



Research Insights

■ Public Health's Role in a Post-ACA World

Summary

The Patient Protection and Affordable Care Act (ACA) contains several provisions which may alter the scope and practice of public health. As a result, governmental public health departments must evolve in order to accommodate the new health landscape and changing demands on the system.¹ Three governmental public health departments—Massachusetts, San Diego, Vermont—are taking unique approaches to this opportunity for public health to innovate in the wake of health systems change.

Introduction

The ACA was signed into law in 2010 with the goal of improving the quality and affordability of health insurance as well as increasing access to primary care and preventive services. The ACA addresses population health in four ways:²

1. Expands insurance coverage (e.g., individual mandate, Medicaid expansions, coverage up to age 26);
2. Improves quality of care (e.g., National Strategy for Quality Improvement);
3. Enhances prevention and promotion measures (e.g., expansion of primary health care training);
4. Promotes community- and population-based activities (e.g., Prevention and Public Health Fund).

Perhaps the most well-known aspect of the ACA is its influence on insurance coverage. The inaugural open enrollment period—the period in which eligible individuals can enroll in a Qualified Health Plan in the Marketplace³—closed March 31, 2014. Most estimates indicate that, to date, more than 8 million people have gained coverage, and the upcoming 2015 enrollment period is expected to secure even more coverage.^{4,5} The law also provides states with additional federal funding to expand their Medicaid programs, in which individuals can enroll at any time given that they meet the requirements.⁶

Despite these increases in health insurance coverage, access issues still remain. Furthermore, it is unclear how coverage expansion will affect changes in the delivery of public health services. Title IV of the ACA, “Prevention of Chronic Disease and Improving Public Health,” outlined new funding mechanisms for public health and established standards for prevention activities.⁷ One such funding mechanism, the Prevention and Public Health Fund, herein referred to as “the Fund,” was established to provide incentives for providers to invest in public health and prevention. The establishment of the Fund is considered one of the most substantial efforts in recent years to fund public health infrastructure. Specifically, the Fund supports scientific prevention programs and allows public health departments to address workforce and sustainability issues, e.g., public health training centers. In addition, in 2013, the Fund allocated millions to federal agencies, as depicted in the table below. The table includes the expected amounts, per the 2014 fiscal year budget.

Genesis of this brief: AcademyHealth's Annual Research Meeting 2014

As part of its efforts to support evidence-based public health and share policy innovations, the Robert Wood Johnson Foundation sponsored an invited panel at the 2014 AcademyHealth Annual Research Meeting to explore how governmental public health may change following implementation of the Patient Protection and Affordable Care Act (ACA). The panel, “Public Health's Role in a Post-ACA World,” featured presentations from Thomas Land, Ph.D., Office of Health Information Policy and Informatics at the Massachusetts Department of Public Health; Wilma Wooten, M.D., M.P.H., County of San Diego Health and Human Services Agency; and Jenney Samuelson, Blueprint for Health, Department of Vermont Health Access. Alefiyah Mesiwala, M.D., M.P.H., Center for Medicare and Medicaid Innovation, moderated the panel. This brief summarizes that discussion.

**Prevention and Public Health Fund
Spending by Agency**
(dollars in millions)

	FY 2013 Final Allocation	FY 2014 Requested Allocation
AHRQ	6.465	7.000
CDC	462.916	831.00
CMS	453.803	0.000
HRSA	1.847	0.000
SAMHSA	14.733	62.000
ACL	9.236	27.700
Subtotal, all GDM	0.000	0.000
Sequestered funds	51.000	72.000
Total, all activities	1,000.000	1,000.000

Final funding amounts for 2015 are not yet known.

Modified from Trust for America's Health. *Prevention and Public Health Fund*. [Internet]. 2014 [updated 2014 Jan 22; cited 2014 Sept 1]. Available from: <http://healthyamericans.org/health-issues/wp-content/uploads/2014/01/PPH-2010-2014-1-22-14.pdf>

These provisions—and the law itself—have the potential to shift the health care system into one that supports health and wellness as well as treats the sick. For example, in 2014, the Centers for Disease Control and Prevention (CDC) was allocated \$146 million in Community Transformation Grants, with the purpose of funding community-level prevention programs.⁸ More recently, on September 25, 2014, the CDC announced an additional \$211 million for 193 awards for states, large and small cities and counties, tribes and tribal organizations, and national and community organizations to focus on populations hardest hit by chronic diseases.⁹

Despite this significant investment, the Fund is not without controversy. Initial federal legislation proposed that the Fund would receive upwards of \$15 billion in investment—\$2 billion per year. Yet, the government has continued to slash allocations for the Fund due to a rising national budget deficit, the enactment of sequestration, reallocation of funds to support the federal health insurance exchange and Medicare's "doc fix," and ultimately, a criticism of the Fund as waste.¹⁰

Public health, historically, has been "a regulator (i.e., emergency preparedness, disease outbreak), 'gap-filler,' and, especially in southern states, a provider;"¹¹ many governmental public health departments have traditionally either provided services to the underserved or contracted with private organizations to do so, allowing them to fill gaps where services were previously underprovided.¹² However, with coverage expansion, fewer patients will likely rely on governmental public health departments for subsidized clinical services.¹³ The most recent Association of State and Territorial Health Officials (ASTHO) profile (2014) further illustrated this movement—"While

provision of STD counseling and partner notification increased from 2010 (79 percent) to 2012 (85 percent), the percentage of state health agencies directly performing all other services remained the same or decreased from 2010 to 2012, with the overall trend decreasing."¹⁴ Beyond the ASTHO profile, early findings from the field of Public Health Services and Systems Research (PHSSR) support this trend and suggest that, as a result, agencies are looking to either develop revenue streams by billing for those services, or are turning away from the provision of health care altogether.^{15,16,17}

As the provision of clinical services largely transitions out of public health's domain,¹⁸ there remains a crucial leadership role for governmental agencies—that of chief health strategists. The Public Health Leadership Forum, in partnership with RESOLVE, released a report, "The High Achieving Governmental Health Department in 2020 as the Community Chief Health Strategist" in order to provide direction in the face of this ensuing change. The forward-thinking document is a call to action to the public health community; it boldly cautions, "Unless [public health] recognize[s] the new circumstances and adapt[s] accordingly, public health will not just be ineffective, it runs the risk of becoming obsolete."

The Forum calls for public health leaders to leverage their knowledge of population health and prevention in order to link clinical care providers with individuals, to provide prevention guidance and expertise, and, in some cases, to continue their safety-net activities, e.g., HIV services.¹⁹ The report suggests six key practices for high-achieving public health departments (*see text box, Key Practices of the Chief Health Strategists of the Future*).

This brief examines three innovative approaches to public health transformation and recognizes challenges that still remain.

**Key Practices of the
Chief Health Strategists of the Future**

1. Adopt and adapt strategies to combat the evolving leading causes of illness, injury, and premature death.
2. Develop strategies for promoting health and well-being that work most effectively for communities of today and tomorrow.
3. Chief health strategists will identify, analyze and distribute information from new, big, and real time data sources.
4. Build a more integrated, effective health system through collaboration between clinical care and public health.
5. Collaborate with a broad array of allies- including those at the neighborhood-level and the non-health sectors-to build healthier and more vital communities.
6. Replace outdated organization practices with state-of-the-art business, accountability, and financing systems.

Source: Public Health Leadership Forum. *The high achieving governmental health department in 2020 as the community chief health strategist*. Washington, DC: RESOLVE Inc.; 2014.

Case Study: Linking Clinical and Community: The Massachusetts Prevention and Wellness Trust

Massachusetts' health reform was first passed in 2006 and then revisited in 2012,²⁰ when the legislation created the Prevention and Wellness Trust as a mechanism for controlling health care costs. Chapter 224 of Massachusetts' health cost containment bill established a \$60 million trust for the Department of Public Health to provide grants to local communities to address the costliest and most preventable health conditions and associated risk factors.²¹

Recipients of funding were required to support clinical and community-based interventions and deliver a positive return-on-investment (ROI) in a 3.5 year period. Herein lies a great challenge for those implementing the Trust: public health benefits are generally dispersed or delayed, and because they occur at the population level versus within individuals, measuring ROI for public health investments is methodologically complex.²² Definitional issues around value further complicate the evaluation of public health interventions;²³ however, the statute stipulates that additional Trust funding is dependent on this evaluation.

The statute established that grantees had to successfully do one or more of the following: reduce rates of preventable health conditions, increase healthy behaviors through evidence-based interventions, increase adoption of workplace-based wellness programs, address health disparities and further develop the evidence base through research, evaluation and continuous quality improvement. The Department partnered with the Statutory Advisory Board, schools of public health, the CDC, and Social Impact Bonds, to determine which interventions have the potential for the most effective implementation, largest clinical impact, greatest ROI and greatest sustainability. They contract with outside evaluators to assist grantees with demonstrating ROI and also provide consultation on opportunities for additional investment by outside sources.

The Trust sought to make outcomes data available to all grantees simultaneously. The statute requires that all grantees use a bi-directional e-referral program funded by the Center for Medicare and Medicaid Innovation (CMMI). The requirement of e-referrals allows for the provision of quantitative data and therefore a strong foundation for program comparison. This critical linkage serves as a measurement tool as well as a quality improvement monitor. Through electronic links, grantees can define referral elements, export data and reports, and also foster continuous quality improvement. This innovative requirement has served to join the disconnected municipalities in Massachusetts, all of which have separate boards of health, resource pools, and populations.

The Department of Health awarded nine grants—collaborative initiatives consisting of municipalities, health plans, clinicians, and community-based organizations, all working towards ameliorating the most

Funding Allocation for Prevention and Wellness Trust

- \$57 million in trust for 4 years;
- No requirement for spending equal amounts annually;
- At least 75% must be spent on grantee awards;
- No more than 10% on worksite wellness programs;
- No more than 15% on administration through Massachusetts Department of Public Health.

Source: Land, T. "Linking Clinical and Community: The Massachusetts Prevention and Wellness Trust." Presentation at the AcademyHealth Annual Research Meeting. San Diego, CA, June 9, 2014.

pressing chronic diseases. As solutions are sought for better integrating public health and health care during this time of health system transformation, lessons are sure to arise from the Massachusetts Department of Public Health's experience with the Trust.

Case Study: Accountable Care Community: Live Well San Diego

The Health and Human Services Agency of San Diego County is one of five business groups of the county government. The Agency provides a broad range of health and social services, promoting wellness, self-sufficiency, and a better quality of life for all individuals and families in San Diego County. The Agency integrates health and social services through a unified service-delivery system;²⁴ it does not conduct primary care. The elimination of primary care service competition has allowed the Agency to take a holistic approach to population health.

The *Live Well San Diego* (LWSD) initiative uses a "10-5-1" model to achieve an "accountable care community." The model uses 10 measures in five areas of influence to support their one vision of overall health.

The 10 measures are depicted in the chart. The five areas of influence include health, knowledge, standard of living, community, and social wellbeing. An exemplary program under the LWSD umbrella is the Community-based Care Transitions Program (CCTP), a CMMI-funded initiative which blends inpatient health care and social service care.²⁵ The goal of CCTP was to improve transitions of 21,340 Medicare fee-for-service patients from inpatient hospital settings to home/care settings. Utilizing the LWSD framework, CCTP sought to improve the quality of care and reduce readmission for high-risk beneficiaries. The initial goal was to reduce readmission by 20 percent in two years. It was imperative that measurable savings to the Medicare program were documented. CCTP consisted of several partnerships among four health care systems in 13 hospitals in San Diego. As of December 31, 2013, CCTP had served 8,506 patients. Readmissions were reduced from 18.6 percent to 8.5 percent that year, on track with their goal.²⁶ The comprehensive coordination among sectors, led by the County Health and Human Services Agency was instrumental in reducing readmission.

Top 10 Live Well San Diego Indicators

- Life expectancy
- Quality of life
- Education
- Unemployment rate
- Income
- Security
- Physical environment
- Built environment
- Vulnerable populations
- Community involvement

Source: Wooten, W. "Accountable Care Community: Advancing Population Health through Live Well San Diego." Presentation at the AcademyHealth Annual Research Meeting, San Diego, CA, June 9, 2014.

Underpinning the model are four strategies: building better service delivery systems, supporting positive and healthy choices, pursuing policy and environmental changes, and improving the culture within the county government. These strategies support three overall components or pillars of the initiative – building better health, living safely, and thriving. All LWSD programs operate under one of these three pillars. As San Diego strives to achieve a solid, comprehensive approach to improving population health, the three pillars of LWSD may provide examples for other health agencies in this post-ACA era.

Case Study: Vermont Blueprint for Health: Community System of Health

Blueprint for Health (Blueprint) is Vermont's state-led initiative to reform health care delivery and affordability. Blueprint was established in 2006 in Act 191 of Vermont's Health Care Affordability Act. Its overall goal is to ensure that all Vermont citizens have access to, and coverage for, high-quality, holistic health care. Blueprint utilizes a highly coordinated approach, including partnerships with providers, the health department, and community health workers, in order to build an integrated health care system. The program began as a multi-stakeholder working group focused on chronic disease. Utilizing the Chronic Care Model,²⁷ the group's initial framework evolved into the current program, a model of comprehensive health delivery.

The model incorporates advanced primary care in the form of Patient-Centered Medical Homes (PCMH) and multi-disciplinary support services in the form of Community Health Teams (CHT). Also integral to the framework is a network of self-management support programs, statewide data systems, multi-insurer payment reform, health information infrastructure, evaluating and reporting systems and learning health system activities. All major insurers in Vermont participate in payment reforms designed to support the PCMH and CHT operations.

Furthermore, the model centers on the incorporation of a leadership network. The program boasts a leader in every aspect of care. Leaders of respective program areas share best practices, collaboratively determine next steps, and discuss allocation of resources. This degree of communication and collaboration has allowed Blueprint to work efficiently across geographic regions and specialties.

Blueprint is a population-focused program, with a mission to provide preventive care across all practices. Blueprint has established new connections and redesigned service delivery. Specifically, it provides services not covered by traditional health plans and largely focuses on prevention e.g. obesity prevention programs. Additionally, Blueprint has shifted attention to social determinants of health (i.e. safe housing, education, employment, access to health care etc.) and works to alleviate disparities by incorporating social services such as housing, food and transportation into its model. The public health department is an integral partner in designing and deploying these programs.

Blueprint's most recent annual report²⁸ (2013) has illustrated tremendous cost savings for the state—an overall investment of \$5 million resulted in an \$81 million saving. Data show that PCMH and CHT patients had improved healthcare patterns and reduced medical expenditures per capita. They were also better connected to non-medical support services.

The Vermont Public Health department has been integral in the oversight of these services. Their expertise has positioned them to connect various stakeholders and strengthen the Blueprint overall.

Conclusion

According to a recent Urban Institute report, the ACA and consequent Medicaid expansion will likely decrease the number of uninsured by 57 percent.²⁹ Yet, gaps in coverage will still remain as the law moves forward and enrollment periods continue. Specifically, states that choose not to expand Medicaid will not see as large of a coverage gain. Additionally, and regardless of Medicaid expansion, undocumented immigrants will remain one of the largest uninsured groups.³⁰ Per tradition, especially in the near term, it is expected that public health will continue to serve as a safety-net provider for these underserved individuals.³¹

In addition to this ACA-driven shift of clinical preventive services (from the public health to the health care system), other conditions also call for governmental public health department transformation. These include changing population health needs (e.g., increased prevalence of chronic disease), changing demographics (e.g., aging population), and the information and data revolution.³²

Innovations in system transformation are happening in Massachusetts, San Diego, and Vermont, where governmental public health is acting as a critical partner in prevention and care delivery. The Massachusetts Department of Public Health offers a new funding mechanism to support well-planned and cost-effective community-level intervention programs. These programs are reducing the incidence of chronic disease and providing a critical link between the community and clinic.

San Diego's approach to health is multi-sectoral; the scale of the program and ability to connect individuals to several resources across multiple sectors showcases the potential for governmental public health to create wholly healthy communities through public and private partnerships.

Vermont's Blueprint program is another example of the ability of governmental public health to act as an instrumental partner and developer of community wellness initiatives. The intentional inclusion of leadership teams and community health workers woven into standard health care delivery is helping the state prioritize prevention of, rather than treatment for, disease and disability.

As the provision of preventive services shifts from the public health to health care sector, governmental public health departments have an opportunity to take on a new role. At this turning point, some public health departments have shown willingness to critically assess this opportunity, and evolve in the face of change. These case studies demonstrate that public health departments can indeed be agents of change—that leadership, partnership, and innovation are occurring in states and communities, and that public health's participation is crucial to the advancement of a culture of health in America.

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Endnotes

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Public Health's Role in a Post-ACA World

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