives: Interest is increasing in collaborations between public health and primary care to address the health of a community. Although the understanding of how these collaborations work is growing, little is known about the barriers facing these partners at the local level. The objective of this study was to identify barriers to collaboration between primary care and public health at the local level in 4 states.

Methods: The study team, which comprised 12 representatives of Practice-Based Research Networks (networks of practitioners interested in conducting research in practice-based settings), identified 40 key informants from the public health and primary care fields in Colorado, Minnesota, Washington State, and Wisconsin. The key informants participated in standardized, semistructured telephone interviews with 8 study team members in 2014 and 2015. Interviews were audio recorded and transcribed verbatim. We analyzed key themes and subthemes by drawing on grounded theory.

Results: Primary care and public health participants identified similar barriers to collaboration. Barriers at the institutional level included the challenges of the primary care environment, in which providers feel overwhelmed and resources are tight; the need for systems change; a lack of partnership; and geographic challenges. Barriers to collaboration included mutual awareness, communication, data sharing, capacity, lack of resources, and prioritization of resources.

Conclusions: Some barriers to collaboration (eg, changes to health care billing, demands on provider time) require systems change to overcome, whereas others (eg, a lack of shared priorities and mutual awareness) could be addressed through educational approaches, without adding resources or making a systemic change. Overcoming these common barriers may lead to more effective collaboration.

Keywords

primary care, public health, integration, qualitative, barriers

Collaboration between public health professionals (or public health organizations) and primary care providers (or primary care organizations) is a strategy for improving population health in communities.[1] Although primary care focuses on providing care to individuals, interest in addressing population-level health,[2-5] responding to the social determinants of health,[6,7] and exploring how to build collaborative relationships outside primary care clinics has increased.[8,9] Public health organizations are also considering how to broaden collaboration with clinics to help address the needs of the community.[10-13] Some activities, such as immunizations and emergency preparedness, have historically included collaboration between public health and primary care.[14] However, public health workers and primary care

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providers have expressed interest in broadening the ways in which primary care and public health come together to address a wide range of topics[15] and develop shared skills and strategies for advancing partnerships.[16]

Institutional factors, such as having a shared mission and vision, along with an alignment of goals and objectives, are valuable for collaboration.[17-20] Key processes are important, such as having a clear, established partnership that is sustainable and implementing strategies to evaluate the partnership or the activities of the partnership.[17,19-22] The ability to collaborate may be influenced by the availability of shared data and analysis capability[18,20-22] and by the presence of various contextual variables, such as social, economic, or environmental factors.[23-25] Finally, the role of resources is central, particularly the need for coordinated infrastructure and funding to support collaboration.[17,19,23,24] Pratt et al[26] suggested that these characteristics of partnerships can be viewed as either foundational aspects of collaboration, which build and strengthen relationships, or as energizing aspects of collaborations, which elevate the collaboration into a shared activity.

Little research has been conducted on local-level barriers to collaboration between public health and primary care. Barriers identified in the literature include a lack of shared language or definitions and the absence of an agreed-upon way to assess or measure collaboration between public health and primary care.[21] The literature also notes concern about the role of health informatics because of the limited sharing of electronic health records between primary care and public health and the limited capacity of health departments to address these concerns.[25] Understanding barriers at the local level can help primary care and public health to increase the depth and breadth of their collaboration.

We explored the continuum of integration proposed by the Institute of Medicine (eg, mutual awareness, cooperation, collaboration, partnership),[1] examined the dimensions of integration on this continuum, and identified factors that facilitate or impede collaboration.[26] Some results of the study (eg, qualitative analysis of key aspects of collaboration)[26] have already been published, whereas other results (eg, findings from a survey of local-level practitioners' experiences with collaboration) are forthcoming. In this article, we report on the barriers to collaboration that were identified by public health and primary care practitioners.

Methods

We conducted a cross-sectional, mixed-methods analysis of barriers to collaboration between public health and primary care in 4 states—Colorado, Minnesota, Washington State, and Wisconsin—in 2014 and 2015.

Participants

The study team comprised 12 members from the 4 states who were members of and represented Practice-Based Research Networks for primary care in public health in each state. Practice-Based Research Networks are networks of practitioners who are interested in conducting research in practice-based settings. Study team members selected participants from the Practice-Based Research Networks in their own states using purposive sampling (ie, a nonprobability sample of experts in the field) and the following criteria: (1) participants had to represent a within-state geographic mix, (2) participants had to be a director or working at a leadership level in their organization, and (3) participants had to indicate familiarity with the "other" sector (ie, public health participants had to have working knowledge, as self-identified by the participants and confirmed by questions during the interview, of the primary care sector and vice versa).

We selected participants for the telephone interviews who knew each other; that is, we selected 1 participant from a public health department and 1 participant from a primary care organization in the same geographic service area who had worked together to some extent. All participants were local-level practitioners and administrators with various self-identified degrees of success in collaboration. We invited 40 participants (10 from each state) from 20 local jurisdictions (5 from each state) to participate by telephone and email, and all agreed to participate. All participants underwent an informed consent process and gave verbal consent for participation before the start of the interviews.

Approach

We developed a semistructured interview guide informed by the literature on key factors important for collaboration by using input from the study team (Box). Interviewers asked participants to reflect on examples of their working relationship, what they felt was important for collaboration, barriers to collaboration, and aspirations for working together. The study team developed a standard interview protocol to ensure consistent interviewing in each state. We collected data on the barriers identified by interviewees; findings on other aspects of collaboration have been reported elsewhere.[26]

Data Collection

Eight study team members in Colorado, Minnesota, Washington State, and Wisconsin (1 primary care and 1 public health Practice-Based Research Network representative in each state) jointly conducted telephone interviews in 2014 and 2015. All participants were interviewed individually. Interviews lasted approximately 1 hour.

Data Analysis

Two study team members from Minnesota read transcripts of the interviews and analyzed the data by using a social constructivist approach to grounded theory, in which data were systematically reviewed to identify themes and

Box. Semistructured interview guide used to interview public health and primary care participants (n = 40) about their experience of collaboration, Colorado, Minnesota, Washington State, and Wisconsin, 2014-2015

1. In general, what has been your experience of primary care and public health working together?
2. Please describe how your organization works with a key partner.
3. When is it beneficial to work together?
4. Are there times when it is less beneficial to work together?
5. How would you describe how closely your organization works together currently with your partner organization?
6. Would you prefer to work together differently? How?
7. Are there factors that influence your ability to collaborate?
8. Have there been changes in how you work together over the last 3 years?
9. Has your experience of collaborating varied by type of program (eg, infectious disease)?
10. What type of interaction do you have with your partner organization on immunizations?
11. How do you work together on cardiovascular disease?
12. In your view, what is needed to promote working together?
13. What makes it hard to work with your partner in the way you would like?
14. What makes it easy to work together?
15. Based on your experience, who usually initiates and organizes public health and primary care working together, and when?
16. How do the systems you work in support or hinder your ability to collaborate?
17. How do you learn from each other?
18. How do you think the way you work together impacts the health of people in the jurisdiction?
19. Are there service areas or topics ripe for greater collaboration?

subthemes.[27,28] The 2 study team members presented themes to the study team for review and discussion throughout the analysis process to further refine the analysis and results. Study team members in each state also shared study results with their respective Practice-Based Research Networks and provided additional feedback to further guide the analysis. We used NVivo version 11[29] to analyze data. The institutional review boards of the University of Colorado Denver, University of Minnesota, University of Washington, and University of Wisconsin–Madison deemed the study exempt.

Results

Interviewees identified the main barriers to collaboration between public health and primary care as institutional barriers, process-related barriers, and resource-related barriers.

Institutional Barriers

Both public health and primary care participants described the current environment in which primary care clinics operate as causing strain for primary care providers through a high patient care demand and a heavy workload. In these demanding work environments, both public health and primary care participants talked about how challenging it was to suggest new ways to work together. Primary care participants particularly described the stress caused by being asked to work in new ways without feeling sufficiently consulted or supported:

> All of a [*sic*] sudden now, in order to do well-child checks, we have to use this particular tool and we have to do this particular thing. And no one, I don't think, really talked to us a lot about the practicality of all this. Are we going to be able to do it? How are we going to be able to do it? (primary care participant, Minnesota)

Respondents from both groups noted that it might not be desirable to collaborate on every topic or health issue. The motivations for not collaborating varied; some participants felt that the primary care environment needed a more nimble, faster response to their needs than could be provided by bureaucratic public health partners. Some participants preferred to keep clinical care activities in the primary care clinic, which could lead to less opportunity for collaboration:

> They've hired their own health educators. They've hired their own behavioral health specialists. They've hired all these people inside their system, and they want to deliver the service in a manner that they could bill for it. And then we're not in it to bill for it; we're in it to do it in a group setting or something. And so, in those areas, we find it varies dramatically that we don't end up presenting very much in their communities for those programs. (public health participant, Colorado)

Health reform was described as affecting relationships by redefining what was a potential billable encounter in primary care, particularly for immunizations. Some public health participants felt that these changes in billing had led to a discouraging change and shared observations that primary care was now providing some care, such as more comprehensive immunizations, in ways that they felt were not effective or appropriate. Inversely, however, some primary care participants reported disappointment that public health was limiting or stopping some of the immunization services it had once provided.

Primary care and public health participants agreed that persistent systemwide barriers to collaboration would require systems-level change. Both groups viewed public health departments as being large, bureaucratic, and slow to change. Additionally, both groups viewed primary care clinics as being nimbler than public health departments but heavily driven by financial reimbursement:

> The world is not ready for that collaborative relationship in that reimbursement rates don't match up to a collaborative system. Guidelines and regulations don't match up to a collaborative system. There are a lot of things that need to be done that we

try to do that just don't really work that well. (public health participant, Washington State)

This clash of systems was seen as contributing to working in isolation, which participants noted was a serious challenge to collaboration. Although participants were interested in collaborative work, they were not sure how to initiate or achieve collaboration. Overall, participants indicated that systems change would be needed to address these barriers and create an opportunity for more effective collaborative relationships. However, respondents were not optimistic about the likelihood that systems would change in ways to address these challenges because of the barriers faced in undertaking systems-level change.

Challenges relating to jurisdictions served by public health and primary care were wide ranging. In some areas, local public health might cover an area served by numerous distinct health systems. Some primary care participants also indicated that the communities they served comprised more than 1 public health jurisdiction. However, this challenge was more commonly noted by public health participants.

Process-Related Barriers

Participants from both primary care and public health reflected on the lack of shared knowledge about each other that made it difficult to collaborate. Participants lacked knowledge about the core activities of each partner, the appropriate role in collaborating, and the populations served. Participants expressed a lack of awareness of each other that could lead to feeling threatened by the prospect of collaboration:

> When you think about integrating primary care and public health, the term can be somewhat threatening to one entity or another. If we can be educated and understand what the other does and that we are not duplicating services… I think that would be beneficial. (public health participant, Wisconsin)

Some primary care participants felt that public health officials did not understand the complexity of primary care well enough to collaborate effectively. Some participants felt that the lack of shared training and transdisciplinary training opportunities was also a barrier. Having shared experiences during training was seen as one way to build mutual awareness across each field.

Both primary care and public health participants described how communication challenges further exacerbate their ability to gain an understanding of each other. A long history of communication exists in some areas, such as infectious disease outbreaks, control, and reporting. In general, however, participants indicated that communication was inconsistent, and both groups of participants described difficulty understanding what the other does, what services they provide, and how they can connect with each other:

> My day-to-day work is so busy taking care of individual patients in the clinic that there's limited time in that respect. But because I think what public health does is important, it would be nice to have more regular contact with public health providers and to know what they're doing, what their goals are, and what services they offer. (primary care participant, Washington State)

Participants cited poor communication as an important barrier to collaboration. Both groups of participants described feeling that they rarely had time to share concerns and ideas about the health of the community. They expressed a desire to communicate more fully, but it was not always clear whom to communicate with or how to communicate.

Both primary care and public health participants were frustrated by their inability to share data. Participants identified problems with both primary care and public health information systems. The presence of multiple health systems in one public health jurisdiction was mentioned as a major complicating factor in identifying the possibility of a shared data platform. Both groups of participants reported benefits to data sharing and that a lack of ability to share data in both directions was a missed opportunity for collaboration.

Resource-Related Barriers

Both primary care and public health participants noted shrinking resources to serve communities and patients. Both groups of participants cited limited time, capacity, or resources to develop new work or new partnerships in the face of struggling to just "keep the lights on" for current services:

> There are just not enough resources to be thoughtful about developing strategies to get you where you know you need to be… because both on the private side and on the public side, we've ratcheted down our staff and our resources to a point where we just come in and open the doors and get the lights on and provide the minimal service every day, and there aren't enough resources to assign somebody to be doing this work. (public health participant, Minnesota)

Some participants, particularly those working in public health, described a reliance on externally funded grants to do new work, which was valued but also posed a challenge for creating sustainable services or partnerships. Some participants also identified the lack of sustainability as affecting their sense of credibility as a partner, particularly with services having to stop and start depending on changes in funding.

In the context of limited resources, the need to prioritize the use of those resources became even more important. Both groups of participants, particularly those who described a lack of shared strategic planning, indicated having either competing priorities or a lack of shared priorities. Without shared planning, participants addressed the most urgent priorities at the expense of developing collaborative responses to the community's needs.

Finally, both groups of participants indicated having limited capacity to partner, which was distinct from having inadequate resources in that it was described as the issue of limited services, limited capacity, or lack of knowledge.

Discussion

Barriers to collaboration between primary care and public health organizations reported in the literature included lacking a shared language or measurement framework[21] and challenges in exchanging health-related data.[25] Participants in this study reported these barriers but also noted a wider range of barriers to collaboration by people working in primary care and public health organizations at the local level. Primary care and public health participants were fairly consistent in identifying their concerns. Recent initiatives have produced resources to support partnerships in deepening their work together, such as the Practical Playbook, which outlines key strategies for building partnerships between primary care and public health.[18] However, to make the best use of such resources, partnerships need to address the common barriers to collaboration, such as those identified by the participants in our study (eg, communication challenges, lack of awareness of each other, demanding work environments, inability to share data).

Some identified barriers are not easily addressed, such as geographic challenges in which one partner may need to collaborate with multiple clinics or health departments across a wide geographic area. The primary care environment, particularly in relation to overwhelmed providers and scarce resources, was a particular concern and highlighted a need for systems change to reduce barriers to collaboration. In particular, reimbursement mechanisms are needed that incentivize health promotion and disease prevention, such as reimbursement for community-based wellness programs attended by patients of primary care clinics and supported by public health.

Other barriers may be more amenable to change. Although a lack of awareness of each other caused difficulty for this group of participants, it suggests that a long-term investment in shared training and a commitment to raising awareness of each other could help address this barrier. Several attempts to engage in shared learning (eg, distance learning) have been successful,[16] showing promise for finding ways to address this barrier to collaboration. That learning could be extended to help both fields identify and overcome common barriers. Both sectors need to communicate with each other, and this communication may be enhanced by prioritizing data sharing. Although sharing data across different systems is challenging, efforts have been made to improve data sharing.[30]

In the context of limited resources, differing competing demands for public health and primary care may contribute to a lack of shared priorities. Identifying processes to enhance shared priorities is possible. One study identified valuing strategic planning and data sharing as a strategy for collaboration.[26] Prioritizing policies that encourage aligned planning processes for both primary care and public health could bring partnerships together to explore and identify shared priorities for limited resources. Undertaking shared strategic planning may help partnerships identify and prioritize barriers to address collaboratively. However, coordination across multiple primary care organizations will be necessary to enable joint planning.

Limitations

This study had several limitations. Our sample included various participants in primary care and public health organizations at a local level but likely did not fully represent the many perspectives held by people who work in these or similar organizations. Participants with an interest in primary care and public health collaboration were likely overrepresented in this sample because of self-selection. Further research exploring these findings with a larger, more diverse sample may be warranted.

Conclusions

Primary care and public health organizations are increasingly motivated to collaborate to improve the health of the community. However, collaboration between these sectors is challenging, and important, longstanding barriers need to be overcome to build and sustain partnerships. Some barriers, such as addressing scarce resources, are particularly burdensome and may require systems and structural changes to support primary care and public health in deeper collaboration. Other challenges, such as shared priority setting and mutual awareness, could be addressed by shifting existing resources or broadening educational approaches to prepare practitioners for the challenges they may encounter in undertaking collaboration.

Authors' Note

The following are members of the Local Primary Care–Public Health Study Group: Beth Gyllstrom, principal investigator (Minnesota), Rebekah Pratt, co-principal investigator (Minnesota), Carol Lange (Minnesota), Laura-Mae Baldwin (Washington), Betty Bekemeier (Washington), Kim Gearin (Minnesota), David Hahn (Wisconsin), Tracy Mrachek (Wisconsin), Kevin Peterson (Minnesota), Don Nease (Colorado), Lisa Van Raemdonck (Colorado), and Susan Zahner (Wisconsin).

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