> **"Health disparities have grown even as medical capabilities have become more sophisticated."**
> *Brandt, et al. Am J Public Health. 2000; 90:707–715*

KEY PRIORITY
CLINICAL AND PUBLIC HEALTH

What is the problem?

Despite having multiple first class and highly ranked health care institutions and high quality public health organizations in our county, according to the 2015 County Health Rankings (University of Wisconsin Population Health Institute) Cuyahoga County ranks in the bottom third (65th) of all 88 counties in Ohio for residents' health outcomes. In addition, even though Cuyahoga County consistently ranks in the top 10 in the state for clinical care (measured by access to and quality of care), our residents are not getting healthier. This is because health is more than just health care. Health is the result of our surroundings, including the policies and systems responsible for creating those surroundings.

Our larger health system, is one of the groups that contributes to the health of our community. It includes both clinical care (health care institutions in our county) and local public health (three local health departments in our county).

Traditionally, clinical care institutions think about health and causes of death in terms of diseases and illnesses, as well as individual risk factors such as genetics and personal behavior (*see page 38, Figure 4, Top Causes of Death, MEDICINE*). These institutions also consider access to quality and affordable health care as one of the primary reasons for poor health outcomes and growing health disparities. Their solutions focus on providing quality and accessible health care, and often do not include addressing the underlying structural and policy issues that shape the opportunities our residents have to be healthy. In contrast, public health has begun to focus more on the social, environmental, economic, and structural causes of illness and death addressing what has been referred to as the "Actual, Actual Causes of Death"—those issues at the root of poor health outcomes and disparities (*see page 38, Figure 4, Top Causes of Death, NEW Public Health*).

KEY TERMS

ACCREDITATION: a process of review for health care organizations to show their ability to meet standards set by a professional accrediting agency. Accreditation is a way for organizations to demonstrate accountability to the individuals and communities they serve. Accreditation forms the foundation for policies and procedures.

CLINICAL CARE/ CLINICAL MEDICINE: High quality and coordinated health care provided by health professionals such as physicians, nurse practitioners, physician assistants, and clinical pharmacists.

COMMUNITY BENEFIT PLAN: A document usually created with the nonprofit health care organization's annual strategic plan that describes how an organization plans to fulfill both its mission of community service and its charitable, tax-exempt purpose. It includes a description of community benefit priorities, projects, staffing, resources, evaluation procedures and expected outcomes, and a description of community involvement.

COMMUNITY HEALTH ASSESSMENT: The ongoing process of regular and organized collection, analysis, and distribution of information on the health needs of the community. This information includes statistics on health status, community health needs, gaps, problems, and assets.

KEY TERMS

DISTRIBUTION OF HEALTH OUTCOMES: variation in health outcomes by gender or geographic area, or for different groups, such as socioeconomic, racial/ethnic, or age groups.

HEALTH CARE INSTITUTION: Every place, institution, building, or agency, whether for profit or nonprofit, which provides facilities with medical, nursing, screening, and other related health services.

INTERNAL REVENUE SERVICE (IRS): Federal governmental body that requires nonprofit health systems to complete a community health needs assessment and community benefit plan.

LARGER HEALTH SYSTEM: An organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations. This includes both clinical care (comprised of many health care systems in Cuyahoga County) and local public health (three local health departments in our county – Cuyahoga County Board of Health, Cleveland Department of Public Health, and Shaker Heights Health Department).

[Figure 4] Top Causes of Death in the U.S. in 2000

MEDICINE		TRADITIONAL PUBLIC HEALTH		NEW PUBLIC HEALTH	
Cause of Death	**Percent**	**Actual Cause of Death**	**Percent**	**Actual Actual Cause of Death**	**Percent**
Diseases of the Heart	29.6	Tobacco	18.1	Low Education	10.2
Malignant Neoplasms	23.0	Poor Diet and Physical Inactivity	16.6	Racial Segregation	7.3
Cerebrovascular Diseases	7.0	Alcohol Consumption	3.5	Low Social Support	6.7
Chronic Lower Respiratory Diseases	5.0	Microbial Agents	3.1	Individual Poverty	5.5
Accidents	4.0	Toxic Agents	2.3	Income Inequality	5.0
Diabetes Mellitus	2.9	Motor Vehicles	1.8	Area Level Poverty	1.6
Minino, et al, 2002 Natl Vital Stat Rep		*Mokdad, et al, 2004, JAMA*		*Galea, et al, 2011, AJPH*	

Historically, both nationally and locally, each part of the larger health system has worked separate from the other, and health professionals often suggest that "clinical care and public health were separated at birth." While our health care and public health organizations provide excellent programs and services in each of their own fields, strengthening the partnership between these two groups will have an even greater impact on the health of our community.

According to the Institute of Medicine, there is a critical need for improved collaboration between public health and clinical care as the institute describes in its landmark report published in 2012: *Primary Care and Public Health: Exploring Integration to Improve Population Health*. **Figure 5** *(see page 39)* shows the process of improved collaboration from working separately or in isolation, toward true partnership. Population health is a concept that both clinical care and public health organizations can use to work toward common community health goals.

[Figure 5] **Primary Care Integration**

Source: Institute of Medicine. Primary Care and Public Health: Exploring Integration to Improve Population Health, March 2012.

At the national level, there are a number of groups working toward better coordination between clinical care and public health. For example, both local public health departments and nonprofit hospital systems are required to conduct a community health assessment to meet accreditation and regulatory requirements. For local public health, this is known as the Community Health Status Assessment (CHSA). HIP-Cuyahoga completed a CHSA in 2013, as part of this Community Health Improvement Planning process (http://ccbh.info/hipcuyahoga/?page_id=1175). The Internal Revenue Service (IRS) requires nonprofit hospital systems to conduct a Community Health Needs Assessment (CHNA) that serves as the foundation for a community benefit plan and includes collaboration between clinical care and public health.

What are the solutions?

The clinical care and public health organizations in our larger health system must move from working in isolation to working in partnership in order to improve the health of our community. This will require a new way of thinking and a new approach by both clinical care and public health leaders and providers. This new thinking begins with the basic willingness to work together on shared goals, while continually showing mutual respect for each other in words and actions. A collaborative approach that builds on the strengths of both clinical care and public health offers new and exciting partnership opportunities that will lead to a healthier community.

Clinical care and public health share a common focus on improved population health and health equity, but each takes a different approach to addressing the populations they serve. Both groups must shift their approaches and funding processes to focus on prevention as the primary means of improving population health. Clinical care must join the current public health movement to broaden its focus from the treatment of illness and disease to include prevention efforts that address complex social issues like education, racial segregation, poverty and inequality—the "Actual, Actual Causes of Death" (*see Figure 4, page 38*). Clinical care leaders and providers must not only change how they value public health, but they also must commit to training and educating a new generation of health care providers who value population health, health equity, and collaboration with public health as a foundational component of their medical practices. Similarly, public health can learn from the experience of clinical medicine in the areas of evaluation and adoption of quality improvement principles.

KEY TERMS

LOCAL PUBLIC HEALTH DEPARTMENT: a government agency on the front lines of public health. The three public health departments in Northeast Ohio are the Cuyahoga County Board of Health, the Cleveland Department of Public Health and the Shaker Heights Health Department.

POPULATION HEALTH: The health outcomes of a group of individuals and the distribution of outcomes within the group.

POPULATION HEALTH OUTCOMES: the result of many factors that combine together to affect the health of individuals and communities, including clinical/medical care, public health, genetics, behaviors, social factors, and environmental factors. Population health is now a well-defined term that is an accepted and valid measure of outcomes for both health care and public health.

INSTITUTE OF MEDICINE: An independent, nonprofit organization that works outside of government to help those in government and the private sector make informed health decisions by providing evidence about important health-related issues across the country.

AN EXAMPLE

White Coats for Black Lives

Countless studies show that racism—experienced interpersonally through ill treatment, or structurally by whole families and neighborhoods—dramatically impacts the health of a community. Addressing health disparities sounds good on paper, but what does it mean in practice? Members of HIP-Cuyahoga's Clinical and Public Health subcommittee are not only learning from one another, but also from the caring medical students at Case Western Reserve University School of Medicine.

After medical students attended sessions about medicine, public health, and institutional racism in their required first course of medical school, these students used their voices to raise the level of discourse over a growing national movement reminding us all that Black Lives Matter.

The students held a "die in" outside the university's Biomedical Research Building to coincide with other protests around the country following the deaths of Michael Brown, Eric Garner and, here in Cleveland, Tamir Rice, at the hands of police.

"This is the community that we serve, and one of our own was affected...These are the people we're trying to protect," medical student Madhuri Nishtala told The Cleveland Plain Dealer, (http://www.cleveland.com/metro/index.ssf/2014/12/case_western_medical_students_1.html).

"The students are acting on what they are learning, and our community will be healthier for it," says Heidi Gullett, MD, MPH, who leads the course and serves as the anchor of the Clinical and Public Health subcommittee. "The School of Medicine's curriculum intentionally focuses on health equity, population health, and health impact assessments, so students get a more complete picture of the many factors that impact their patients' lives and ability to be healthy."

HIP-Cuyahoga members contributed to the course by giving lectures that used maps, data, and examples taken directly from Cuyahoga County. Lectures focused on topics like implicit bias and the health impacts of the redlining process in the county.

Dr. Gullett says she believes that student actions such as the "die-in" illustrate how medical students are expanding their role in the community and opting to take a stand. "It showcases that it's not just about their role as direct health care providers, but that understanding the larger context is critical when working with patients and communities," she adds.

School of Medicine professors, like Dr. Gullett, support students as they take risks to ensure the infusion of HIP-Cuyahoga's core values in their work, in the county's health centers, and neighborhoods. "Our unique emphasis on public health, patient advocacy, and eliminating institutionalized racism and structural inequality from the medical field have inspired and empowered many of us to be agents of change," says medical student Vanessa Van Doren.

"After they graduate, these young health professionals not only will treat patients, but they will also understand the importance of linking medicine and public health, so we can heal our entire community and ensure everyone can enjoy healthy lives and safe communities," says Dr. Gullett. "We can't afford not to train the next generation of health professionals this way. The vast majority of things that cause our patients to be sick cannot be treated in the exam room. We have to train our students to understand and address the true drivers of illness and disease."

In response to Cuyahoga County's segmented health system, as well as the growing health disparities and inequities, the Clinical Care and Public Health subcommittee developed an action plan focused on policy change and a demonstration of partnership. In general, these efforts include:

» County level policy change that would combine our local Community Health Status Assessment process, led by our local public health organizations, with the Community Health Needs Assessment process, led by our local hospital systems. The coordination of these two assessments builds on the strengths of both groups by allowing for data collection that better represents the needs of everyone in our county. It also will help identify opportunities where clinical care and public health can partner to address important health issues for a much greater community impact.

» Practical demonstration of partnership between clinical care (a hospital system), public health (local public health departments), a community nonprofit organization, and a Medicaid managed care company (insurer), focused on improving health outcomes related to pediatric asthma. Asthma is a major health issue in our county affecting about 48,500 children. African-American children are the most likely to have asthma. Furthermore, this chronic disease is highly influenced by environmental breathing triggers that can be controlled. Public health and community organizations have reduced these environmental causes effectively in many cases. But when integrated as part of a medical plan of care for affected children, it will lead to marked improvements in their health outcomes and financial savings to the families and health care system.

Why does it matter?

Sustainable changes in population health and reductions in inequities in our community cannot and will not be realized without improved cooperation and collaboration between public health and clinical care organizations on policy development and health outcomes. The health and economic vitality of our community and our residents is at stake. Now is the time to act on the many opportunities that clinical care and public health have to work together because everyone in our county should have the opportunity to reach his or her fullest health potential.

Summary of Goals and Intended Outcomes

SHORT-TERM (1-2 YEARS)

» Northeast Ohio hospitals will include HIP-Cuyahoga representatives in planning their next CHNA.
» Local hospital leadership will participate in HIP-Cuyahoga.
» We will create and implement a demonstration project on pediatric asthma with a defined Medicaid population.
» Ohio Medicaid leadership will be engaged in discussing the cost effectiveness of financially reimbursing clinical care and public health partnership efforts around improved asthma outcomes. We will secure external funding to support and sustain our subcommittee's work.

MID-TERM (3-5 YEARS)

» We will create a clear plan to coordinate the next CHSA and CHNA in Cuyahoga County.
» We will work collaboratively on the next CHSA and CHNA during every stage of the process—from planning through implementation and development of community benefit plans.
» Ohio Medicaid consistently will fund public health efforts around asthma home interventions and consider funding for other collaborative initiatives that address other chronic conditions.

LONG-TERM (5+ YEARS)

» Health equity will serve as a foundation for the work of both public health and clinical care organizations.
» Collaboration between local public health and clinical care organizations will be a standard business practice.
» State-level policies will reflect the importance of collaboration for CHSA and CHNA. We will secure funding to support clinical care and public health working together to write community benefit and community health improvement plans.
» The health and quality of life of our community will improve.

Subcommittee Structure

The anchor organization and individuals responsible for this subcommittee are:

Environmental Health Watch (EHW)
Kim Foreman, Interim Executive Director

EHW is a healthy homes movement pioneer. It has worked locally for 35 years to address environmental health with hospital and health department partners through nationally recognized research and direct service. EHW has built a strong grassroots network of residents and community stakeholders genuinely engaged in environmental health. HIP-Cuyahoga selected EHW as an anchor organization based on its vast experience in the Healthy Homes program that has demonstrated a true collaborative approach to improving asthma outcomes following home remediation.

Case Western Reserve University School of Medicine
Heidi Gullett, MD, MPH
Assistant Professor, Case Western Reserve University School of Medicine,
Department of Family Medicine and Community Health
Population Health Liaison, Cuyahoga County Board of Health
Co-chair, HIP-Cuyahoga Consortium

The School of Medicine serves as the second anchor organization based on its partnership with the Cuyahoga County Board of Health which created the population health liaison position. This position, currently held by Heidi Gullett, MD, MPH, provides dedicated time toward further developing the partnership and shared initiatives between the two organizations. The School of Medicine's most recent strategic plan makes community health a priority, further strengthening this formal partnership.

For more information on this subcommittee or to get involved, please contact:
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