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Leading Through Health System Change: A Public Health Opportunity

Georgia Health Policy Center

National network of public health institute

Leading through Health System Change:

A Public Health Opportunity

Planning Tool

Georgia Health Policy Center at Georgia State University
National Network of Public Health Institutes

Georgia Health Policy Center

The Georgia Health Policy Center (GHPC), housed within Georgia State University's Andrew Young School of Policy Studies, provides evidence-based research, program development, and policy guidance. We work locally, statewide, and nationally to improve health status at the community level. The GHPC focuses on solutions to complex issues facing health care today including insurance coverage, long-term care, health care reform, children's health, and the development of rural and urban health systems. Today the center is at work throughout Georgia and in more than 200 communities across the nation, helping communities achieve health improvement. Please visit www.gsu.edu/ghpc to learn more.

National Network of Public Health Institutes (NNPHI)

Created in 2001 as a forum for public health institutes (PHIs), today NNPHI convenes its members and partners at the local, state, and national levels in efforts to address critical health issues. NNPHI's mission is to support national public health system initiatives and strengthen PHIs to promote multi-sector activities resulting in measurable improvements of public health structures, systems, and outcomes. Learn more about NNPHI and its member institutes at www.nnphi.org.

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- Health Reform 101
- Looking at Health Reform through an Adaptive Lens
- Putting Adaptive Thinking into Action

Select **one of the three** questions and complete the guided practice:

Guided Practice 1

- Define Your Question: What role will public health play in the **provision of clinical services?**
- Collect Information
- Select an Option
- Apply Adaptive Actions
- Create a Simplified Implementation Plan

Guided Practice 2

- Define Your Question: What role will public health play in the surveillance and monitoring of health status?
- Collect Information
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Guided Practice 3

- Define Your Question: What role will public health play in **community health planning?**
- Collect Information
- Select an Option
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- Create a Simplified Implementation Plan

Print Plan and Begin Implementation

Repeat with another Guided Practice Question, or use the 5-step process with your own question

Introduction

The changes inherent in the Affordable Care Act (health reform) have extensive implications for all aspects of the U.S. health system: financing, service delivery, public health, coverage and access, quality, and ultimately, well-being. During this critical period of health system transformation, public health has the opportunity to address both technical and adaptive challenges, think systemically, and begin to lay the groundwork for strategic action and innovation.

This tool has been designed for public health practitioners at all levels to practice using adaptive thinking as they grapple with the many questions presented by health reform and health system transformation.

Using this Planning Tool

The changes facing your organization are complex and therefore, so are future options. At the core of this project is an interactive tutorial and planning tool designed to assist you, public health leaders, in learning how to apply adaptive thinking skills to the legal, administrative, and financial health reform challenges facing your organization. Through the information and exercises provided by experts from the Centers for Disease Control and Prevention, the Georgia Health Policy Center at Georgia State University, and the National Network of Public Health Institutes, you will learn valuable techniques to plan for the future of public health.

Time Needed:
4 to 8 hours of time over a period of a week or two, to complete one guided practice.

The process will likely require four to eight hours of time over a period of a week or two to complete a guided practice. Any method you prefer to complete these steps is allowed. You may work as an individual participant or as part of a team within an organization. Additionally, feel free to bring in whatever data you will need to help you respond to the questions.

This is a planning tool intended to heighten your learning capacity and leadership skills in relation to health reform and health system transformation. Central to this tool are two key components. The first component is a five-step planning process. The steps in this process are key to helping your team focus on the actions that lead to innovation and strategic thinking. The second key component is understanding technical and adaptive challenges. Technical challenges, while not "simple" are solvable. Through research and practice, effective approaches have been designed and adopted even if they require intense skill and expertise, such as architectural design. Adaptive challenges, on the other hand, are quite different. They are often being seen for the first time. There is no expert, no one with "the answer." Solutions require both experimentation and innovation, as in the case of managing rainforest ecosystems. Learning to use the five-step planning process and an adaptive problem-solving approach are, we believe, the key to responding to this opportunity for change.

The tutorial and planning tool you are about to use is designed using a guided-practice approach. Rather than just provide the tool and instructions, you will be guided through examples where much of the background work has been provided for you. But, your team will still have to do the analysis and strategic thinking to arrive at a solution. The goal of this approach is to make the planning tool more real-world and contextual.

Once you have fully completed one of the guided practices in the tutorial and planning tool, you can repeat the exercise with another of the provided guided practices, then take the process and apply it to your own strategic planning efforts.

Key Components:

- **Five Step Planning Process:** The steps in this process are key to helping your team focus on the actions that lead to innovation and strategic thinking.
- **Technical vs. Adaptive Challenges: Technical challenges, while not "simple" are solvable. Adaptive challenges are quite different. There is no expert, no one with "the answer."**

As you progress through the planning tool, you will document your information related to each step of the process. This opportunity will be identified with a **Your Turn** button.

At the end of each question, you will be able to print out a report that includes the question you worked on, background information related to your question, the answer you chose to address your question, the adaptive actions you used in answering your question, and an implementation plan for action. The planning tool will probably have the most benefit if you work through it with a small group of individuals who would most likely be working with you on the question in the real world.

You can complete each question all at once or break them down into more easily digestible parts depending on how much time you have available. You may also want to take a break to gather data or information that will help make answering a question more meaningful to you or your organization. As you consider each question, think about your planning in a three to five year time horizon. Remember, this planning tool is designed to help you, as a public health leader, be more effective in addressing public health questions in the context of health care reform. The commitment you bring to the work will be reflected in what you get out of it in the end.

If you are using the electronic version of this tutorial and planning tool in PDF format, two interactive functions are built into the tool:

- Live URL links - When cited resources are available online, the resource will have a light blue underline under the text indicating that you can click your cursor on the area and your Internet browser will be directed to the website where the resource resides. Your Internet browser setting may prevent this function from working correctly; you may need to check your browser settings. URLs can change without notice; if the embedded link does not work, the URL address may have changed. Use your search engine (e.g., Google, Bing, Yahoo) to find the new web address.
- Interactive forms - In the **Your Turn** sections of this planning tool, you can type your responses directly into the blank cells of the PDF. Click your cursor at any point in the blank cell. The cursor will appear in the top left corner of the cell. You will need to save the PDF file to your computer to save the text that you enter in these cells. It is recommended that you save your file with a unique file name to protect against accidentally saving the blank form over your information. Like all documents, it is recommended that you save your work frequently. You are able to share this file with others via email or file sharing tools.

The citations in the planning tool refer to items in the bibliography, located at the end of the planning tool. The URLs listed in the bibliography are also hyperlinked, although no blue underline appears under this text. The online version of this planning tool may be accessed at http://www.metacat.net/metacat/app/ghpc.

Through this project, we hope to provide you with a new conceptual framework for leading, as well as, navigating and leveraging multiple aspects of the health reform law to improve population health.

Health Reform 101

In order to plan for the future of public health, a common understanding about the key provisions of the Affordable Care Act (ACA) is needed. The ACA was signed into law in the spring of 2010. One of the goals of the ACA is to decrease the number of uninsured Americans. The Georgia Health Policy Center developed a framework to educate others about the ACA. It includes: sources of health care coverage, funding and spending, the major components of change, and a timeline.

Sources of Coverage

Non-elderly Americans obtain health insurance through their employer, individual private insurance, Medicaid/Children's Health Insurance Program, Other [Medicare (disabled or end-stage renal patients), Champus, CHAMPVA (coverage for armed forces and veterans families) and Indian Health Services], or remain uninsured. The expansion of both public and private coverage through the ACA is expected to insure approximately 14 million more Americans in 2014 and up to 29 million Americans by 2022.[9] Major changes will occur with the addition of health insurance exchanges and the potential expansion of Medicaid, which is now a state decision as determined by the Supreme Court in June 2012.

By 2019, it is estimated that the percentage of uninsured Americans will decrease from 18% to 10%. Approximately 56% will be covered by employer-based insurance, 2% will be covered by private insurance, 9% will be covered through health insurance exchanges, and 19% will be covered by Medicaid, depending on individual state decisions.[62]

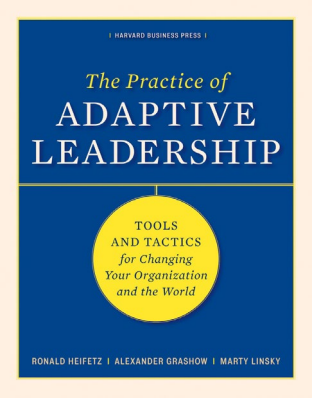
Spending and Sources of Revenue

The Congressional Budget Office estimates that spending related to the ACA will be approximately $1.6 trillion over a decade.[9] The largest share of the costs will fund the expansion of Medicaid coverage and fund the subsidies to individuals in the health insurance exchanges. In order to remain deficit neutral, new revenues must be generated. Revenue sources include savings in Medicare (e.g., reductions to annual updates in payments and changes in the calculations for Medicare Advantage plans) and new taxes, fees, and penalties (e.g., fees for medical devices and insurers, fines/penalty payments from businesses and individuals). It is hoped that, through new models of care delivery such as Accountable Care Organizations (ACOs) and efficiencies created by vehicles such as electronic health information exchanges (e.g., through reduced duplication of services), the overall health care cost curve will begin to bend downward from its current, upward trend.

Changes in public coverage	Eligibility for Medicaid programs will be expanded to include all Americans up to 133% of the Federal Poverty Level (FPL) in states that choose to expand Medicaid coverage. The June 28, 2012 Supreme Court decision indicated that states, without penalty, could choose not to expand Medicaid. The expansion will potentially increase the number eligible for Medicaid by approximately 16 million Americans, with the largest increase being childless adults not currently eligible. The full cost of this expansion will be paid by the federal government beginning in 2014, with a phase-in of state share starting in 2017 (up to 10% of expansion costs). The federal government retains 90% of new and ongoing expansion costs beginning in 2020. The Congressional Budget Office estimates that the law will result in approximately 1.6 trillion dollars in new federal spending over the ten years to fund subsidies of private insurance and to pay for the expansion of Medicaid.
Changes in private coverage	Modifications in current insurance regulation practices include: community rating rather than risk-adjusted premiums; no pre-existing condition exclusions; no lifetime and very limited annual benefits caps; prior approval of rate increases; and a mandatory minimum medical loss ratio of 80 or 85% (by group size). The legislation also creates a high-risk pool as a bridge to provide a way to obtain coverage until other insurance market reforms are fully implemented. In addition, it mandates the creation of health insurance exchanges, with the structure either determined by each state alone, states in partnership with the federal government, or the federal government alone, depending on what states decide to do or their readiness to act. The exchanges will establish common rules for benefits and pricing; offer consumers a choice of plans; provide consumers information about their choices; facilitate plan enrollment; and administer the subsidies for people who earn less than 400% of the FPL.
Changes in health care quality	A variety of strategies address the need for improved quality of care: incorporating best practices and systemically collecting and analyzing health care data; streamlining and coordinating care, as well as encouraging interdisciplinary treatments; instituting a series of quality-driven incentives and penalties for providers; and funding to study and implement evidence-based practices related to the financing and delivery of Medicare. Many of these strategies focus on decreasing the overall cost of health care.
Increased focus on prevention and wellness	Efforts to improve population health and well-being will be coordinated by a national council, guided by the first-ever national prevention strategy and sustained by a dedicated prevention fund. Improvements to individual health will be supported by research and innovation and implemented through insurance coverage requirements and state and community programs. Wellness and prevention services and research will be expanded to focus on physical activity, nutrition, emotional wellness, smoking cessation, and other chronic disease priorities. Medicare and newly qualified plans will be required to provide a range of recommended preventive and wellness services in their qualified health plans, and employers will be permitted to incentivize employee participation in wellness programs. State and local agencies will be given opportunities to apply for federal funds to implement programs to create healthier communities.

Timeline

For a fully-interactive timeline with key provisions of the health reform law organized by year and searchable by topic, visit the Kaiser Family Foundation website at http://healthreform.kff.org/Timeline.aspx.



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Looking at Health Reform through an Adaptive Lens

Health reform presents many opportunities for public health, but to take full advantage of these opportunities, state, local, and community leaders must be able to navigate through uncharted territory and be willing to deviate from their plans as learning takes place.

Marty Linsky and Ronald Heifetz, leaders in the field of management consulting, write extensively about the differences between technical and adaptive challenges. While their teachings have not previously been used in the context of health reform, this planning tool employs Linsky and Heifetz' theory on adaptive leadership to provide a framework of the role public health officials must take in this environment. According to Linsky and Heifetz, technical challenges, while not simple are solvable. Through research and practice, effective approaches have been designed and adopted even if they require intense skill and expertise (such as brain surgery). Adaptive challenges, on the other hand, are quite different. They are often being seen for the first time. There is no expert, no one with "the answer." Solutions require both experimentation and innovation. This table has examples of technical and adaptive challenges.

Technical Challenges	Adaptive Challenges
• Easily defined • Obvious proven solution • Expert to call to solve the problem • Can be resolved through Standard Operating Procedures (SOPs)	• Hard to define • No clear solution • No expert who can solve the problem • Perhaps new, never seen before
Examples	**Examples**
• Building a hospital • Fixing a broken computer • Implementing health reform	• Eliminating poverty • Reforming public education • Implementing health reform

Adapted from Ronald A. Heifetz and Marty Linsky, *A Survival Guide for Leaders*

Health reform presents both types of challenges for public health leaders. Some are routine and technical, while others are adaptive and require planning, building partnerships, gathering information, and building capacity. According to Linsky and Heifetz in *When Leadership Spells Danger,* "a challenge for adaptive leadership is to engage people in distinguishing what is essential to preserve from their organization's heritage from what is expendable. Successful adaptations are thus both conservative and progressive. They make the best possible use of previous wisdom and know-how. The most effective leadership anchors change in the values, competencies, and strategic orientations that should endure in the organization."[22] Public health leadership requires a diagnostic capacity that identifies the forces at play that constantly shape health reform. These include legal, administrative, and financial, among others.

In the next section, you will begin to put adaptive thinking into action.

Putting Adaptive Thinking into Action

In this section of the workbook, you will practice using adaptive thinking to answer questions related to health reform by working through three example questions. These examples were drawn from the peer-reviewed literature, national white papers, and expert review. The three questions are:

1. What role will public health play in the provision of clinical services?

2. What role will public health play in the surveillance and monitoring of health status?

3. What role will public health play in community health planning?

After working through one example question, you should be able to apply a series of steps to any question you may have that does not have a ready-made solution. The steps in the process are:

Step 1: Define your question. What is it that you want to know? Is the question unique to your organization or do you think it might apply to others?

Step 2: Collect information about your question related to the Affordable Care Act. What exactly is written in the law? You may have to go directly to the law or read what others have said related to the law and your question. Are there new approaches or ways of thinking about your question being practiced in other states? Chances are you will be able to learn something about your question from others. Gathering information from the law is one place to start. You may want to collect additional state and local information.

Step 3: Think about the feasible options and select one to begin your analysis. When you think about your question, what are the possible ways you could answer the question?

Step 4: Apply adaptive actions related to your question. The planning tool describes eight adaptive actions you can apply to the answer option you choose. Some might be very relevant to your work and others may not.

Step 5: Create a simplified implementation plan. This step will help you think about a concrete way to move forward related to staffing, budgeting and funding, and developing a management plan in the context of how you choose to answer your question.

Guided Practice 1

Step 1: Define Your Question

What role will public health play in the provision of clinical services?

Step 2: Collect information about your question related to the Affordable Care Act

Overview

In addition to covering up to 14 million more Americans by 2014 (up to 29 million Americans by 2022) and mandating the coverage of certain benefits, the ACA is anticipated to improve access to existing services and usual sources of care.[9] However, challenges will remain even after the ACA is fully implemented. Access barriers to both coverage and care may still exist for certain groups, and the supply of primary care providers may not be sufficient to ensure timely access to care for all. Consequently, there is likely to still be a role for robust public health services beyond the ACA's full implementation in 2014, including safety net services, high-value public health services (e.g., direct observed therapy for TB, HIV screening/partner notification, immunizations), enhanced public health services (e.g., patient navigators), and linked public health services (e.g., Diabetes Prevention Program, tobacco cessation).

Minimum Coverage

The ACA also extends coverage to new services. A package of essential health benefits will be required of any new plan offered.

The required minimum coverage includes:

- ambulatory care,
- emergency services,
- hospitalization,
- maternity and newborn care,
- mental health and substance abuse disorder services,
- prescription drugs,
- rehabilitative and habilitative services and devices,
- laboratory services,
- preventive and wellness services, and
- chronic disease management.[28, 61]

Children's dental services will be required of plans offered in the state health benefit exchanges.[56] Tobacco cessation programs will be required as a Medicaid benefit for pregnant women.

Clinical Services

Of particular interest to the public health community, new private health plans and insurance policies are required as of September 23, 2010 to offer preventive services rated "A" (strongly recommended) or "B" (recommended) by the U.S. Preventive Services Task Force (USPSTF), vaccinations recommended by the Advisory Committee on Immunization Practices, and Bright Futures recommendations of the American Academy of Pediatrics, in addition to guidelines to be developed for women through the Health Resources and Services Administration (HRSA), all without paying a copayment, coinsurance, or deductible.[19, 34, 48, 52, 59, 60]

Medicare beneficiaries are also included in many of the preventive services requirements,[19, 58] and they are also eligible for an annual, personalized, wellness exam that includes a personalized health risk assessment.[12, 28]

Out-of-Pocket Costs

By requiring health plans to provide evidence-based preventive services with no out-of-pocket costs, the ACA transforms the United States' public and private health care financing systems into vehicles for promoting public health.[14] Although Medicaid expansion will be a state decision, the ACA has provided the potential to expand coverage to millions more Americans, and those individuals with new coverage will be able to take advantage of mandated preventive services.

The Role of Public Health in Providing Clinical Services Now...

Focuses on detection, screening, and management of specific diseases and conditions (notably cardiovascular diseases, immunizations, communicable diseases, and cancer).

The Role of Public Health in Providing Clinical Services After ACA...

Might, for example, result in public health agencies and departments offering more assessment and case management services while acting as partner members of health plan networks.

Changing Roles

In its June 2011 brief on the Implementation of the Patient

Protection and Affordable Care Act, the National Association of County and City Health Officials (NACCHO) encouraged local health departments to assess whether a clinical care role makes sense and whether they need to develop new business models to invoice or contract for services. NACCHO also suggested that local health departments consider applying to become a "public entity" FQHC or pursue partnership opportunities with FQHCs, such as co-location of services, referrals, or purchase of services. The National Association of Community Health Centers (NACHC), in the October 2010 report on FQHCs and local health departments, provides an overview of partnership opportunities available to FQHCs and local health departments; outlines a planning process; and identifies considerations in developing referral, co-location, and purchase of service arrangements.

Massachusetts Lessons

Several lessons related to access can be drawn from Massachusetts after it enacted an individual mandate within its health reform law in 2006 similar to the individual mandate in the ACA.

A 2011 study comparing Massachusetts Behavioral Risk Factor Surveillance Survey (BRFSS) data with several other states, before and after Massachusetts implemented its mandate, found that there was a significant reduction in individuals forgoing care because of cost and a significant improvement in access to a personal physician,[44] particularly for low-income adults.[36]

However, the gains in coverage and access attenuated in 2009 due to the global financial crisis.[37] Still, there are likely to be significant gains in access nationwide as a result of the ACA.[16]

Access Challenges

Several groups may continue to have particular challenges in accessing coverage or services. A 2009 study of the Massachusetts experience found that about 20 percent of adults were told that a doctor's office was not accepting patients or that their particular type of coverage was not being accepted, and the problem was more common for adults with Medicaid coverage and lower incomes than for adults with private coverage or higher incomes.[36] Others may fail to enroll for coverage due to bureaucratic barriers.[55]

The ACA is designed to ensure access for individuals who might face these barriers by creating provisions for community patient navigators who will facilitate enrollment and access to providers.[26] This facilitation of access may be particularly important in rural areas where there typically are fewer providers, patients must travel longer distances for care, and, consequently, provider usage decreases.[24]

Primary Care Workforce

Of particular importance in monitoring access to services under the provisions of the ACA is the supply of the primary care workforce, including physicians and nurses.[18]

> With an **additional 14 million individuals** expected to be newly covered under the ACA in 2014, provider supply becomes an even more critical issue, especially for those enrolled in Medicaid.

The Health Resources and Services Administration (HRSA) estimates that 67 million people live in health professional shortage areas.[23] An unintended but predictable consequence could be that demand for services further outstrips supply.[30] Typically, fewer physicians accept Medicaid patients relative to Medicare and commercially insured patients due to low reimbursement rates.[6] Although the ACA attempts to address this by increasing Medicaid rates so that they are equivalent to Medicare rates, the impact is expected to be limited, as the increase is only temporary.[17,32] Also, the states with the fewest providers - the south and mountain west - already have Medicaid rates comparable to Medicare rates and will see relatively little impact from increased Medicaid rates.

While the ACA provides $31 million in student stipends to schools of nursing over five years to train nurse practitioners and $30 million in student stipends over five years to fund 28 primary care physician assistant training programs,[63] even this increased capacity will not meet the anticipated demand.

One way to address the provider shortage is to take full advantage of the skills of the nurse practitioner and physician assistant workforces.[40] Scope of practice laws that allow nurse practitioners and physician assistants to perform at the top of their licenses can help alleviate some of the pressure for access to primary care.[17, 45] One model put forward redefines

the nature of primary care practice, creating a bi-level primary care structure where non-physician practitioners are largely responsible for routine primary care, and physicians are responsible for more complex cases and broader population health measures.[57]

In the short run, the need for the full range of public health preventive services will not go away. As Massachusetts demonstrated, the reorganization of its Uncompensated Care Pool left gaps in access and generated stress for traditional providers of care to the uninsured.[27] As a result, visits to the emergency departments increased.[46] The ACA seeks to reduce annual disproportionate share hospital (DSH) funding by $20 billion by 2020; many public hospitals are highly dependent on the payments.[53] On the plus side, the ACA offers $12.5 billion to expand community health centers and adds an additional 15,000 new providers for the centers.[31]

A variety of models will be needed in order to provide access **to the 41 million individuals expected to still be without health insurance** after the ACA is fully implemented and to meet the expected demand of those that are insured but unable to obtain appointments due to provider capacity.

Community health centers are not the only source of access for the uninsured, and there are a number of successful models in practice across the U.S., including physician volunteer models, not-for-profit models, multi-share coverage models, and community hospital-based network models. A 2011 study of four such models showed that safety net programs provided care in 2008 that was approximately one-quarter to one-half the cost of similar coverage from Medicaid or private insurance.[21]

As a public health leader, how does your situation relate to what is described about clinical services from the ACA? Enter your observations in the open entry area below. Some questions are provided below to get your thinking started.

Question 1: *What role will public health play in the provision of clinical services?*

How does your situation relate to what is described above about clinical services from the ACA? Are you providing clinical services now or should it be a part of your strategy to provide them over the next three to five years to carry out the core function of assurance? Will there be a market for these services? Who else in your community provides these services? Is there opportunity for partnership or a coordination role for public health?

Your Observations:

Step 3: Think about the Feasible Options and Select One to Begin Your Analysis

There could be many options related to the role public health may play in the provision of clinical services. A technical way of answering the question might be to simply think about whether or not you will provide the services and how much funding you will get in the future. A more adaptive way to reframe this question might be:

> **"In carrying out the core function of assurance, how can public health establish new partnerships with payers, purchasers, providers, and others to broker or directly deliver clinical health services, especially for vulnerable populations?"**

Three options are presented to help you think about how you might approach the question. In everyday application, you may need to combine more than one option; however, for this practice, choose only one. Read and consider each option and then record your response in the **Your Turn** section.

Option 1:

Continue to provide clinical services, but seek reimbursement from Medicaid, Medicare, and commercial payers, depending on the type of service.

According to a 2010 fact sheet by NACCHO, 13 percent of local health departments nationwide directly provided comprehensive primary care services. Twenty-seven percent provided oral health services, and 10 percent provided behavioral health services. In many jurisdictions, reimbursement by third party payers is not sought. For those local health departments that do provide direct services, reimbursement might improve overall financial sustainability. Some questions you might want to consider are:

- In order to accept third party reimbursement, what new partnerships would be helpful or essential?
- What new expertise might be required?
- What new regulations, certifications, or agreements with insurers would be needed?
- What new data systems might be needed?

Example: *The Laurens County, Georgia Health Department realized it needed to begin to think about doing business differently under health reform, including seeking new funding, exploring a fee-for-service business model, and building capacity to invoice third party payers. It is likely more providers will be needed to serve the population enrolled in the programs operated by the department. Improving collaboration among the health department, primary care providers, and the local community is seen as a priority.*

Option 2:

Assume a lead role in assuring access to clinical services without being the primary provider of those services in your area.

Linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable is one of the ten essential public health services, and there are multiple opportunities provided by the ACA to enhance this role.

Public health departments could also explore employing patient navigators as a potential revenue stream within the framework of health benefits exchanges. They could consider becoming the hub of a community referral network, linking individuals to a variety of care without actually providing the care. Or, public health could assume a lead role in community safety net planning, working to build a community-based, high performing safety net.

Example: *The SPARC program (Sickness Prevention Achieved through Regional Collaboration) has shown documented success in broadening the use of recommended preventive services among older adults. A rigorous evaluation supported by CDC found increases in immunizations for influenza and pneumococcal disease, and screening for breast, cervical, and colorectal cancers as well as screening for elevated cholesterol and high blood pressure. SPARC's approach is to establish collaboration and coordination among a wide variety of community agencies and organizations (e.g., local health departments, area agencies on aging, health care providers, and other key players) with a vested interest in improving the health of community residents. SPARC does not deliver services; rather, it creates, facilitates, and monitors community-wide strategies that make it easier for individuals to get their screenings and immunizations in places convenient for them. An innovative feature of SPARC is Vote & Vax, a strategy that makes vaccines and appointments for cancer screenings available at polling places on election days.*[10]

Option 3:

Consider leveraging public health practice to guide the development of patient-centered medical homes (PCMH).

According to the Agency for Healthcare Research and Quality, a patient-centered medical home is a primary care model that focuses on care that is patient-centered, comprehensive, coordinated, accessible, and is also focused on quality and safety. The model rests on the essential building blocks of health information technology, workforce development, and payment reform. The ACA presents multiple opportunities for providers to engage in practice transformation toward a PCMH, and some believe the PCMH model will be dominant in the next three to five years.

Example: *Iowa's Health Reform Act has tasked the Iowa Department of Public Health (IDPH) with developing a plan for implementation of a statewide patient-centered medical home system. The initial phase will focus on providing a patient-centered medical home for children who are eligible for Medicaid. The second phase will focus on providing a patient-centered medical home for adults covered by the IowaCare Program and for adults eligible for Medicaid. The third phase will focus on providing a patient-centered medical home for children covered by the hawk-i program (Iowa's CHIP program) and adults covered by private insurance and self-insured adults. IDPH also will work with the Iowa Department of Administrative Services to allow state employees to use the patient-centered medical home system. To guide the Department in achieving these goals, the Medical Home System Advisory Council will make recommendations to IDPH on the plan for implementation of a statewide, patient-centered medical home system.*[25]

Which of the three options presented above is the most appealing to you as a public health leader as you think about your organization over the next three to five years? Why? Enter your observations below.

Question 1: *In carrying out the core function of assurance, how can public health establish new partnerships with payers, purchasers, providers, and others to broker or directly deliver clinical health services, especially for vulnerable populations?*

Choose one preferred option:

- ☐ **Option 1:** Continue to provide clinical services, but seek reimbursement from Medicaid, Medicare, and commercial payers.
- ☐ **Option 2:** Assume a lead role in assuring access to clinical services without being the primary provider of those services in your area.
- ☐ **Option 3:** Consider leveraging public health practice to guide the development of patient-centered medical homes (PCMH).

Why is this option your preferred choice for your organization for the next three to five years?

Step 4: Apply Adaptive Actions

The ACA presents dozens of adaptive challenges for public health leaders and practitioners. By their very nature, these challenges have no ready answer or response. Public health practitioners must learn as they go, making sense of what is happening as it unfolds and adjusting accordingly.

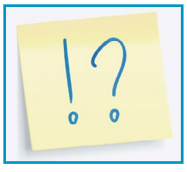
In the fall of 2010, Georgia Health Policy Center researchers conducted 15 health reform strategic assessments with public health departments, state department staff, community-based organizations, large and small provider practices, and large and small employers.[20] Eight strategic actions emerged from the work and can be applied here to help you think about a number of adaptive health reform challenges.

Influencing Decisions

Many of the decisions for implementing the ACA will occur at the state level and have not yet been made, creating a tremendous opportunity for public health to influence policymakers and service providers through community forums, social media, responding to government "requests for comments," being networked to information, and convening diverse stakeholder groups.

Educating Others

Public health leaders understand the ACA to varying degrees and at different levels, and those who understand more about the law and its potential impact on public health have the opportunity to educate others at the state and local levels. Public health is viewed as a community leader, and the opportunity exists for public health to play a role in convening stakeholders in order to understand better how the ACA will impact potential partners. In this role, public health can share what is known about the opportunities the ACA creates for improving the community's health. In the process of educating others, information should be neutral, simple, accurate, and accessible to all.



Planning Under Uncertainty

Because the changes in the health reform law will take place over several years, public health leaders are faced with the daunting prospect of making decisions without complete information.

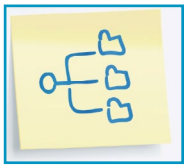
In addition, they are acutely aware that the provisions of the law itself might change. It is often said that jazz musicians listen to what is being played and play what is missing. Like jazz musicians, strategic thinkers must be improvisational in their thinking and planning. Some ideas to help public health leaders plan under uncertainty include identifying the most likely scenarios and then using them as a foundation for planning; pursuing good ideas, even in the absence of reform; building good information systems to track progress and identify needed adjustments; and looking for "win-win" opportunities that can be created through collaboration with multiple partners.

Staying Abreast of New Information

Given the length and complexity of the ACA, it is challenging to stay on top of all the regulations, administrative decisions, and guidance that has been, and will continue to be, issued from various sources. Even more difficult is sorting out what this information means and how it should be used. Still, adaptive thinkers must seek out the latest information related to the challenges they are facing. Some sources of new information related to the ACA include the Federal Register, national association Web publications, healthcare.gov, listservs, and information clearinghouses at the state level. To better utilize these sources, dedicated staff is sometimes needed for research opportunities, supportive infrastructure, grant writing capacity, and the ability to benchmark progress. Since most organizations cannot dedicate staff to all of these functions, partnership is all the more important.

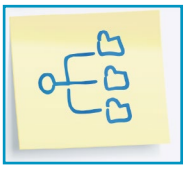
Creating New Partnerships

New collaborations are critical to the success of health reform. Some of the partnerships needed to implement health reform may involve coalitions among public health, community health centers, provider communities, hospitals, businesses, universities, social service organizations, community-based organizations, the faith-based community, state and local government authorities, senior centers, and others. Effectively forging such partnerships requires a neutral, respected convener who is ideally not an entity that stands to directly benefit from the partnership.



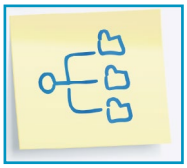
Building Workforce Capacity

The elimination of copays, deductibles, and coinsurance for many preventive services will likely increase the demand for providers in both the public health and private workforces. Particularly for the public health workforce, this will depend on the various health reform opportunities public health agencies pursue.[23, 24, 30, 36, 44, 45, 63] Meeting the workforce shortfall may require incentives to retain providers in needed locations, educational initiatives to ensure the pipeline produces providers that match workforce needs, the provision of technology training and education, and better utilization of the current workforce, including reorganizing provider teams and considering new types of providers. The Association of State and Territorial Health Officials' (ASTHO) analysis of workforce enhancements in the ACA is a good resource.[4]



Building Information Technology Capacity

The ACA will further stimulate demand for electronic records and other health data and increasingly require complex data sharing systems. Institutional information technology needs and requirements vary and reflect the idiosyncratic and unique nature of organizations. The most likely information technology capacity needs related to the ACA will involve designing or purchasing patient management and clinical management systems, sharing data among systems, building systems that can accommodate the increase in anticipated volume of claims and provider information, and developing data system standards for health. Public health agencies may want to consider becoming repositories for surveillance data and other public health information. A part of that creation might include capacity for quality measurement at the population level.



Building Care Coordination Capacity

The ACA includes a number of features for improving coordination of care, including a requirement that health insurance exchanges contract with professional associations and local organizations to provide exchange navigator services; funding to support improved care transition services for high-risk Medicare beneficiaries; establishment of community-based, interdisciplinary care teams; and grants to support comprehensive, coordinated, and integrated health care services for low-income populations. To build capacity for care coordination, organizations will need to understand the administrative requirements; be able to link different types of care; influence decisions about health reform; assist health networks in obtaining pertinent information (perhaps surveillance information); and obtain the technical ability to collect information.

So far, you have described how your organization relates to the provision of clinical services in the context of health reform, you have selected one option for moving forward, and you have documented why that option resonates with your organization. Now you have the opportunity to think about strategic actions related to the option you selected. If you were going to pursue an option related to clinical services, which strategic actions would you consider implementing and why? Record your answers in the table below.

Question 1: *In carrying out the core function of assurance, how can public health establish new partnerships with payers, purchasers, providers, and others to broker or directly deliver clinical health services, especially for vulnerable populations?*

Your choice:

- ☐ **Option 1:** Continue to provide clinical services, but seek reimbursement from Medicaid, Medicare, and commercial payers.
- ☐ **Option 2:** Assume a lead role in assuring access to clinical services without being the primary provider of those services in your area.
- ☐ **Option 3:** Consider leveraging public health practice to guide the development of patient-centered medical homes (PCMH).

Some questions about each adaptive action are provided below to get your thinking started.

Influencing Decisions: Where are the leverage points for influencing decisions related to your question? Who can you engage to influence those decisions?	
Educating Others: Who needs to know about your situation related to health reform? What are the facts? How will you communicate them?	

Planning Under Uncertainty: What are the most likely scenarios related to your question and how can you use them as a foundation for planning? What are the information systems you might need to access or build?	
Staying Abreast of New Information: How will you learn of changes in the ACA related to your question? What partnerships can you leverage to do this?	
Creating New Partnerships: What new partnerships might advance your strategy? Who can serve as a neutral convener of these new partnerships?	
Building Workforce Capacity: Will you need new types of workers or more workers to achieve your goals? How can you ensure there will be sufficient capacity?	
Building Information Technology Capacity: What sort of IT capacity will you need to achieve your goals? Are there partnerships you can leverage to expand or create this capacity?	
Building Care Coordination Capacity: How will you transition from providing services to coordinating services or adding coordination to the existing provision of services? What partners will be necessary? What certifications will be required?	

Step 5: Simplified Implementation Plan

The last step in thinking adaptively about questions related to health reform is creating a simplified implementation plan for the way in which you have chosen to respond to your original question and the adaptive actions that will help you get there. Thinking about three fundamental factors for the actions you wish to take will help you to gain clarity about what is feasible: staffing, budget and a funding strategy, and a management plan. The CDC has several resources on program planning, improvement, and evaluation that can be found at http://www.cdc.gov/stltpublichealth/program/.

Staffing

The staff responsible for program implementation and the partners who provide program guidance are key factors in the ultimate success or failure of a new venture. In planning for implementation, it is important to determine the most effective structure for program continuation.

During this step of the planning process, you will want to assess different aspects of your program and determine what changes may be needed to achieve maximum efficiency. This can be a difficult conversation because you may have to make hard decisions about how many and which staff will be needed to support the activities that you want to initiate. Most likely, you will want someone from outside your program staff to facilitate this conversation.

Some questions that may help you think about staffing are: What expertise is needed to initiate this activity? Can some of the activities be absorbed by our partners? Can any activities be undertaken by volunteers rather than paid staff? What paid staff will be necessary to initiate our activities? Who will employ the paid staff? Are there any union bargaining rules that must be considered?

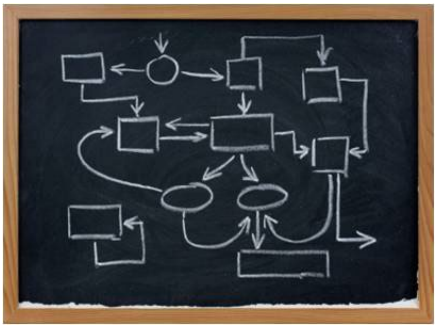
Budget and Funding Strategy

Having a clear idea of the cost of sustaining your activities is an essential part of the implementation planning process. You may want to project your costs for a minimum of three years so you get a complete picture of the total cost of the activity, including one-time cash expenditures, on-going operational expenses, etc. Developing a line item budget for each activity is necessary for determining your funding strategy.

Sources of funding include grants, government budgets, contributions or sponsorships, revenue from events, earned income and dedicated sources such as fees, indirect funding sources such as in-kind services and volunteerism, and the redirection of existing funding that may result from new efficiencies or other activities. As you think about these types of funding streams, also think about the local sources of funding available to you within each category. Brainstorm with your partners to make a list of possible funders/supporters for your actions. Be as specific as possible. For instance, do not list "businesses." Instead, include the names of actual businesses in your community that you can contact for support.

Sustainability heavily depends on diversification of funding sources. You will want to identify potential sources from a variety of methods. Remember that many activities are sustained through partnerships. As a part of your sustainability planning process, you should discuss the role that your partners can realistically play in the long-term support of your actions.

Management Plan



How you manage new activities and the staff and partners who will undertake them is an important part of your simple implementation plan. Some questions that will help get you started thinking about a management plan include: What has worked well in managing your current activities and relationships? What could be improved? What management functions will be required of your new actions? What is the best strategy for managing these functions? Do you need to employ a project coordinator or can the coordination role be handled by your staff or undertaken by partners?

The last step in thinking adaptively about your questions about health reform is creating your own simplified implementation plan for the option you have chosen to address your question and adaptive actions that will help you get there. Now you will create your implementation plan by answering the questions below.

Question 1: *In carrying out the core function of assurance, how can public health establish new partnerships with payers, purchasers, providers, and others to broker or directly deliver clinical health services, especially for vulnerable populations?*

Your choice:

- ☐ **Option 1:** Continue to provide clinical services, but seek reimbursement from Medicaid, Medicare, and commercial payers.
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Staffing	
What expertise is needed to initiate this activity?	
Can some of the activities be absorbed by your partners?	
Can any activities be undertaken by volunteers rather than paid staff?	
What paid staff will be necessary to initiate your activities?	

Who will employ the paid staff?	
Budget and Funding Strategy	
What is the three-year cost for this activity?	
What are the one-time expenditures?	
What are the ongoing operational expenses?	
What are your possible funding sources?	
What community partners can be approached for direct or indirect support?	
Management Plan	
What has worked well in managing your current activities and relationships?	

What could be improved?	
What management functions will be required of your new actions?	
What is the best strategy for managing these functions?	
Do you need to employ a project coordinator or can the coordination role be handled by your staff or undertaken by partners?	

You have now completed the five steps that will help you practice shifting your thinking from a technical perspective to a more adaptive perspective. The steps are:

Step 1: Define your question. What is it that you want to know? Is the question unique to your organization or do you think it might apply to others?

Step 2: Collect information about your question related to the Affordable Care Act. What exactly is written in the law? You may have to go directly to the law or read what others have said related to the law and your question. Are there new approaches or ways of thinking about your question being practiced in other states? Chances are you will be able to learn something about your question from others. Gathering information from the law is one place to start. You may want to collect additional state and local information.

Step 3: Think about the feasible options and select one to begin your analysis. When you think about your question, what are the possible ways you could answer the question?

Step 4: Apply adaptive actions related to your question. The planning tool describes eight adaptive actions you can apply to the answer option you choose. Some might be very relevant to your work and others may not.

Step 5: Create a simplified implementation plan. This step will help you think about a concrete way to move forward related to staffing, budgeting and funding, and a management plan in the context of how you choose to answer your question.

This process can be used with any challenging question for which there may not be a ready-made solution — not just questions about health reform. The process takes time, but it can lead to a higher level of thinking than merely reaching for the easier, technical solution.

Guided Practice 2

Step 1: Define Your Question

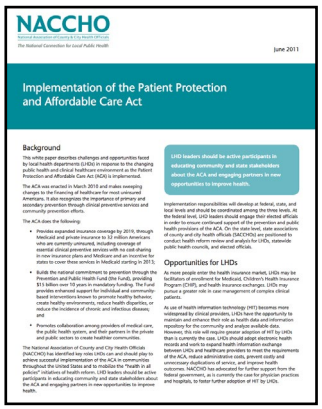
What role will public health play in the surveillance and monitoring of health status?

Step 2: Collect information about your question related to the Affordable Care Act

Use of Health Information

Although most of the media and policy focus on enhanced health informatics has been concentrated on the private health care sector, health informatics is also of critical importance to state and local public health for:

- increasing recognition of health care errors as a major public health problem;
- supporting public health's mission to protect the public's health and safety;
- its potential to improve the core public health functions, including assessment, policy development and assurance, and many of the essential health services; and
- involving the public sector in the development of local health care systems that can improve and protect the health of people in the community.[35]



NACCHO June 2011 Brief
ISBN #978-1-4221-5576-4

NACCHO calls for health departments to adopt electronic health records and work to expand health information exchange between health departments and health care providers to meet the requirements of the Affordable Care Act (ACA.)[41]

Public Health & Health Information Exchange

Preliminary suggestions for measuring the impact of Health Information Exchange (HIE) on public health in specific cases include:

- reporting laboratory diagnoses,
- reporting physician-based diagnoses,
- public health investigation,
- antibiotic-resistant organism surveillance,
- disease-based non-reportable laboratory data, and
- population-level quality monitoring.[51]

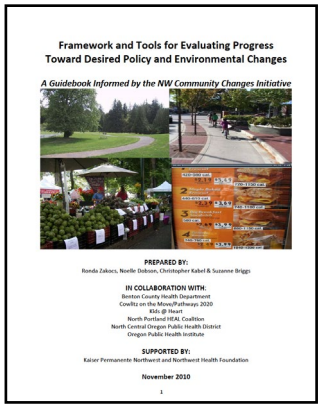
Prevention may be a key area where public health converges with the promise of HIE. The data may help agencies identify when an intervention needs to be performed and evaluate the impact of that intervention.[5]

Leadership

Health departments are well positioned organizations to provide leadership in building local capacity for electronic health information exchange. Their responsibilities for core public health functions and essential public health services, such as community assessment, disease investigation, disease registries, syndromic surveillance, and immunization registries, rely increasingly on electronic information. The potential for electronic medical records to support these functions and services is reinforced by the ACA's meaningful use objectives. Meaningful use of electronic health records is intended to improve patient care by improving quality, safety, efficiency, and reducing health disparities; engaging patients and families in their healthcare; improving care coordination; and improving population and public health.[13]

Measuring Impact

Health departments will likely have the opportunity to play enhanced roles in measuring the impacts of community-driven strategies and policy changes. A presentation at the 2011 APHA Annual Meeting by the Institute of Medicine (IOM), provided an overview of two reports. "Measurement and the Law" addresses data needs, accountability, determinants of health, clinical care and population health. The second report, "A Framework and Tools for Evaluating Progress Toward Desired Policy and Environmental Changes" by the Northwest Community Changes Initiative contains a



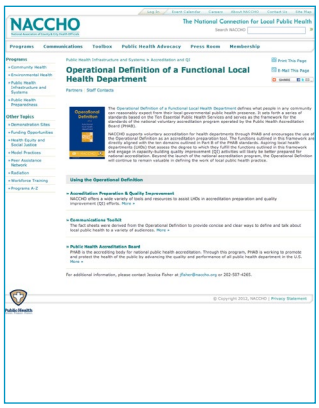
Northwest Community Changes Initiative

multi-component methodology for evaluating community-driven policy and environmental change initiatives and includes tools and data that coalitions can use to measure progress, mobilize constituents, and tell their story.

A 2011 Urban Institute report looked at national and state-level (Massachusetts) potential medical care cost savings achievable through modest reductions in the prevalence of several diseases associated with the same lifestyle-related risk factors.[43] Given the emphasis on prevention in the ACA, this model may be useful to evaluate public health-related prevention activities using public health data.

Accreditation

Finally, health departments' involvement in developing and using health information technology (HIT) can substantially improve their ability to meet recently developed accreditation and performance standards.[35] In 2005, NACCHO prepared the report, Operational Definition of a Functional Local Health Department, which served as the framework for the development of the standards for the national voluntary accreditation program. Stating that "accreditation of public health agencies is expected to play a significant role in strengthening the performance, effectiveness, and accountability of the public health system," The Network for Public Health Law also developed an issue brief, Public Health Agency Accreditation and Shared Service Delivery. The brief outlines the legal issues to be addressed if states want to participate in the national voluntary accreditation, and provides a list of select state laws and policies, articles, presentations, reports, and other key resources.



NACCHO Report, 2005

The Network for Public Health Law Issue Brief

As a public health leader, how does your situation relate to what is described about the surveillance and monitoring of health status from the ACA? Enter your observations in the open entry area below.

Question 2: *What role will public health play in the surveillance and monitoring of health status?*

How does your situation relate to what is described about the surveillance and monitoring of health status?

Your Observations:

Step 3: Think about the Feasible Options and Select One to Begin Your Analysis

There could be many options related to the role public health may play in the surveillance and monitoring of health status. A technical way of answering the question might be to simply think about what surveillance functions you will continue to provide and how much funding you will get in the future. A more adaptive way to reframe this might be:

> **"In carrying out the core function of assessment, how can public health partner in the development of quality metrics for Medicaid, Accountable Care Organizations (ACOs), health insurance exchanges, and others as a result of new opportunities made available through health reform?"**

Three options are presented below to help you think about how you might approach the question. In everyday application, you may need to combine more than one option; however, for this practice, choose only one. Read and consider each option and then record your response in the **Your Turn** section.

Option 1: **Continue to provide basic public health surveillance functions, but align information technology capacity with meaningful use requirements.**	Surveillance is one of the 10 essential public health services, and the ACA presents an opportunity for building on this capacity by leveraging public health's experience in quality metrics for use in many of the new types of structures or functions created by the ACA. However, many public health departments face the very real situation of challenging budgets, and it may be enough to simply re-envision how the department manages surveillance with an eye toward improving the systems that enable the surveillance function. Understanding that financial resources may be limited, public health entities may need to create new partnerships in order to increase their information technology capacity, and some of these partnerships may be in the private sector.

Example: *The Minnesota e-Health Initiative is a public-private collaborative with a vision to accelerate the adoption and use of health information technology in order to improve health care quality, increase patient safety, reduce health care costs, and improve public health. Minnesota has been a leader in pursuing e-health policies and applying statutory mandates and governmental funding to accelerate the adoption of HIT, electronic health records, and health data standards. e-Health activities in Minnesota are coordinated by the Minnesota Department of Health (MDH) through the Minnesota e-Health Initiative, a public-private collaborative that has broad support from health care providers, payers, and professional associations. Guided by a 25-member advisory committee, the Initiative represents stakeholders' commitment to work together to identify and address barriers of common interest, prioritize resources, and achieve Minnesota's mandates. The initiative fulfills the statutory role of the Minnesota e-Health Advisory Committee and sets the gold standard nationally for a model public-private partnership.*[6]

Option 2:

Take a leadership role in coordinating a local health information exchange.

Public health has a defined role to play in the meaningful use requirement of health information exchange related to the reporting of immunizations, receiving syndromic surveillance data, and receiving lab results electronically. Public health entities that wish to do so can take steps to become the nexus for planning health information exchanges, furthering a shared interest in data and information that supports prevention.

Example: *The New York HIE and the NY State Health Department were the first to implement the NHIN CONNECT Gateway as an interface for federal-state health information exchange. The NHIN CONNECT gateway is a software solution that helps agencies, and other organizations, share health-related information and securely links their existing systems to the NHIN. The NHIN CONNECT solution enables secure and interoperable electronic health information exchanges with other NHIN participating organizations, including federal agencies, state, tribal and local-level health organizations, and health care participants in the private sector.*[11]

Option 3:

Take a leadership role in developing quality metrics for Medicaid, ACOs, health insurance exchanges, or other opportunities in the ACA within your community or state.

Public health already has experience in measuring quality at the community and population levels. Through partnerships, this experience can be leveraged to impact how state Medicaid departments measure their health impact as coverage expands under the ACA, how ACOs evaluate the management of a defined population, and how health insurance exchanges measure the quality of the plans offered in the exchange.

Example: *The Greater New Orleans area was selected to serve as a pilot community for the eventual wide-scale use of health information technology through the HHS Office of the Coordinator for Health Information Technology's Beacon Community Program. The grant was awarded to the Greater New Orleans area through a collaborative convened by the Louisiana Public Health Institute (LPHI). The Crescent City Beacon Community (CCBC) initiative seeks to achieve meaningful and measurable improvements in healthcare quality, safety, and efficiency in the Greater New Orleans area. Goals include improved quality of care at the population level in measurable ways, the implementation of HIT as the enabler for efficiency and scalability, creation of community-level standards of care for chronic disease management, and enhancement of linkages across health systems and other state and federal Quality Improvement (QI) and HIT activities. Partners in addition to LPHI include community health centers, Tulane University, the Louisiana Department of Health and Hospitals, and three hospitals or health systems.*[38]

Which of the three options presented above is the most appealing to you as a public health leader as you think about your organization over the next three to five years? Why? Enter your observations below.

Question 2: *In carrying out the core function of assessment, how can public health partner in the development of quality metrics for Medicaid, ACOs, health insurance exchanges, and others as a result of new opportunities made available through health reform?*

Choose one preferred option:

- ☐ **Option 1:** Option 1: Continue to provide basic public health surveillance functions, but align information technology capacity with meaningful use requirements.
- ☐ **Option 2:** Take a leadership role in coordinating a local health information exchange.
- ☐ **Option 3:** Take a leadership role in developing quality metrics for Medicaid, ACOs, health insurance exchanges or other opportunities in the ACA within your community or state.

Why is this option your preferred choice for your organization for the next three to five years?

Step 4: Apply Adaptive Actions

The ACA presents dozens of adaptive challenges for public health leaders and practitioners. By their very nature, these challenges have no ready answer or response. Public health practitioners must learn as they go, making sense of what is happening as it unfolds and adjusting accordingly.

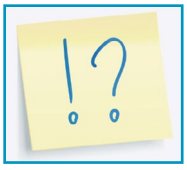
In the fall of 2010, Georgia Health Policy Center researchers conducted 15 health reform strategic assessments with public health departments, state department staff, community-based organizations, large and small provider practices, and large and small employers.[20] Eight strategic actions emerged from the work and can be applied here to help you think about a number of adaptive health reform challenges.

Influencing Decisions

Many of the decisions for implementing the ACA will occur at the state level and have not yet been made, creating a tremendous opportunity for public health to influence policymakers and service providers through community forums, social media, responding to government "requests for comments," being networked to information, and convening diverse stakeholder groups.

Educating Others

Public health leaders understand the ACA to varying degrees and at different levels, and those who understand more about the law and its potential impact on public health have the opportunity to educate others at the state and local levels. Public health is viewed as a community leader, and the opportunity exists for public health to play a role in convening stakeholders in order to understand better how the ACA will impact potential partners. In this role, public health can share what is known about the opportunities the ACA creates for improving the community's health. In the process of educating others, information should be neutral, simple, accurate, and accessible to all.



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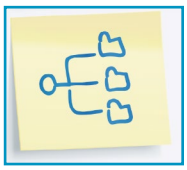
New collaborations are critical to the success of health reform. Some of the partnerships needed to implement health reform may involve coalitions among public health, community health centers, provider communities, hospitals, businesses, universities, social service organizations, community-based organizations, the faith-based community, state and local government authorities, senior centers, and others. Effectively forging such partnerships requires a neutral, respected convener who is ideally not an entity that stands to directly benefit from the partnership.



Building Workforce Capacity

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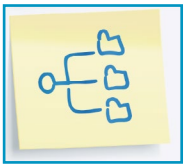

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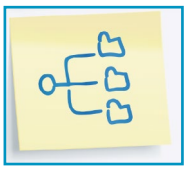
The ACA will further stimulate demand for electronic records and other health data and increasingly require complex data sharing systems. Institutional information technology needs and requirements vary and reflect the idiosyncratic and unique nature of organizations. The most likely information technology capacity needs related to the ACA will involve designing or purchasing patient management and clinical management systems, sharing data among systems, building systems that can accommodate the increase in anticipated volume of claims and provider information, and developing data system standards for health. Public health agencies may want to consider becoming repositories for surveillance data and other public health information. A part of that creation might include capacity for quality measurement at the population level.



Building Care Coordination Capacity

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So far, you have described how your organization relates to the role public health may play in the surveillance and monitoring of health status in the context of health reform, you have selected one option for possibly moving forward, and you have documented why that option resonates with you or your organization. Now you have the opportunity to think about strategic actions related to the option you selected. If you were going to pursue an option related to the surveillance and monitoring of health status, which strategic actions would you consider implementing and why? Record your answers in the table below.

Question 2: *In carrying out the core function of assessment, how can public health partner in the development of quality metrics for Medicaid, ACOs, health insurance exchanges, and others as a result of new opportunities made available through health reform?*

Your choice:

- ☐ **Option 1:** Option 1: Continue to provide basic public health surveillance functions, but align information technology capacity with meaningful use requirements.
- ☐ **Option 2:** Take a leadership role in coordinating a local health information exchange.
- ☐ **Option 3:** Take a leadership role in developing quality metrics for Medicaid, Accountable Care Organizations, health insurance exchanges or other opportunities in the ACA within your community or state.

Some questions about each adaptive action are provided below to get your thinking started.

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Step 5: Simplified Implementation Plan

The last step in thinking adaptively about questions related to health reform is creating a simplified implementation plan for the way in which you have chosen to respond to your original question and the adaptive actions that will help you get there. Thinking about three fundamental factors for the actions you wish to take will help you to gain clarity about what is feasible: staffing, budget and a funding strategy, and a management plan. The CDC has several resources on program planning, improvement, and evaluation that can be found at http://www.cdc.gov/stltpublichealth/program/.

Staffing

The staff responsible for program implementation and the partners who provide program guidance are key factors in the ultimate success or failure of a new venture. In planning for implementation, it is important to determine the most effective structure for program continuation.

During this step of the planning process, you will want to assess different aspects of your program and determine what changes may be needed to achieve maximum efficiency. This can be a difficult conversation because you may have to make hard decisions about how many and which staff will be needed to support the activities that you want to initiate. Most likely, you will want someone from outside your program staff to facilitate this conversation.

Some questions that may help you think about staffing are: What expertise is needed to initiate this activity? Can some of the activities be absorbed by our partners? Can any activities be undertaken by volunteers rather than paid staff? What paid staff will be necessary to initiate our activities? Who will employ the paid staff? Are there any union bargaining rules that must be considered?

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Having a clear idea of the cost of sustaining your activities is an essential part of the implementation planning process. You may want to project your costs for a minimum of three years so you get a complete picture of the total cost of the activity, including one-time cash expenditures, on-going operational expenses, etc. Developing a line item budget for each activity is necessary for determining your funding strategy.

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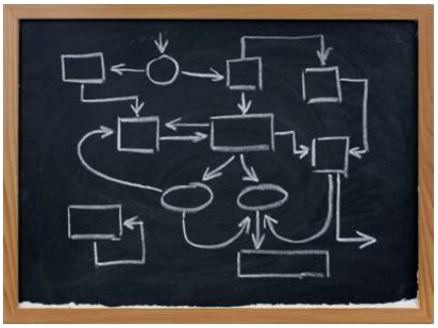
Management Plan



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What paid staff will be necessary to initiate your activities?	
Who will employ the paid staff?	
Budget and Funding Strategy	
What is the three-year cost for this activity?	
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What community partners can be approached for direct or indirect support?	
Management Plan	
What has worked well in managing your current activities and relationships?	
What could be improved?	
What management functions will be required of your new actions?	
What is the best strategy for managing these functions?	
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Continue onto question 3 in order to gain more practice.

Guided Practice 3

Step 1: Define Your Question

What role will public health play in community health planning?

Step 2: Collect information about your question related to the Affordable Care Act

Overview

Under the ACA, there is a requirement that not-for-profit (NFP) hospitals conduct regular health needs assessments and develop health improvement plans as part of their community benefit requirement. At the same time, incentives are being provided by the Voluntary National Accreditation of Local Health Departments (LHDs) Program for LHDs to conduct assessments and develop community health improvement plans (CHIP) at the state and local levels. Linking the assessment and planning processes will be an efficient way of addressing the compliance needs of not-for-profit hospitals while at the same time assisting the accreditation readiness of health departments.[1]

Assessments

Public health agencies have the opportunity to consult with area hospitals to determine how assessments might be done collaboratively in an effort to address important population health improvement goals such as reaching all communities with preventive services, achieving better management of chronic illnesses and conditions, and raising community health literacy levels.[49] These collaborations should acknowledge the significant role community hospitals have historically played in meeting the health needs of the community.

Accreditation

The ACA requirement around community benefit corresponds to the accreditation efforts of local health departments. Community health needs assessments and improvement planning are accreditation requirements as well as integral to the community benefit requirements. Public health agencies are in a very good position to assist hospitals with data collection, analysis, identification of community partners, and the development of health improvement plans.[50] The inclusion of public health agencies in nonprofit hospitals' needs assessment and planning processes, as well as in the hospitals' community benefit programs and activities, offers a number of advantages to hospitals seeking to satisfy their community benefit responsibilities.[54] These include public health expertise, experience with community health needs assessment, and access to vulnerable populations.

Engaging Non-Profit Hospitals

LHDs have a new opportunity to engage their local non-profit hospitals in community health assessment and improvement because of changes in the ACA on how these hospitals qualify for their non-profit status through providing community benefit. To qualify as community benefit, initiatives must respond to an identified community need and meet at least one of the following criteria:

- Improve access to health care services;
- Enhance health of the community;
- Advance medical or health knowledge; or
- Relieve or reduce the burden of government or other community efforts.[7]

Historically, the majority of community benefit funds have been spent on charity care, while a smaller portion has been invested in community-based efforts such as community health improvement planning. The ACA revises the tax exemption standards applicable to non-profit hospitals by adding several new components to the Internal Revenue Code. Among other revisions, non-profit hospitals will now be required to conduct a community health needs assessment, widely publicize assessment results, and adopt an implementation strategy to meet needs identified by the assessment.[42] These changes provide a new opportunity for LHDs to engage non-profit hospitals by leveraging community benefit requirements for community health improvement.

As a public health leader, how does your situation relate to what is described about community health planning from the ACA? Enter your observations in the open entry area below.

Question 3: *What role will public health play in community health planning?*
How does your organizational situation relate to what is described about community health planning from the ACA?
Your Observations:

Step 3: Think about the Feasible Options and Select One to Begin Your Analysis

There could be many options related to the role public health has in community health planning. A technical way of answering the question might be to simply think about what community health planning activities you will continue to engage in and how much funding you will get in the future. A more adaptive way to reframe this question might be:

> **"How can public health be a convener of new partnerships toward collective impact for community health planning, especially in light of new opportunities for hospital community benefit created by the ACA?"**

Three options are presented below to help you think about how you might approach the question. In everyday application, you may need to combine more than one option; however, for this practice, choose only one. Read and consider each option and then record your response in the **Your Turn** section.

Option 1: **Develop policies and plans that support individual and community health efforts while reaching out to new partners.**	Many public health entities are already engaged in varying forms of health planning within their states and communities. New ways of envisioning the planning process can infuse fresh perspective by bringing new partners to the table. For example, public health may seek to engage with land use, open space, transportation and urban design partners in order to impact food access, physical activity, housing choice and equity, transportation choices, clean air and water, and more.[3]

Example: *Beginning in 2008, the Will County Health Department (Will County) and Provena Saint Joseph Medical Center co-chaired Will County's Community Health Plan Committee, which adopted the community-driven MAPP process. This multi-stage framework for prioritizing public health issues helps communities identify existing resources for addressing such issues, as well as for developing and implementing community health improvement plans. The resulting community health plan, approved by Will County in January 2011, is a comprehensive strategic plan to improve the local public health system and community health. To provide ongoing data collection, assessment, and monitoring of plan implementation, the county established a Monitoring and Evaluation team.*[54]

Option 2:

Use the opportunity in the ACA related to community health needs assessment and implementation planning to build on the accreditation readiness of public health departments.

Community health needs assessment and improvement planning are requirements for both not-for-profit hospitals as a part of their community benefits requirements under the ACA and for public health departments as a prerequisite for accreditation. Public health can leverage this opportunity to engage hospitals and other partners in simultaneously meeting their own accreditation needs, the assessment and implementation planning needs of partner hospitals, and the health improvement needs of the community.

Example: *Until recently, North Carolina's state accreditation-driven local health department community needs assessment cycle was every four years. The North Carolina Local Health Department Accreditation Board, part of the North Carolina Department of Health and Human Services, recognized that inconsistent needs assessment cycles for North Carolina health departments and nonprofit hospitals would challenge their ability to conduct collaborative needs assessments. As a result, the state modified the accreditation standard to require local health departments to conduct needs assessments every three to four years. This revision allows local health departments and nonprofit hospitals to collaborate in conducting their community needs assessments on a cycle consistent with both the hospitals' federal community needs assessment responsibility and the state's assessment requirement for local health department accreditation.*[54]

Option 3:

Be a convener of new partnerships toward collective impact for community health planning.

In their article in the Stanford Social Innovation Review, Kramer and Kania state that large-scale social change requires broad cross-sector coordination, yet the social sector remains focused on the isolated intervention of individual organizations. Collective impact requires a shared agenda, common measurement systems, mutually reinforcing activities, continuous communication, and backbone support organizations.[29] Public health can assume the role of one of those backbone support organizations in organizing collective impact for health improvement.

Example: *The Georgia Health Policy Center, a member of the National Network of Public Health Institutes, has partnered with two county public health departments, the Georgia Department of Public Health, the United Way of Metropolitan Atlanta, the Atlanta Regional Commission, the Georgia Hospital Association, the Centers for Disease Control and Prevention, the Carter Center, the Philanthropic Collaborative for a Healthy Georgia, several metropolitan Atlanta hospitals, and others on the Atlanta Regional Collaborative for Health Improvement (ARCHI). ARCHI seeks to leverage the opportunities in the ACA related to the community benefit requirement to achieve collective impact for shared investment in regional health improvement. The collaborative will be including transportation and the built environment in its planning efforts as it seeks to improve health in Fulton and DeKalb Counties.*

Which of the three options presented above is the most appealing to you as a public health leader as you think about your organization over the next three to five years? Why? Enter your observations below.

Question 3: *How can public health be a convener of new partnerships toward collective impact for community health planning, especially in light of new opportunities for hospital community benefit created by the health reform law.*

Choose one preferred option:

- ☐ **Option 1:** Develop policies and plans that support individual and community health efforts while reaching out to new partners.
- ☐ **Option 2:** Use the opportunity in the ACA related to community health needs assessment and implementation planning to build on the accreditation readiness of public health departments.
- ☐ **Option 3:** Be a convener of new partnerships toward collective impact for community health planning.

Why is this option your preferred choice for your organization for the next three to five years?

Step 4: Apply Adaptive Actions

The ACA presents dozens of adaptive challenges for public health leaders and practitioners. By their very nature, these challenges have no ready answer or response. Public health practitioners must learn as they go, making sense of what is happening as it unfolds and adjusting accordingly.

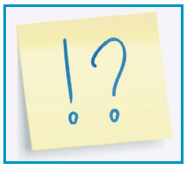
In the fall of 2010, Georgia Health Policy Center researchers conducted 15 health reform strategic assessments with public health departments, state department staff, community-based organizations, large and small provider practices, and large and small employers.[20] Eight strategic actions emerged from the work and can be applied here to help you think about a number of adaptive health reform challenges.

Influencing Decisions

Many of the decisions for implementing the ACA will occur at the state level and have not yet been made, creating a tremendous opportunity for public health to influence policymakers and service providers through community forums, social media, responding to government "requests for comments," being networked to information, and convening diverse stakeholder groups.

Educating Others

Public health leaders understand the ACA to varying degrees and at different levels, and those who understand more about the law and its potential impact on public health have the opportunity to educate others at the state and local levels. Public health is viewed as a community leader, and the opportunity exists for public health to play a role in convening stakeholders in order to understand better how the ACA will impact potential partners. In this role, public health can share what is known about the opportunities the ACA creates for improving the community's health. In the process of educating others, information should be neutral, simple, accurate, and accessible to all.



Planning Under Uncertainty

Because the changes in the health reform law will take place over several years, public health leaders are faced with the daunting prospect of making decisions without complete information.

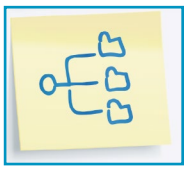
In addition, they are acutely aware that the provisions of the law itself might change. It is often said that jazz musicians listen to what is being played and play what is missing. Like jazz musicians, strategic thinkers must be improvisational in their thinking and planning. Some ideas to help public health leaders plan under uncertainty include identifying the most likely scenarios and then using them as a foundation for planning; pursuing good ideas, even in the absence of reform; building good information systems to track progress and identify needed adjustments; and looking for "win-win" opportunities that can be created through collaboration with multiple partners.

Staying Abreast of New Information

Given the length and complexity of the ACA, it is challenging to stay on top of all the regulations, administrative decisions, and guidance that has been, and will continue to be, issued from various sources. Even more difficult is sorting out what this information means and how it should be used. Still, adaptive thinkers must seek out the latest information related to the challenges they are facing. Some sources of new information related to the ACA include the Federal Register, national association Web publications, healthcare.gov, listservs, and information clearinghouses at the state level. To better utilize these sources, dedicated staff is sometimes needed for research opportunities, supportive infrastructure, grant writing capacity, and the ability to benchmark progress. Since most organizations cannot dedicate staff to all of these functions, partnership is all the more important.

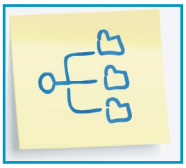
Creating New Partnerships

New collaborations are critical to the success of health reform. Some of the partnerships needed to implement health reform may involve coalitions among public health, community health centers, provider communities, hospitals, businesses, universities, social service organizations, community-based organizations, the faith-based community, state and local government authorities, senior centers, and others. Effectively forging such partnerships requires a neutral, respected convener who is ideally not an entity that stands to directly benefit from the partnership.



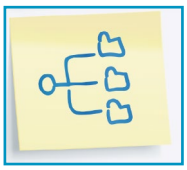
Building Workforce Capacity

The elimination of copays, deductibles, and coinsurance for many preventive services will likely increase the demand for providers in both the public health and private workforces. Particularly for the public health workforce, this will depend on the various health reform opportunities public health agencies pursue.[23, 24, 30, 36, 44, 45, 63] Meeting the workforce shortfall may require incentives to retain providers in needed locations, educational initiatives to ensure the pipeline produces providers that match workforce needs, the provision of technology training and education, and better utilization of the current workforce, including reorganizing provider teams and considering new types of providers. The Association of State and Territorial Health Officials' (ASTHO) analysis of workforce enhancements in the ACA is a good resource.[4]



Building Information Technology Capacity

The ACA will further stimulate demand for electronic records and other health data and increasingly require complex data sharing systems. Institutional information technology needs and requirements vary and reflect the idiosyncratic and unique nature of organizations. The most likely information technology capacity needs related to the ACA will involve designing or purchasing patient management and clinical management systems, sharing data among systems, building systems that can accommodate the increase in anticipated volume of claims and provider information, and developing data system standards for health. Public health agencies may want to consider becoming repositories for surveillance data and other public health information. A part of that creation might include capacity for quality measurement at the population level.



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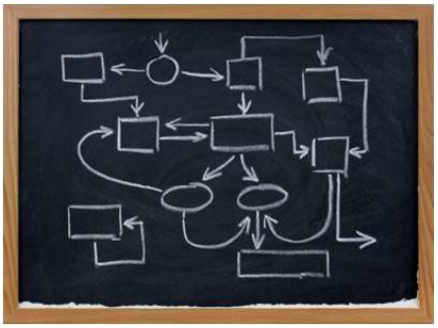

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Georgia Health Policy Center
Andrew Young School of Policy Studies
Georgia State University
14 Marietta Street, NW, Suite 221
Atlanta, GA 30303
(404) 413-0314
www.gsu.edu/ghpc

National Network of Public Health Institutes
1515 Poydras Street, Suite 1200
New Orleans, LA 70112
(504) 301-9811
www.nnphi.org