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# ACA Funding for Georgia Community Health

October 2012

The Affordable Care Act (ACA) provides support for community-based organizations (CBOs) to improve community health through health and wellness promotion, chronic disease prevention, and assurance of quality health care. This policy brief will examine the current status of this funding, outline the distribution of the grant awards nationally and in Georgia, and provide a framework for how, going forward, organizations might adapt to the changing health policy environment.

## Introduction

Several new and expanded federal grant programs, authorized under the ACA, offered funding for CBOs to retool and partner with local public health and health care providers to improve community health. Over the last two years, CBOs have received funding to: connect community members to prevention and wellness services; coordinate access to appropriate health care services; and link individuals to coverage.

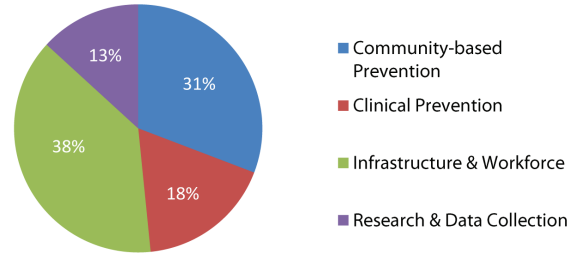
Many programs and awards were funded through the Prevention and Public Health Fund, which is administered through the Department of Health and Human Services (HHS). Other programs, however, still await funding appropriations. While the recent U.S. Supreme Court ruling is unlikely to have any direct impact on the administration of the Fund, the uncertainties of the national economy have resulted in ongoing budget reductions to the Fund's original appropriation.

## The Prevention and Public Health Fund

The Prevention and Public Health Fund, created by Section 4002 of the ACA, represents the nation's first mandatory funding effort to help communities strengthen programs to prevent disease and improve public health. According to the ACA, the Fund would be allocated \$15 billion between FY 2010 and FY 2019, and \$2 billion each subsequent fiscal year.

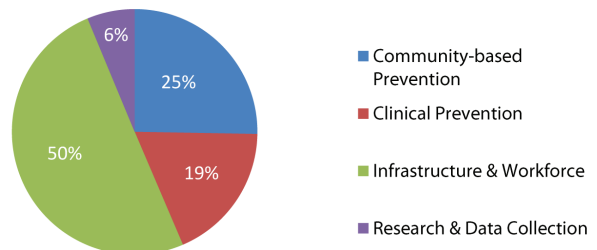
In FY 2010, HHS disbursed the majority of the \$500 million to support programs that had previously experienced budget cuts. For example, \$250 million went to strengthen the primary care workforce, and \$70 million to local health departments for clinical prevention efforts such as responding to infectious disease outbreaks. In FY 2011, HHS received \$750 million from the Fund and distributed it as follows:

## Prevention Fund Distribution (National) FY 2010 & FY 2011



Thus combining the last two fiscal periods (FY 2010 & FY 2011), nearly \$1.25 billion was distributed to community-based and clinical prevention activities, public health infrastructure improvements, workforce development, and research and data collection. Georgia's share of the allocation was \$18.25 million.

## Prevention Fund Distribution (Georgia) FY 2010 & FY 2011



Given the nation's economic realities, the initial \$15 billion allocation for 10 years is being continually reexamined and in February 2012, passage of the Middle Class Tax Relief and Job Creation Act (Public Law 112-96), reduced the Fund's spending by 37.3% (\$6.25 billion) from FY 2013 to FY 2021.

In addition to these generalized funding cuts, other changes to program awards may occur in FY 2013. The Community Transformation Grants (CTG) program is proposed to be decreased by \$80 million, while both the Racial and Ethnic Approaches to Community Health (REACH) and the Preventive Health and Health Services Block Grant (PHHS) are proposed for complete elimination.

## Community-Relevant Grants and Awards in Georgia

Over the last two years, some program, grant, and demonstration awards were funded through the Prevention and Public Health Fund, and administered by the Centers for Disease Control and Prevention (CDC). Other awards, however, resulted from ACA appropriations which were administered through partner agencies of the HHS, e.g. Health Resources and Services Administration (HRSA). The table below attempts to capture community-relevant grants and awards made by these federal agencies to organizations throughout Georgia for this period.

As noted in the table, some community-based organizations were the primary or principal recipients of the federal award; in other cases, the organizations were secondary beneficiaries resulting from competitive bid processes initiated by the primary recipient agency. Some communities are also deriving “brick and mortar” benefit from capital improvement and building projects focused on community health centers and school-based clinics.

Table 2: Community-Relevant Grants and Awards in Georgia

| Grant Award  | Details  | Awardee  | Fiscal Year |
|--|--|--|-------------|
| Maternal, Infant, and Early Childhood Home Visiting (MIECHV) – Formula Award     | Support the expansion and implementation of home visiting programs that are part of comprehensive, high-quality early childhood systems in states.   | Principal: Georgia Department of Public Health - \$3,635,264   | 2011        |
| Maternal, Infant, and Early Childhood Home Visiting (MIECHV) – Competitive Award | Aimed at amplifying program efforts supported by the MIECHV formula grants program and other state resources; to be used to implement evidence-based home visiting programs and provide direct services to families and young children in need of support through state and community-level partnerships and collaborations.                     | Principal: Governor’s Office for Children and Families - \$2,527,954<br>Secondary: Prevent Child Abuse, Clarke Co.; Cordele Housing Authority, Crisp Co.; DeKalb Co. Gov., DeKalb Co.; Coastal Coalition for Children, Glynn Co.; City of Perry System of Care, Houston Co.; Columbus Consolidated Gov., Cooperative Extension Department, Muscogee Co.; Family Support Council, Inc., Whitfield Co. | 2011        |
| Community Transformation Grant (Large, Capacity-building)                        | Build capacity to support healthy lifestyles and reduce the impact of chronic diseases on the community. Collaborative efforts will focus on healthy eating, active living, tobacco-free environments, as well as quality preventive and clinical services.  | Principal: Cobb County - \$499,000   | 2011        |
| Community Transformation Grant (Small)   | Get Healthy West Georgia project focused on reducing rates of obesity, improving nutritional awareness, increasing physical activity, reducing tobacco use prevalence, and improving emotional well-being and overall mental health in three rural and underserved counties in West Georgia  | Principal: Tanner Medical - \$1,219,468  | 2012        |
| Family-to-Family Health Information Centers                                      | Establish community-based, family-staffed and operated centers that provide information to parents of children with disabilities and special health needs. This is done to assist decision making about care, promote good treatment decisions, increase cost-effectiveness, and improve health outcomes in the population of disabled children. | Principal: Parent to Parent of Georgia, Inc. - \$95,700  | 2012        |
| National Diabetes Prevention Program   | Demonstration award aimed at examining the impact of structured, evidence-based lifestyle change programs on preventing type 2 diabetes among people at high risk.   | Principal: YMCA of Coastal Georgia - \$50,000  | 2011        |

*Note: The information shared in this brief is based on the law as it is known at this time and is our best interpretation of the data. As the law is written into rules and regulations, it will be further interpreted. Details may change during this process.*

Table 2: Community-Relevant Grants and Awards in Georgia, *Continued*

| Grant Award  | Details  | Awardee  | Fiscal Year          |
|--|--|--|----------------------|
| Comprehensive Chronic Disease Prevention             | Increase access to healthy foods in communities around the state; increase efforts to create healthier places to live, work and play; promote physical activity and nutrition and reduce tobacco use and exposure; conduct demonstration projects to combat the obesity epidemic in Georgia; build community capacity around health improvement. | Principal: Georgia Department of Public Health - \$1,496,240<br>Secondary: Center for Pan Asian Community Services, Inc.; Georgia Academy of Pediatrics; Georgia Coalition for Physical Activity and Nutrition; Georgia State University; Georgia Institute of Technology; Project Open Hand-Atlanta                                       | 2011                 |
| Community Care Transitions Program                   | Collaboration between community-based organizations, social workers and hospital providers using recognized care transition tools and services to effectively manage transitions, provide discharged patients with self-care education, report process and outcome measures and reduce preventable re-hospitalizations.                          | Principal: Atlanta Regional Commission*<br>Secondary: Emory University Hospital Midtown; Gwinnett Medical Center; Piedmont Hospital; Southern Regional Hospital; WellStar Cobb Hospital; WellStar Kennestone Hospital<br><i>*CBOs are paid an all-inclusive rate per eligible discharge, based on the cost of care transition services</i> | 2012                 |
| Health Center Planning                               | Demonstration of need for health services in the community from public or non-profit organizations seeking a grant to plan for the development of a comprehensive primary care health center.  | Principal: East Georgia Health Cooperative (Washington) - \$79,631   | 2011                 |
| School-Based Health Centers Capital Program          | Addressing significant and pressing capital needs to improve delivery and support expansion of services at school-based health centers to improve access to health services for children at a school-based health center.  | Principal: Ware County Board of Education - \$345,710<br>Principal: Berrien County Collaborative - \$403,592<br>Principal: Meridian Education Resource Group, Inc. (DeKalb County) - \$500,000   | 2012<br>2011<br>2011 |
| Capital Development – Building Capacity Grant        | Enabling existing health centers to expand their facilities, improve existing services, and serve more patients.   | Principal: Neighborhood Improvement Project, Inc. (Augusta) - \$4,903,414<br>Principal: Oakhurst Medical Centers, Inc. (Stone Mountain) - \$5,000,000  | 2012                 |
| Capital Development – Immediate Facility Improvement | Providing existing health centers with the resources to address pressing facility and equipment needs.   | Principal: Albany Area Primary Health Care, Inc. - \$487,236<br>Principal: West End Medical Center, Inc. (Atlanta) - \$238,087<br>Principal: Curtis V. Cooper Primary Health Center, Inc. (Savannah) - \$500,000   | 2012                 |

### Developing a Framework for Adapting to the Changing Health Policy Environment

In the fall of 2010, Georgia Health Policy Center researchers conducted 15 health reform strategic assessments with community-based organizations, public health departments, state department staff, large and small provider practices, and large and small employers. Several strategic actions for implementing health reform evolved from the work. As communities continue to focus on health reform efforts related to community-based prevention, clinical prevention, infrastructure and workforce, and research and data collection, these actions can help leaders think about and develop a framework for adapting to the changing health policy environment.

## 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 advocacy groups, health providers, social service agencies, and associations to influence decisions. Decisions can be influenced through conversations with legislators, contributions to community forums, responses to government “requests for comments,” utilization of social media to share information, and convening diverse stakeholder groups.

## Staying Abreast of New Information and Educating Others

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. In addition, it is possible the provisions of the law itself might change. Adaptive thinkers must seek out the latest information related to the challenges they are facing. Community leaders and providers understand the ACA to varying degrees and at different levels, and those who do understand more about the law and its potential impact on their communities have the opportunity to educate others at the state and local levels. Community-based organizations can convene stakeholders in order to understand better how the ACA will impact potential partners, and identify the opportunities for improving the community’s health.

## Planning Under Uncertainty

Because the changes in the health reform law will take place over several years, community leaders are faced with the daunting prospect of making decisions and planning strategically without complete information. Some ideas to help 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.

## Creating New Partnerships

Some of the partnerships needed to implement health reform will include multi-stakeholder coalitions of public and private sector providers, businesses, state and local government authorities, social service organizations, and others. Effectively forging such partnerships requires a neutral, respected convener, a role that might be played by some CBOs. A major opportunity collaboration is the ACA requirement for not-for-profit hospitals to conduct community health needs assessments. Local health departments and community-based organizations can partner with hospitals to conduct these assessments, and also coordinate the implementation of plans to address community benefit needs of the hospitals and health improvement and social service needs of the community. Another opportunity is to serve a role in post-discharge care coordination in partnership with hospitals.

## Building Workforce Capacity

When health reform is fully implemented, there will likely be an increased demand for primary care and other health providers. Meeting the workforce shortfall may require incentives to retain providers in needed locations, initiatives to ensure the workforce pipeline, and better utilization of the current workforce. This also means training a workforce that is culturally competent and able to effectively provide care to individuals with complex health care and social service needs. One concern of particular importance for service organizations and safety net providers is the need to assist patients in understanding and accessing the health care system. Community health workers, patient navigators and others in a clinic extender role are important to ensuring that traditionally underserved and vulnerable populations get an appropriate source of coverage and are connected to care.

## Building Information Technology Capacity

The ACA will stimulate demand for electronic records and other health data and increasingly require complex data sharing systems. The most likely information technology capacity needs related to the ACA will involve designing or purchasing patient and clinical management systems, sharing data among systems, building systems that can accommodate the anticipated increase in volume of claims and provider information, and developing data system standards for health. Community-based, collaboratives might help to improve quality of care at the population level by creating community-level standards of care for chronic disease management and enhancing information linkages across local and state health systems and activities.

## 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; 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, and obtain the technical ability to collect information. Community agencies do not have to actually deliver the services, but they can create, facilitate and monitor community-wide strategies that make it easier for individuals to get screenings, vaccinations, and other health and social services in places convenient for them.

## Conclusion

The ACA has provided significant funding opportunities to support community-based organizations. In addition to taking advantage of these funding opportunities, communities must also be able to navigate through uncharted territory and be willing to adapt to their changing environment. Community leaders must learn as they go, making sense of what is happening as it unfolds and adjusting accordingly.