LEADING THROUGH HEALTH SYSTEM CHANGE

Planning TOOL

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

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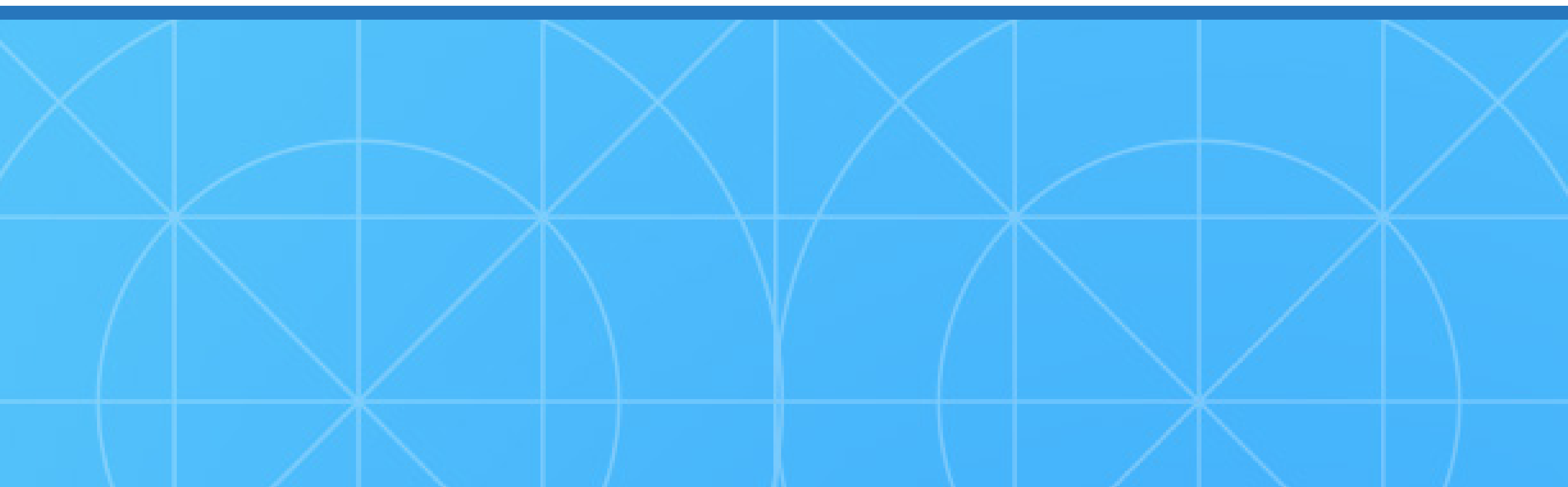


Introduction

USING THIS PLANNING TOOL

This interactive tutorial and planning tool is designed to assist you in thinking about the legal, administrative, and financial challenges facing your organization as a result of health system transformation. Through the information and guided practices provided in this tool you will learn skills to help you plan for the future of public health.

The process will likely require four to eight hours of time over a period of a week or two to complete a guided practice. You may work as an individual or as part of a team. Bring in whatever data you think you will need to respond to the questions.

This is a planning tool intended to heighten learning capacity and leadership skills in relation to health reform and health system transformation. Central to the tool are two key components. The first is a five-step planning process. The steps in this process are key to helping leaders focus on the actions that lead to innovation and strategic thinking. The second is understanding the difference between technical and adaptive challenges and how applying adaptive thinking skills can help you respond flexibly as the health care landscape continues to evolve.

The tutorial and planning tool you are about to use is designed using a guided-practice approach. Rather than simply providing you with the tool and instructions, you will be guided through examples where much of the background work has been done for you. You or your team will still have to provide 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 complete another, or use the five-step process to apply it to your own unique question.

HEALTH REFORM 101

A common understanding about the key provisions of the Affordable Care Act (ACA) will facilitate planning for the future of public health. 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 the following framework — Health Reform 101 — to educate others about the ACA. It includes sources of health care coverage, funding and spending, the major components of change, and a timeline for the implementation of key provisions.

SOURCES OF HEALTH CARE COVERAGE

Nonelderly Americans obtain health insurance through their employer, individual private insurance, Medicaid/Children's Health Insurance Program (CHIP), other [Medicare (disabled or end-stage renal patients), Champus, CHAMPVA (coverage for armed forces and veterans' families), and Indian Health Services], or they remain uninsured. The expansion of both public and private coverage through the ACA insured approximately 19 million more Americans in 2015 and is expected to insure up to 27 million Americans by 2022.[1] Major changes have already occurred with the addition of health insurance Marketplaces and the expansion of Medicaid in the 31 states and the District of Columbia (as of December 3, 2015[2]) that have chosen to do so. As of 2015, 12 million individuals had been covered through Marketplaces, and 11 million had been covered by Medicaid/CHIP.[3]

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 individual insurance off the Marketplace, 9% will be covered through health insurance Marketplaces, and 19% will be covered by Medicaid, depending on individual state decisions.[4]

SPENDING AND SOURCES OF REVENUE

The Congressional Budget Office estimates that spending related to the ACA will be approximately $1.35 trillion over a decade.[5] The largest share of the costs will fund individual subsidies in the health insurance Marketplaces and the expansion of Medicaid coverage. In order for health reform to remain deficit neutral, new revenues must be generated. Revenue sources include savings in Medicare (e.g., reductions to annual payment updates and changes in the calculations for Medicare Advantage plans) and new taxes, fees, and penalties (e.g., fees for medical devices and insurers, fines and 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 (HIEs) (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

Federal eligibility for Medicaid programs has been expanded to include all Americans up to 133% of the federal poverty level (FPL) in states that choose to expand Medicaid coverage. The expansion could 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 Medicaid expansion was 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. CBO estimates that the law will result in approximately $920 billion in new federal spending over the next 10 years to pay for the expansion of Medicaid.[6] As of 2015, 31 states (including Washington, D.C.) have adopted Medicaid expansion, seven of which have done so through Section 1115 waivers.[7] However, it should be noted that the June 28, 2012, Supreme Court decision found that states, without penalty, could choose not to expand 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 created a temporary high-risk pool as a bridge to provide a way to obtain coverage until other insurance market reforms are fully implemented. In addition, it mandated the creation of health insurance Marketplaces, 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 Marketplaces 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. As of 2016, there were 13 state-based Marketplaces, four federally supported state Marketplaces (state-based, but using the federal information technology platform), seven state-partnership Marketplaces, and 27 federally facilitated Marketplaces.[8]

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 also focus on decreasing the overall cost of health care.

INCREASED FOCUS ON PREVENTION AND WELLNESS

Efforts to improve population health and well-being are coordinated by a national council, guided by the first-ever national prevention strategy and sustained by a dedicated prevention fund. Improvements to individual health are supported by research and innovation and implemented through insurance coverage requirements and state and community programs. Wellness and prevention services and research expanded to focus on physical activity, nutrition, emotional wellness, smoking cessation, and other chronic disease priorities. Medicare and newly qualified plans are required to provide a range of recommended preventive and wellness services in their qualified health plans, and employers are permitted to incentivize employee participation in wellness programs. State and local agencies have been 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.

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. The changes leaders are likely to have to manage require a more adaptive response rather than a technical response.

Marty Linsky and Ronald Heifetz, leaders in the field of management consulting, have written extensively about the differences between technical and adaptive challenges. While their teachings have not previously been used in the context of health, this planning tool employs Linsky and Heifetz's theory on adaptive leadership to provide a framework for the role public health leaders 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

Health reform presents both types of challenges for public health leaders. Some are routine and lend themselves to technical responses, while others are adaptive and require planning, building partnerships, gathering information, and building capacity of various types. 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."[9]

Public health leadership requires a diagnostic capacity that identifies the forces at play that constantly shape health reform and health transformation. These include legal, administrative, and financial forces, among others.

Referring to his work in psychiatry, Heifetz said,

> "When a person comes to you with a problem, it's not your job actually to solve their problem. It's your job to develop their capacity to solve their own problem."[10]

Similar to Heifetz's reference to his own work, this planning tool is designed to develop the capacity to solve the challenges facing you as the health and health care landscape continues to evolve. In the next section, you will begin to put adaptive thinking into action.

PUTTING ADAPTIVE THINKING INTO ACTION

In this section, you will practice using adaptive thinking to address questions related to health reform by working through three example questions. These examples were drawn from peer-reviewed literature, white papers, and expert review and reflect key issues that public health may face as health and health care evolve and change. 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 all the way through one question, you should be able to use the same process to address any challenge you may have that does not have a ready-made solution. The steps in the process are:

STEP 1: DEFINE A QUESTION.

What is it that you want to know? Is the question unique to the organization or do you think it might apply to others? Is this a priority issue for the organization?

STEP 2: COLLECT INFORMATION ABOUT THE QUESTION.

What exactly is written in the ACA? You may need to go directly to the law's text or read what others have written. Gathering information from the law is one place to start, and you may need to collect additional information that is important for the local context. Are there new approaches or ways of thinking about the question that may extend your thinking?

STEP 3: THINK ABOUT FEASIBLE OPTIONS.

Once you have reviewed relevant information about the question, you will be better prepared to think about possible ways you could address it. With new information, you will be prepared to reframe the question from a more adaptive perspective. Then, you can think about options to address it. The options may range from the more technical to the more adaptive.

STEP 4: APPLY ADAPTIVE ACTIONS.

With the question reframed from an adaptive perspective, you will be ready to think about action. The planning tool describes eight adaptive actions you might apply to the challenge. By considering each of the adaptive actions, you will be training yourself to consider a much wider range of response than if you remained in a technical mindset.

STEP 5: CREATE AN IMPLEMENTATION PLAN.

With adaptive actions considered, this step will assist you in thinking about a simple yet concrete way to move forward related to staffing, budgeting, and developing a management plan in the context of how you choose to answer the question. Completing this step enables you to record an approach for moving the solution to your challenge from abstract ideas to action.

Introduction: Bibliography

[1] CBO. (2015). "Insurance Coverage Provisions of the Affordable Care Act — CBO's January 2015 Baseline." Retrieved January 11, 2016, from https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-01-ACAtables.pdf.

[2] Kaiser. (January 12, 2016). "Status of State Action on the Medicaid Expansion Decision." Retrieved January 14, 2016, from http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[3] CBO. (2015). "Insurance Coverage Provisions of the Affordable Care Act — CBO's January 2015 Baseline." Retrieved January 11, 2016, from https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-01-ACAtables.pdf.

[4] Custer, W. S., Ph.D. (2013). Center for Health Services Research, Institute of Health Administration, J. Mack Robinson College of Business, Georgia State University.

[5] CBO. (2015). "Insurance Coverage Provisions of the Affordable Care Act — CBO's January 2015 Baseline." Retrieved January 11, 2016, from https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-01-ACAtables.pdf.

[6] Ibid.

[7] Kaiser. (January 12, 2016). "Status of State Action on the Medicaid Expansion Decision." Retrieved January 14, 2016, from http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[8] Kaiser. (2016). "State Health Insurance Marketplace Types, 2016." Retrieved January 14, 2016, from http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/.

[9] Heifetz, Ronald A., and Linsky, M. (2004). When Leadership Spells Danger. Educational Leadership. 61.7 (April 2004: 33-37).

[10] NPR. (2013). Lessons in Leadership: It's Not About You. (It's about them). Retrieved February 25, 2016, from http://www.npr.org/2013/11/11/230841224/lessons-in-leadership-its-not-about-you-its-about-them.

Guided Practice 1

STEP 1: Define a question.

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

STEP 2: Collect information about the question.

For the guided-practices, the following information has been collected for you.

OVERVIEW

In addition to covering up to 19 million more Americans in 2015 (up to 27 million Americans by 2022) and mandating the coverage of certain benefits, the Affordable Care Act (ACA) is anticipated to improve access to existing services and usual sources of care.[11] However, challenges remain, even after the ACA has largely been implemented. Access barriers to both coverage and care still exist for certain groups. In some areas, particularly rural parts of the country, the supply of primary care providers, limited provider networks of Marketplace health plans, and hospital closures may make timely access to care difficult to achieve.[12] Consequently, there is likely to still be a role for clinical public health services beyond the ACA's full implementation, including safety net services, high-value public health services (e.g., direct observed therapy for TB, HIV screening and partner notification, immunizations), enhanced public health services (e.g., patient navigators), and linked public health services (e.g., diabetes prevention programs, tobacco cessation).

MINIMUM COVERAGE

The ACA extends coverage to new services. A package of essential health benefits is required of all new plans.

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.[13]

Children's dental services are required of plans offered in the insurance Marketplaces.[14] Tobacco cessation services are 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 were 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, vaccinations recommended by the Advisory Committee on Immunization Practices, Bright Futures recommendations of the American Academy of Pediatrics, and preventive services guidelines for women supported by the Health Resources and Services Administration (HRSA), all without paying a copayment, coinsurance, or deductible.[15]

Medicare beneficiaries are also included in many of the preventive services requirements,[16] and they are also eligible for an annual wellness exam that includes a personalized health risk assessment.[17]

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.[18] Although Medicaid expansion is a state decision, the ACA has provided the potential to expand coverage to millions more Americans, and individuals with new coverage will be able to take advantage of mandated preventive services.

CHANGING ROLES FOR PUBLIC HEALTH

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 directly provide, contract for, or bill for clinical services. Some state public health departments, such as Georgia's Department of Public Health, have created billing resource manuals to assist public health providers in navigating the enrollment and billing process.[19]

NACCHO also suggested that local health departments consider applying to become a "public entity" federally qualified health center (FQHC) or pursue partnership opportunities with FQHCs, such as colocation of services, referrals, or purchase of services. Additionally, the de Beaumont Foundation, Duke Community and Family Medicine, and the Centers for Disease Control and Prevention (CDC) have developed and made available online a "Practical Playbook" supporting greater collaboration between public health and primary care. The Practical Playbook provides a variety of resources to guide public health departments and primary care providers in their pursuit of partnership opportunities, such as FQHC colocation, Accountable Care Organizations (ACOs), and hospital partnerships grounded in community health needs assessments (CHNAs).[20]

ADVANTAGES OF ACCESS

Because the individual mandate, Marketplace, Medicaid expansion, and other components of the ACA critical to greater access were not implemented until 2014, the research on health care access and utilization as a result of the ACA is still emerging. However, early research indicates that, post-ACA, access to health care services has increased for many. A national study in 2014, utilizing the Gallup-Healthways Well-Being Index and initial Department of Health and Human Services Medicaid and Marketplace enrollment statistics, found that insurance uptake resulted in significant increases to access, including increased likelihood of having a personal doctor and decreased inability to afford medical care.

Additionally, significant insurance coverage gains were found for persons eligible for Medicaid expansion, those eligible for Marketplace tax subsidies, as well as groups with high baseline uninsured rates, such as young adults and Hispanics.

Another national study using CDC's National Health Interview Survey data found that adults ages 19-25 and 26-34 experienced significant decreases in delayed and foregone care, resulting largely from better insurance cost and coverage due to the ACA.[21]

ACCESS CHALLENGES

Even with the increased availability of insurance, several groups may continue to have challenges in accessing coverage or services. A 2009 study of the Massachusetts health care expansion found that about 20% 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.[22] Although utilization has not yet surged post-ACA, it has been predicted that increased coverage will eventually

result in similar access problems.[23] Additionally, in order to keep premiums low, many Marketplace health plans have created narrower provider networks, often leaving out key doctors and hospitals in their region.[24] Others may simply fail to enroll for coverage due to bureaucratic barriers,[25] in spite of the existence of insurance "navigators" created by the ACA to facilitate Marketplace health plan enrollment.[26]

In the short run, the need for a range of preventive services will not go away, and if primary care providers are unable to meet the demand, hospitals may shoulder the burden in the face of pending payment cuts. 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.[28]

If behaviors are similar post-ACA, hospitals, already facing the ACA's reductions to their annual disproportionate share hospital (DSH) funding (originally $20 billion by 2020; subsequent legislation has since delayed and revised this amount to $43 billion from 2018 to 2025),[29] may find themselves unable to fill in the service gaps. Moreover, unless the Centers for Medicare and Medicaid Services develops a DSH reduction methodology that accounts for differences between Medicaid expansion and nonexpansion states, many public hospitals that are highly dependent on DSH payments[30] may be particularly vulnerable to the cuts in states where Medicaid is not expanded and a larger number of uninsured remain.[31]

Thus, even post-ACA, public health may need to continue its role in ensuring access to safety net services.[32]

As a public health leader, how does the context in which you work relate to what is described about clinical services? Enter your observations below. Some questions are provided to get your thinking started.

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

- How does the context in which you work relate to what is described about clinical services?
- 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? Will there be a market for these services?
- Are you in a Medicaid expansion state?
- Are you in a health professional shortage area?
- 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 the Analysis.

There are likely many options related to the role public health will play in the provision of clinical services. Approaching the question from a technical perspective might lead one to simply think about whether or not the organization will provide clinical services and how much funding will be available from various sources to provide them in the future. A more adaptive way to approach the 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?"

The three options below will help you think about how you might approach the question about clinical services. In practice, you might 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.

1 | **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 2015 paper in the American Journal of Public Health, as of 2013, a minority of local health departments provided clinical services such as maternal and child health, oral health, and HIV/AIDS treatment, although a 2014 report showed that, of those who do, the majority bill some form of third-party payment.[33] For those local health departments that do provide clinical 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 financial systems might be needed?

EXAMPLE:

The Maricopa County Department of Public Health has a service area of more than 4 million individuals but is one of the least resourced health departments of its size in the United States. The Arizona Partnership for Immunization began working on behalf of health departments such as the Maricopa County Health Department to create the infrastructure to bill for immunizations in 2008. During the first partial year of billing in 2013, the Maricopa County Department of Public Health was successful in receiving $366,688 in reimbursements after spending $301,682 on vaccines.

2 Option 2: Assume a lead role in ensuring access to clinical services without being the primary provider of those services.

Linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable is one of the 10 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 insurance Marketplaces. You 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 Nebraska Public Health Solutions District Health Department, along with six critical-access hospitals within the district, created the Healthy Pathways program to provide low-cost alternatives for care, assist with self-care, and decrease admissions to emergency rooms. Healthy Pathways is a comprehensive program that uses a holistic approach to ensure individuals have the tools and resources necessary to manage and improve health. The program provides case management services to link individuals with the necessary health care resources including, but not limited to, assistance with applications for government assistance, when applicable.

- https://www.ruralhealthinfo.org/community-health/care-coordination/files/public-health-solutions-provider-brochure.pdf
- http://phsneb.org/wp-content/uploads/2015/06/Annual-Report-01.13.16-FINAL-version.pdf

3 Option 3: Consider building on the strengths of public health practice to guide the development of patient-centered medical homes (PCMHs).

According to the Agency for Healthcare Research and Quality, a PCMH 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.

EXAMPLE:

In 2013, the Vermont Department of Health spearheaded a specialty opiate treatment PCMH program. The program, called “Hub and Spoke,” has a component that provides specialty care for substance abuse and co-occurring mental health disorders known as “hubs” and facilities that provide step-down treatment such as counseling. In 2014, the Department of Vermont Health Access reviewed claims data of Medicaid participants in hub programs and predicted that continued investment in the hub program will save Medicaid dollars by decreasing costs in areas such as residential treatment and independent lab work.

- http://healthaffairs.org/blog/2015/12/08/not-your-usual-suspects-roles-for-state-agencies-in-pcmh-payment-reforms/
- http://vtdigger.org/2014/03/20/addiction-treatment-hubs-save-money-state-says/

Which of the three options is the best strategy for your organization over the next three to five years? Why? Enter your observations and rationale below.

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 ensuring access to clinical services without being the primary provider of those services in your area.
- ☐ **OPTION 3:** Consider building on the strengths of public health practice to guide the development of patient-centered medical homes (PCMHs).

Why is this option your preferred choice as you think ahead three to five years?

STEP 4: Apply Adaptive Actions

The ACA presents many 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 staff, community-based organizations, hospitals, large and small provider practices, and large and small employers.[34] Eight priority strategic actions emerged from the work that can be applied here to help you think about challenges with which you are faced.

INFLUENCING DECISIONS

Many decisions for implementing health reform continue to occur at the state level. Although many of those decisions have been made over the past few years, there is still 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 who understand more about the law and its potential impact on public health have the opportunity to educate others. The opportunity exists for public health, as a leader, to play a role in convening stakeholders to 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 effects of the health reform law continue to unfold and the impacts will not be known for several years, public health leaders are faced with a daunting prospect of continuing to have to make decisions without complete information. In addition, they are acutely aware that the provisions of the law itself might change over time. 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 future scenarios and then using them as a foundation for planning; pursuing good ideas, even in the absence of certainty; 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 law, 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. Adaptive thinkers must seek out the latest — even imperfect — information related to the challenges they are facing. Sources of information related to the ACA include the Federal Register, national association websites, www.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 even more important.

CREATING NEW PARTNERSHIPS

New partners are critical to the success of health reform. Some of the partnerships needed to implement health reform 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, ideally, will not directly benefit from the partnership.

BUILDING WORKFORCE CAPACITY

The elimination of copays, deductibles, and coinsurance for many preventive services will likely drive demand for providers in both the public health and private health care workforces. Particularly for the public health workforce, this will depend on the various health reform opportunities public health agencies pursue.[35] 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, technology training and education, and better utilization of the current workforce, including reorganizing provider teams and considering new types of providers.

BUILDING INFORMATION TECHNOLOGY CAPACITY

The ACA will further stimulate demand for electronic health records and other health data that require complex data-sharing systems. Information technology (IT) needs and requirements vary across institutions and reflect the idiosyncratic nature of organizations. The most likely IT capacity needs related to the ACA will involve designing or purchasing 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.

BUILDING CARE COORDINATION CAPACITY

The ACA has 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 administrative requirements, be able to link different types of care, 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's context relates to the provision of clinical services, you have selected an option for moving forward, and you have documented why that option makes sense for your organization. Now you will think through potential 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 ensuring 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 PCMHs.

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 the question? • Who can you engage to influence those decisions?	

EDUCATING OTHERS: • Who needs to know about how the particular challenge relates to health reform or health transformation? • What are the facts? • How will you communicate them?	
PLANNING UNDER UNCERTAINTY: • What are the most likely future scenarios given what you know, and how can you use them as a foundation for planning?	
STAYING ABREAST OF NEW INFORMATION: • How will you systematically learn of changes related to the ACA and health transformation? • What partnerships can you leverage to do this?	
CREATING NEW PARTNERSHIPS: • What new partnerships might advance the strategy? • Who can serve as a neutral convener of these new partnerships?	
BUILDING WORKFORCE CAPACITY: • Will you need new types of professionals to achieve your goals? • How can you ensure there will be sufficient workforce capacity?	

BUILDING IT CAPACITY: • What sort of IT capacity will you need to achieve the 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 needed? • What professional certifications will be required?	

STEP 5: Create an Implementation Plan

The last step in thinking adaptively about questions related to health reform and health transformation is to create a plan in order to move into action. Thinking about three fundamental components will help you gain clarity about what is feasible: staffing, budget and funding strategy, and a management plan.

STAFFING

The staff responsible for program implementation and the partners who provide program guidance are key to 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 you want to initiate. Most likely, you will want someone from outside the organization to facilitate the conversation.

Some questions that may help you think about staffing include these:

- What expertise is needed to initiate this activity?
- Can some of the activities be absorbed by partners?
- Can any activities be undertaken by volunteers rather than paid staff?
- What paid staff will be necessary to initiate the activities?
- Who will employ the staff?
- Are there any union bargaining rules that must be considered?

BUDGET AND FUNDING STRATEGY

Having a clear idea of the cost of building or sustaining the activities is an essential part of the implementation planning process. You may want to project the costs for a minimum of three years to obtain a complete picture of the total cost of the activity, including one-time cash expenditures, ongoing operational expenses, etc. Developing a line item budget for each activity is necessary for determining the 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 and supporters for the 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. Remember that many activities are sustained through partnerships. As a part of the sustainability planning process, you should discuss the role that partners can realistically play in the long-term support of the actions.

MANAGEMENT PLAN

How you manage new activities and the staff and partners who will undertake them is an important part of the implementation plan. Some questions that will help you start thinking about a management plan include these: What has worked well in managing the current activities and relationships? What could be improved? What management functions will be required of the 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 existing staff or undertaken by partners?

The last step in thinking adaptively about questions related to health reform is creating an implementation plan for the option you have chosen. You will create an 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?

Staffing
• What expertise is needed to initiate this activity? • Can some of the activities be absorbed by partners? • Can any activities be undertaken by volunteers rather than paid staff? • What paid staff will be necessary to initiate the activities? • Who will employ the 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 the possible funding sources?
- What community partners can be approached for direct or indirect support?

Management Plan

- What has worked well in managing current activities and relationships?
- What could be improved?
- What management functions will be required of the 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 staff or undertaken by partners?

You have now completed the five steps that will help shift your thinking from technical to adaptive. The steps are:

STEP 1: Define a question.

What is it that you want to know? Is the question unique to the organization or do you think it might apply to others? Is this a priority issue for the organization?

STEP 2: Collect information about the question.

What exactly is written in the ACA? You may need to go directly to the law's text or read what others have written. Gathering information from the law is one place to start, and you may need to collect additional information that is important for the local context. Are there new approaches or ways of thinking about the question that may extend your thinking?

STEP 3: Think about feasible options.

Once you have reviewed relevant information about the question, you will be better prepared to think about possible ways you could address it. With new information, you will be prepared to reframe the question from a more adaptive perspective. Then, you can think about options to address it. The options may range from the more technical to the more adaptive.

STEP 4: Apply adaptive actions.

With the question reframed from an adaptive perspective, you will be ready to think about action. The planning tool describes eight adaptive actions you might apply to the challenge. By considering each of the adaptive actions, you will be training yourself to consider a much wider range of response than if you remained in a technical mindset.

STEP 5: Create an implementation plan.

With adaptive actions considered, this step will assist you in thinking about a simple yet concrete way to move forward related to staffing, budgeting, and developing a management plan in the context of how you choose to answer the question. Completing this step enables you to record an approach for moving the solution to your challenge from abstract ideas to action.

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 an easier, technical solution.

Guided Practice 1: Bibliography

[11] CBO. (2012). "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision." Retrieved January 14, 2016, from https://www.cbo.gov/publication/43472.

[12] Associated Press (2014) "Health law impacts primary-care doc shortage," Goodman, L. J. and Norbeck, T. (2014) "Affordable Care Act Fails to Address Physician Shortages — Here's How We Can Better Deal with This Challenge," Glied, S. and Ma, S. (2015). How Will the Affordable Care Act Affect the Use of Health Care Services? The Commonwealth Fund, Smith, M. and Goodnough, A. (2015) "Closing a Hospital, and Fearing for the Future."

[13] Kaiser. (2010). "Impact of Health Reform on Women's Access to Coverage and Care." Retrieved January 14, 2016, from https://kaiserfamilyfoundation.files.wordpress.com/2012/03/7987-03-health-reform-implications-for-women_s-access-to-coverage-and-care.pdf, Wechsler, J. (2010). "Health reform expands drug coverage, supports outcomes research." Formulary 45(5): 168169.

[14] Sparer, M. (2011). "US Health Care Reform and the Future of Dentistry." American Journal of Public Health 101(10): 1841-1844.

[15] Flowers, L., and Nonnemaker, L. (2010). Improvements to Medicare's Preventive Services under Health Reform. Washington D.C., AARP Public Policy Institute, Thorpe, K., and Philyaw, M. (2010). "Impact of health care reform on medicare and dual medicare-medicaid beneficiaries." The Cancer Journal 16(6): 584-587, Virgo, K., Burkhardt, E., Cokkinides, V., and Ward, E. ibid. "Impact of health care reform legislation on uninsured and medicaid-insured cancer patients." 577-583, Lavarreda, S. A., Brown, E. R., and Bolduc, C. D. (2011). "Underinsurance in the United States: An Interaction of Costs to Consumers, Benefit Design, and Access to Care." Annual Review of Public Health 32(1): 471-482, Pollack, H. (2011). "Health Reform and Public Health: Will Good Policies but Bad Politics Combine to Produce Bad Policy?" University of Pennsylvania Law Review 159(6): 2061-2081, Shortridge, E., Moore, J., Whitmore, H., O'Grady, M., and Shen, A. (2011). "Policy implications of first-dollar coverage: a qualitative examination from the payer perspective." Public Health Reports 126(3): 394-399.

[16] Flowers, L., and Nonnemaker, L (2010). Improvements to Medicare's Preventive Services under Health Reform. Washington, D.C., AARP Public Policy Institute, Thorpe, K., and Philyaw, M. (2010). "Impact of health care reform on Medicare and dual Medicare-Medicaid beneficiaries." The Cancer Journal 16(6): 584-587.

[17] Kaiser. (2010). "Impact of Health Reform on Women's Access to Coverage and Care." Retrieved January 14, 2016, from https://kaiserfamilyfoundation.files.wordpress.com/2012/03/7987-03-health-reform-implications-for-women_s-access-to-coverage-and-care.pdf, CDC. (2011). "A Framework for Patient-Centered Health Risk Assessments." Retrieved January 14, 2016, from http://www.cdc.gov/policy/hst/hra/index.html.

[18] Cogan, J. (2011). "The Affordable Care Act's preventive services mandate: breaking down the barriers to nationwide access to preventive services." The Journal of Law, Medicine & Ethics 39(3): 355-365.

[19] Georgia Department of Public Health (December 2013). Public Health Billing Resource Manual.

[20] de Beaumont Foundation, Duke Community and Family Medicine and the Centers for Disease Control and Prevention. (2014). "Practical Playbook." Retrieved February 3, 2016, from https://www.practicalplaybook.org/about.

[21] Sommers, B., et. al., (2013). "The Affordable Care Act has led to significant gains in health insurance and access to care for young adults." Heatlh Affairs 32: 165–174, Monaghan, M. (2014). "The Affordable Care Act and implications for young adult health." Transl Behav Med 4(2): 170-174.

[22] Long, S., and Masi, P. (2009). "Access and affordability: an update on health reform in Massachusetts, fall 2008." Health Affairs 28(4): W578-W587.

[23] Goodman, J. (June 25, 2015). "Six problems with the ACA that aren't going away," from http://healthaffairs.org/blog/2015/06/25/six-problems-with-the-aca-that-arent-going-away/.

[24] Ibid.

[25] Sommers, B. D. (2007). "Why millions of children eligible for Medicaid and SCHIP are uninsured: poor retention versus poor take-up." Health Affairs 26(5): W560.

[26] Jacobi, J., Watson, S., and Restuccia, R. (2011). "Implementing health reform at the state level: access and care for vulnerable populations." The Journal of Law, Medicine & Ethics 39 Suppl 1(1): 69-72.

[27] Jacobson, P., and Jazowski, S. (2011). "Physicians, the Affordable Care Act, and primary care: disruptive change or business as usual?" Journal of General Internal Medicine 26(8): 934-937.

[28] Patel, K., and McDonough, J. (2010). "From Massachusetts to 1600 Pennsylvania Avenue: aboard the health reform express." Health Affairs 29(6): 1106-1111.

[29] MACPAC. (2016). "Disproportionate share hospital payments." Retrieved February 3, 2016, from https://www.macpac.gov/subtopic/disproportionate-share-hospital-payments/.

[30] Smulowitz, P., Lipton, R., Wharam, J. F., Adelman, L., Weiner, S., Burke, L., et al., (2011). "Emergency department utilization after the implementation of Massachusetts health reform." Annals of Emergency Medicine 58(3): 225-234.

[31] MACPAC. (2016). "Disproportionate share hospital payments." Retrieved February 3, 2016, from https://www.macpac.gov/subtopic/disproportionate-share-hospital-payments/.

[32] Landers, G. M. (2016). "Whether Health Departments Should Provide Clinical Services After the Implementation of the Affordable Care Act." American Journal of Public Health(0): e1-e2.

[33] Landers, G. M. (2016). "Whether Health Departments Should Provide Clinical Services After the Implementation of the Affordable Care Act." American Journal of Public Health(0): e1-e2

[34] GHPC. (2001). Health Reform, From Insights to Strategies, A Variety of Perspectives. Atlanta, GA, Georgia State University: 44.

[35] Wilson, J. F. (2008). "Primary Care Delivery Changes as Nonphysician Clinicians Gain Independence." Annals of Internal Medicine 149(8): 597-600, Long, S., and Masi, P. (2009). "Access and affordability: an update on health reform in Massachusetts, fall 2008." Health Affairs 28(4): W578-W587, Hunsaker, M., and Kantayya, V. S. (2010). "Building a Sustainable Rural Health System in the Era of Health Reform." Disease-a-Month 56(12): 698-705, Kapp, M. (2011). "Conscripted physician services and the public's health." The Journal of Law, Medicine & Ethics 39(3): 414-424, Pande, A., Ross-Degnan, D., Zaslavsky, A., and Salomon, J. (2011). "Effects of Healthcare Reforms on Coverage, Access, and Disparities: Quasi-Experimental Analysis of Evidence from Massachusetts." American Journal of Preventive Medicine 41(1): 1-8, Paradise, J. (2011). Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants. Washington, D.C., Kaiser Commission on Medicaid and the Uninsured, HRSA. (2015). "Shortage Designation Homepage." Retrieved January 14, 2016, from http://www.hrsa.gov/shortage/.

Guided Practice 2

STEP 1: Define a question.

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

STEP 2: Collect information about the question.

USE OF HEALTH INFORMATION

The American Recovery and Reinvestment Act of 2009 (ARRA) created a number of opportunities and requirements for providers around the use of electronic health records (EHRs), including setting meaningful use standards and encouraging participation in health information exchange (HIE). Meaningful use of EHRs is intended to improve patient care by increasing quality, safety, efficiency, and reducing health disparities; engaging patients and families in their health care; improving care coordination; and improving population and public health.[36] HIE, driven by meaningful use of health information technology (HIT), hopes to improve health care quality, efficiency, and safety by enabling the sharing of patient-level data among diverse health care participants.[37]

The Affordable Care Act (ACA) builds upon ARRA's meaningful use of HIT by directing the secretary of the Department of Health and Human Services (HHS) to integrate quality-of-care measures into provider EHR meaningful use reporting, and prioritize grants and contracts for those who develop quality measures incorporating meaningful use.[38] The ACA also encourages meaningful use of HIT through its support of new health service models such as Accountable Care Organizations (ACOs) and patient-centered medical homes, which utilize EHR and data-sharing to improve quality of care, efficiency of services, and patient health. Ultimately, meaningful use of HIT among providers should help to further the ACA's overall goal of improving population health.

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.[39]

National Association of County and City Health Officials (NACCHO) calls for health departments to adopt EHRs and work to expand HIE between health departments and health care providers to meet the goals and requirements of the ACA.[40]

PUBLIC HEALTH AND HEALTH INFORMATION EXCHANGE

Preliminary suggestions for measuring the impact of HIE on public health in specific cases include:

- Reporting laboratory diagnoses,
- Reporting physician-based diagnoses,
- Public health investigation,
- Antibiotic-resistant organism surveillance,
- Disease-based nonreportable laboratory data, and
- Population-level quality monitoring.[41]

Prevention may be a key area where public health converges with the promise of HIE. Data may help agencies identify when an intervention needs to be performed and support evaluation of the impact of that intervention.[42]

LEADERSHIP

Health departments are well positioned to provide leadership in building local capacity for electronic HIE. 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 HIE to support these functions and services is reinforced by meaningful use and the ACA's population health objectives. As trusted leaders in population health, public health departments might leverage their role in the community to convene and engage providers in HIE.

MEASURING IMPACT

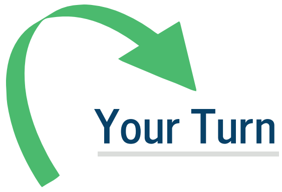
Health departments will likely have the opportunity to play an enhanced role in measuring the impacts of community-driven strategies and policy changes. A presentation at the 2011 American Public Health Association Annual Meeting by the Institute of Medicine, provided an overview of two reports. *Measurement 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 multicomponent 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 examined potential cost savings achievable through modest reductions in the prevalence of several diseases associated with 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

In addition to helping to further ACA population health goals, health departments' involvement in developing and using HIT can substantially improve their ability to meet recently developed accreditation and performance standards.[44] 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.



As a public health leader, how does the context in which you work relate to what is described about the surveillance and monitoring of health status? Enter your observations below.

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

- How does the context in which you work 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 the Analysis.

There are likely many options related to the role public health could play in the surveillance and monitoring of health status. Approaching the question from a technical perspective might lead one to simply think about what surveillance functions one might continue to provide and how much funding will be available 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, ACOs, health insurance exchanges, and others as a result of new opportunities made available through health reform?"

The three options below will help you think about how you might approach the question about surveillance. In practice, you might 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.

1 | **Option 1:** Continue to provide basic public health surveillance functions, but align information technology (IT) 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 through the ACA. However, many public health departments face the reality 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 IT capacity, and some of these partnerships may be in the private sector.

EXAMPLE:

The California Reportable Disease Information Exchange (CalREDIE) is an electronic surveillance and reporting system utilized by six branches within the Division of Communicable Disease Control (DCDC) at the California Department of Public Health (CDPH), local health departments (LHDs), health care providers, and public and private laboratories. Its main objective is to make disease reporting, investigation, and tracking more efficient for LHDs. CalREDIE automates the reporting process by eliminating the need to send data to CDPH because of the shared, centralized database. Nearly all reportable communicable diseases can be reported through the CalREDIE system in real time. In 2012, CalREDIE was awarded one of e.Rupublic's Center for Digital Government Best of the Web and Digital Government Achievement Awards.

- http://www.cdph.ca.gov/data/informatics/tech/Documents/CalREDIE_Overview_LocalUsers_April2013.pdf

2 Option 2: Take a leadership role in coordinating an HIE.

Public health has a defined role to play in the meaningful use requirement of HIE related to reporting 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 HIEs, furthering a shared interest in data and information that supports prevention.

EXAMPLE:

The Iowa Department of Public Health created a collaborative known as Iowa e-Health to develop the Iowa Health Information Network (IHIN). IHIN allows authorized providers the ability to share real-time health information including medical history, allergies, and prescribed medications and dosage. As of 2014, 107 of 119 hospitals were subscribers, along with 400 primary and specialty clinics, long-term care providers, surgery centers, physical therapy providers, and home health providers. In 2014, IHIN partnered with Nebraska Health Information Initiative to exchange health information from both states primarily to assist practices along state lines that may serve individuals in both states.

- http://www.thegazette.com/subject/news/business/iowa-health-information-network-grows-20141022
- http://www.healthcareitnews.com/news/iowa-move-health-information-exchange

3 Option 3: Take a leadership role in developing quality metrics for Medicaid, ACOs, health insurance exchanges, or other opportunities in the ACA within the community or state.

Public health already has experience in measuring quality at the community & population levels. Through partnerships, this experience can be leveraged to impact how state Medicaid departments measure health impact as coverage expands under the ACA, how ACOs evaluate effectiveness within a defined population, & how Health Insurance Marketplaces measure plan quality.

EXAMPLE:

The greater New Orleans area was selected to serve as a pilot community for the eventual wide-scale use of HIT through the HHS Office of the Coordinator for Health Information Technology's Beacon Community Program. The grant was awarded through a collaborative convened by the Louisiana Public Health Institute (LPHI). The Crescent City Beacon Community (CCBC) initiative sought to achieve meaningful and measurable improvements in health care quality, safety, and efficiency with a focus on diabetes and cardiovascular disease. Partners in addition to LPHI included community health centers, Tulane University, the Louisiana Department of Health and Hospitals, and three hospitals or health systems. As a result of the CCBC, the Greater New Orleans Health Information Exchange (GNOHIE) was implemented & became fully operational in 2012. The CCBC imitative was completed on September 30, 2013, & has transitioned into the Partnership for Achieving Total Health to manage the GNOHIE.

- http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4371439/
- http://www.crescentcitybeacon.org/
- http://gnohie.org/

Which of the three options is the best strategy for your organization over the next three to five years? Why? Enter your observations and rationale 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, & others as a result of new opportunities made available through health reform?

CHOOSE ONE preferred option:

☐ **OPTION 1:** Continue to provide basic public health surveillance functions, but align information technology (IT) capacity with meaningful use requirements.

☐ **OPTION 2:** Take a leadership role in coordinating an HIE.

☐ **OPTION 3:** Take a leadership role in developing quality metrics for Medicaid, ACOs, health insurance exchanges, or other opportunities in the ACA within the community or state.

Why is this option your preferred choice as you think ahead three to five years?

STEP 4: Apply Adaptive Actions

The ACA presents many 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 staff, community-based organizations, hospitals, large and small provider practices, and large and small employers.[45] Eight priority strategic actions emerged from the work that can be applied here to help you think about challenges with which you are faced.

INFLUENCING DECISIONS

Many decisions for implementing health reform continue to occur at the state level. Although many of those decisions have been made over the past few years, there is still 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 who understand more about the law and its potential impact on public health have the opportunity to educate others. The opportunity exists for public health, as a leader, to play a role in convening stakeholders to 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 effects of the health reform law continue to unfold and the impacts will not be known for several years, public health leaders are faced with a daunting prospect of continuing to have to make decisions without complete information. In addition, they are acutely aware that the provisions of the law itself might change over time. 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 future scenarios and then using them as a foundation for planning; pursuing good ideas, even in the absence of certainty; 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 law, 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. Adaptive thinkers must seek out the latest — even imperfect — information related to the challenges they are facing. Sources of information related to the ACA include the Federal Register, national association websites, www.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 even more important.

CREATING NEW PARTNERSHIPS

New partners are critical to the success of health reform. Some of the partnerships needed to implement health reform 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, ideally, will not directly benefit from the partnership.

BUILDING WORKFORCE CAPACITY

The elimination of copays, deductibles, and coinsurance for many preventive services will likely drive demand for providers in both the public health and private health care workforces. Particularly for the public health workforce, this will depend on the various health reform opportunities public health agencies pursue.[46] 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, technology training and education, and better utilization of the current workforce, including reorganizing provider teams and considering new types of providers.

BUILDING INFORMATION TECHNOLOGY CAPACITY

The ACA will further stimulate demand for electronic health records and other health data that require complex data-sharing systems. Information technology (IT) needs and requirements vary across institutions and reflect the idiosyncratic nature of organizations. The most likely IT capacity needs related to the ACA will involve designing or purchasing 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.

BUILDING CARE COORDINATION CAPACITY

The ACA has 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 administrative requirements, be able to link different types of care, 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's context relates to the surveillance and monitoring of health status, you have selected an option for moving forward, and you have documented why that option makes sense for your organization. Now you will think through potential 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?

CHOOSE ONE preferred option:	
☐	**OPTION 1:** Continue to provide basic public health surveillance functions, but align information technology (IT) capacity with meaningful use requirements.
☐	**OPTION 2:** Take a leadership role in coordinating an HIE.
☐	**OPTION 3:** Take a leadership role in developing quality metrics for Medicaid, ACOs, health insurance exchanges, or other opportunities in the ACA within the community or state.

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 the question? • Who can you engage to influence those decisions?	

EDUCATING OTHERS: • Who needs to know about how the particular challenge relates to health reform or health transformation? • What are the facts? • How will you communicate them?	
PLANNING UNDER UNCERTAINTY: • What are the most likely future scenarios given what you know, and how can you use them as a foundation for planning?	
STAYING ABREAST OF NEW INFORMATION: • How will you systematically learn of changes related to the ACA and health transformation? • What partnerships can you leverage to do this?	
CREATING NEW PARTNERSHIPS: • What new partnerships might advance the strategy? • Who can serve as a neutral convener of these new partnerships?	
BUILDING WORKFORCE CAPACITY: • Will you need new types of professionals to achieve your goals? • How can you ensure there will be sufficient workforce capacity?	

BUILDING IT CAPACITY: • What sort of IT capacity will you need to achieve the 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 needed? • What professional certifications will be required?	

STEP 5: Create an Implementation Plan

The last step in thinking adaptively about questions related to health reform and health transformation is to create a plan in order to move into action. Thinking about three fundamental components will help you gain clarity about what is feasible: staffing, budget and funding strategy, and a management plan.

STAFFING

The staff responsible for program implementation and the partners who provide program guidance are key to 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 you want to initiate. Most likely, you will want someone from outside the organization to facilitate the conversation.

Some questions that may help you think about staffing include these:

- What expertise is needed to initiate this activity?
- Can some of the activities be absorbed by partners?
- Can any activities be undertaken by volunteers rather than paid staff?
- What paid staff will be necessary to initiate the activities?
- Who will employ the staff?
- Are there any union bargaining rules that must be considered?

BUDGET AND FUNDING STRATEGY

Having a clear idea of the cost of building or sustaining the activities is an essential part of the implementation planning process. You may want to project the costs for a minimum of three years to obtain a complete picture of the total cost of the activity, including one-time cash expenditures, ongoing operational expenses, etc. Developing a line item budget for each activity is necessary for determining the 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 and supporters for the 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. Remember that many activities are sustained through partnerships. As a part of the sustainability planning process, you should discuss the role that partners can realistically play in the long-term support of the actions.

MANAGEMENT PLAN

How you manage new activities and the staff and partners who will undertake them is an important part of the implementation plan. Some questions that will help you start thinking about a management plan include these: What has worked well in managing the current activities and relationships? What could be improved? What management functions will be required of the 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 existing staff or undertaken by partners?

The last step in thinking adaptively about questions related to health reform is creating an implementation plan for the option you have chosen. You will create an implementation plan by answering the questions 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?

Staffing

- What expertise is needed to initiate this activity?
- Can some of the activities be absorbed by partners?
- Can any activities be undertaken by volunteers rather than paid staff?
- What paid staff will be necessary to initiate the activities?
- Who will employ the 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 the possible funding sources?
- What community partners can be approached for direct or indirect support?

Management Plan

- What has worked well in managing current activities and relationships?
- What could be improved?
- What management functions will be required of the 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 staff or undertaken by partners?

Guided Practice 2: Bibliography

[36] CMS. (2010). "Medicare & Medicaid HER Incentive Program." Retrieved January 14, 2016, from http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MU_Stage1_ReqOverview.pdf.

[37] HealthIT.gov. (March 27, 2015). "Accelerating Health Information Exchange (HIE)." Retrieved January 14, 2016, from https://www.healthit.gov/policy-researchers-implementers/accelerating-health-information-exchange-hie.

[38] Patient Protection and Affordable Care Act §3002(d); §931(c)(2).

[39] Livingwood, W. C., Coughlin, S., and Remo, R. (2009). Public Health & Electronic Health Information Exchange: A Guide to Local Agency Leadership, Institute for Public Health Informatics and Research.

[40] NACCHO (2011). Implementation of the Patient Protection and Affordable Care Act.

[41] Shapiro, J. (2007). "Evaluating Public Health Uses of Health Information Exchange. National Institutes of Health." Journal Biomed Information 40(6 Suppl): S46-S49.

[42] Booz Allen Hamilton Inc. (2010). "Q and A: Health Information Exchange and Public Health, interview with Mark Ciampa, a Senior Associate," from http://www.boozallen.com/insights/ideas/expertvoices/healthinformation-exchange/details/public-health-information-exchange.

[43] Ormond, B., Waidmann, T., and Spillman, B. (2011). Modeling Potential Savings from Prevention, Urban Institute.

[44] Livingwood, W. C., Coughlin, S., and Remo, R. (2009). Public Health & Electronic Health Information Exchange: A Guide to Local Agency Leadership, Institute for Public Health Informatics and Research.

[45] GHPC. (2001). Health Reform, From Insights to Strategies, A Variety of Perspectives. Atlanta, GA, Georgia State University: 44.

[46] Wilson, J. F. (2008). "Primary Care Delivery Changes as Nonphysician Clinicians Gain Independence." Annals of Internal Medicine 149(8): 597-600, Long, S., and Masi, P. (2009). "Access and affordability: an update on health reform in Massachusetts, fall 2008." Health Affairs 28(4): W578-W587, Hunsaker, M., and Kantayya, V. S. (2010). "Building a Sustainable Rural Health System in the Era of Health Reform." Disease-a-Month 56(12): 698-705, Kapp, M. (2011). "Conscripted physician services and the public's health." The Journal of Law, Medicine & Ethics 39(3): 414-424, Pande, A., Ross-Degnan, D., Zaslavsky, A., and Salomon, J. (2011). "Effects of Healthcare Reforms on Coverage, Access, and Disparities: Quasi-Experimental Analysis of Evidence from Massachusetts." American Journal of Preventive Medicine 41(1): 1-8, Paradise, J. (2011). Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants. Washington, D.C., Kaiser Commission on Medicaid and the Uninsured, HRSA. (2015). "Shortage Designation Homepage." Retrieved January 14, 2016, from http://www.hrsa.gov/shortage/.

Guided Practice 3

STEP 1: Define a question.

What role will public health play in community health planning?

STEP 2: Collect information about the question.

OVERVIEW

Under the Affordable Care Act (ACA), there is a requirement that nonprofit hospitals conduct regular community health needs assessments (CHNAs) 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 at the state and local levels. Linking the assessment and planning processes will be an efficient way of addressing the compliance needs of nonprofit hospitals while at the same time assisting the accreditation readiness of health departments.[47]

HOSPITAL COMMUNITY BENEFIT

LHDs have an opportunity to engage local nonprofit hospitals in CHNA and improvement planning due to changes in the ACA about how nonprofit hospitals qualify for nonprofit status by 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.[48]

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 revised the tax exemption standards applicable to nonprofit hospitals by adding several new components to the Internal Revenue Code. Among other revisions, nonprofit hospitals are now required to conduct a CHNA (at least every three years), widely publicize assessment results, and adopt an implementation strategy to meet needs identified by the assessment.[49]

The Internal Revenue Service final regulations on CHNA, released in December 2014, require that hospitals solicit and utilize input from a "governmental public health department (or equivalent department or agency)," which would include LHDs, as well as state, regional, or tribal departments of public health. Hospitals may determine which level of public health department is best suited for their CHNA and work with that organization.[50] Additionally, the final regulations encourage hospitals to collaborate on CHNAs with a variety of partners, including other hospitals, public health departments, and nonprofit organizations by allowing collaborating groups to submit one joint CHNA.[51]

PUBLIC HEALTH ACCREDITATION

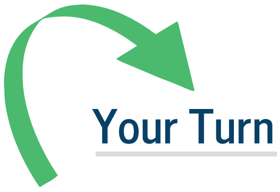
The ACA requirement around community benefit corresponds to the accreditation efforts of LHDs. CHNAs and improvement planning are not only integral to hospital community benefit requirements, they are also accreditation requirements for public health departments.[52] Public health agencies have the opportunity to consult with area hospitals to determine how CHNAs 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.[53] These collaborations should acknowledge the significant role community hospitals have historically played in meeting the health needs of the community.

ENGAGING NONPROFIT HOSPITALS

Public health agencies are in a very good position to assist hospitals with key aspects of community benefit work: data collection, analysis, epidemiological understanding, identification of community partners, and the development of CHNAs and health improvement plans.[54] Nonprofit hospitals can benefit greatly from partnering with LHDs in order to carry out community benefit requirements. Advantages of working with LHDs include public health expertise, experience with CHNA, in-depth knowledge of the local community, and access to vulnerable populations.[55] Prior to the release of the final regulations on CHNA, a number of hospitals around the country recognized these advantages and already joined with LHDs on their community benefit work.[56]

Now that the final regulations on CHNA have been released and hospitals are required to solicit and utilize input from a governmental public health department of their choice, LHDs should reach out to area hospitals and demonstrate their value and common community health goals in order to position themselves as that partner.



As a public health leader, how does the context in which you work relate to what is described about community health planning? Enter your observations below.

QUESTION 2: What role will public health play in community health planning?

- How does the context in which you work relate to what is described about community health planning?

Your Observations:

STEP 3: Think About the Feasible Options and Select One to Begin the Analysis.

There are likely many options related to the role public health could play in community health planning. Approaching the question from a technical perspective might lead one 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 approach this question this 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 health reform?"

The three options below will help you think about how you might approach the question about community health planning. In practice, you might 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.

1 | **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 various 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 might 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.[57]

EXAMPLE:

In 2015, the Allegheny County Health Department of Pennsylvania was selected as one of four sites for the Robert Wood Johnson Foundation's program Bridging for Health: Improving Community Health through Innovations in Financing. In 2014, the Allegheny County Health Department completed a CHNA and developed the Plan for a Healthier Allegheny (PHA) through collaborative efforts of 70-plus stakeholders within the community. Stakeholders included foundations, government agencies, businesses, education providers, hospitals and health systems, nonprofits, and community-based organizations. The PHA will serve as a guide and framework for future collaborative efforts to make sustainable changes in public health in Allegheny County.

- http://www.achd.net/pr/pubs/2016release/012916_DASH.html
- http://www.achd.net/pha/index.html

2 | **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.

CHNA and improvement planning are requirements for both nonprofit hospitals as a part of their community benefit 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:

The American Public Health Association (APHA) partnered with the Centers for Disease Control and Prevention in (CDC) 2012 to provide grant funding to APHA-affiliated regional public health associations to assist with accreditation. Health departments seek national accreditation through the Public Health Accreditation Board, which evaluates the departments' abilities in areas such as providing access to care, developing policies, and investigating public health emergencies. In 2016, 13 states received funding from APHA to assist with accreditation. APHA affiliates are assisting health departments with preparing for accreditation requirements, including organizing students in master of public health programs to assist with creating accreditation guidance documents and visiting local health departments to assess their readiness for accreditation.

3 | **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.[58] Public health can assume the role of a backbone support organization in organizing collective impact for health improvement.

EXAMPLE:

Healthy! Capital Counties is a partnership developed in 2010 between Ingram County, Mid-Michigan District, and Barry-Eaton District Health Departments of Michigan along with six local hospitals serving these areas. The partnership was convened as a result of the need for a CHNA and improvement planning as required by the ACA with a goal to improve health outcomes. As of December 2015, Healthy! Capital Counties published their second Community Health Profile and Needs Assessment, outlining factors that influence health as well as current health outcomes to better serve the community.

- http://www.naccho.org/topics/infrastructure/healthy-people/upload/NACCHO-Healthy-People-Mtg-HCC.pdf
- http://www.healthycapitalcounties.org/

Which of the three options is the best strategy for your organization over the next three to five years? Why? Enter your observations and rationale 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 health reform?

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 CHNA 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 as you think ahead three to five years?

STEP 4: Apply Adaptive Actions

The ACA presents many 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 staff, community-based organizations, hospitals, large and small provider practices, and large and small employers.[59] Eight priority strategic actions emerged from the work that can be applied here to help you think about challenges with which you are faced.

INFLUENCING DECISIONS

Many decisions for implementing health reform continue to occur at the state level. Although many of those decisions have been made over the past few years, there is still 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 who understand more about the law and its potential impact on public health have the opportunity to educate others. The opportunity exists for public health, as a leader, to play a role in convening stakeholders to 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 effects of the health reform law continue to unfold and the impacts will not be known for several years, public health leaders are faced with a daunting prospect of continuing to have to make decisions without complete information. In addition, they are acutely aware that the provisions of the law itself might change over time. 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 future scenarios and then using them as a foundation for planning; pursuing good ideas, even in the absence of certainty; 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 law, 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. Adaptive thinkers must seek out the latest — even imperfect — information related to the challenges they are facing. Sources of information related to the ACA include the Federal Register, national association websites, www.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 even more important.

CREATING NEW PARTNERSHIPS

New partners are critical to the success of health reform. Some of the partnerships needed to implement health reform 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, ideally, will not directly benefit from the partnership.

BUILDING WORKFORCE CAPACITY

The elimination of copays, deductibles, and coinsurance for many preventive services will likely drive demand for providers in both the public health and private health care workforces. Particularly for the public health workforce, this will depend on the various health reform opportunities public health agencies pursue.[60] 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, technology training and education, and better utilization of the current workforce, including reorganizing provider teams and considering new types of providers.

BUILDING INFORMATION TECHNOLOGY CAPACITY

The ACA will further stimulate demand for electronic health records and other health data that require complex data-sharing systems. Information technology (IT) needs and requirements vary across institutions and reflect the idiosyncratic nature of organizations. The most likely IT capacity needs related to the ACA will involve designing or purchasing 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.

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So far, you have described how your organization's context relates to the provision of community health planning, you have selected an option for moving forward, and you have documented why that option makes sense for your organization. Now you will think through potential strategic actions related to the option you selected.

If you were going to pursue an option related to community health planning, which strategic actions would you consider implementing and why? Record your answers in the table 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 health reform?

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 CHNA 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.

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 the question? • Who can you engage to influence those decisions?	

EDUCATING OTHERS: • Who needs to know about how the particular challenge relates to health reform or health transformation? • What are the facts? • How will you communicate them?	
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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 you want to initiate. Most likely, you will want someone from outside the organization to facilitate the conversation.

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The last step in thinking adaptively about questions related to health reform is creating an implementation plan for the option you have chosen. You will create an implementation plan by answering the questions 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 health reform?

Staffing

- What expertise is needed to initiate this activity?
- Can some of the activities be absorbed by partners?
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- What paid staff will be necessary to initiate the activities?
- Who will employ the 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 the possible funding sources?
- What community partners can be approached for direct or indirect support?

Management Plan

- What has worked well in managing current activities and relationships?
- What could be improved?
- What management functions will be required of the 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 staff or undertaken by partners?

Guided Practice 3: Bibliography

[36] CMS. (2010). "Medicare & Medicaid HER Incentive Program." Retrieved January 14, 2016, from http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MU_Stage1_ReqOverview.pdf.

[47] Abbott, A. (2011). "Community Benefits and Health Reform: Creating New Links for Public Health and Not-for-Profit Hospitals." Journal of Public Health Management & Practice 17(6): 524-529.

[48] Catholic Health Association. (2012). "What counts as community benefit." Retrieved January 14, 2016, from http://www.chausa.org/whatcounts/.

[49] IRS. (June 9, 2015). "New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act." Retrieved January 14, 2016, from https://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501%28c%29%283%29-Hospitals-Under-the-Affordable-Care-Act, NACCHO. (2011). "MAPP and Non-Profit Hospitals: Leveraging Community Benefit for Community Health Improvement." Retrieved January 14, 2016, from http://www.naccho.org/topics/infrastructure/mapp/loader.cfm?csModule=security/getfile&pageid=202123, Somerville, M. H., et al., (2013). Hospital Community Benefits after the ACA: The State Law Landscape, The Hilltop Institute.

[50] IRS. (2015, June 9, 2015). "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return: 2015 Addendum." Retrieved January 14, 2016, from https://www.irs.gov/irb/2015-5_IRB/ar08.html.

[51] Ibid.

[52] RWJF. (2011). "Public Health and Community Benefit: A Q&A with RWJF's Abbey Cofsky." Retrieved January 14, 2016, from http://www.rwjf.org/en/culture-of-health/2011/06/public-health-and-community-benefit-a-newpublichealth-qa-with-abbey-cofsky-program-officer-at-the-robert-wood-johnson-foundation.html.

[53] Rosenbaum, S. and Margulies, R. (2011). "Tax-exempt hospitals and the patient protection and Affordable Care Act: Implications for public health policy and practice." Law and the Public's Health; Public Health Reports 126: 283-286

[54] RWJF. (2011). "Public Health and Community Benefit: A Q&A with RWJF's Abbey Cofsky." Retrieved January 14, 2016, from http://www.rwjf.org/en/culture-of-health/2011/06/public-health-and-community-benefit-a-newpublichealth-qa-with-abbey-cofsky-program-officer-at-the-robert-wood-johnson-foundation.html.

[55] Somerville, M. H., et al., (2012). Hospital Community Benefits after the ACA: Partnerships for Community Health Improvement, The Hilltop Institute.

[56] Ibid.

[57] APHA. (2012). Planning for Public Health.

[58] Kania, J. and Kramer, M. (2011). Collective impact, Stanford social innovation review.
Kapp, M. (2011). "Conscripted physician services and the public's health." The Journal of Law, Medicine & Ethics 39(3): 414-424.

[59] GHPC. (2001). Health Reform, From Insights to Strategies, A Variety of Perspectives. Atlanta, GA, Georgia State University: 44.

[60] Wilson, J. F. (2008). "Primary Care Delivery Changes as Nonphysician Clinicians Gain Independence." Annals of Internal Medicine 149(8): 597-600, Long, S., and Masi, P. (2009). "Access and affordability: an update on health reform in Massachusetts, fall 2008." Health Affairs 28(4): W578-W587, Hunsaker, M., and Kantayya, V. S. (2010). "Building a Sustainable Rural Health System in the Era of Health Reform." Disease-a-Month 56(12): 698-705, Kapp, M. (2011). "Conscripted physician services and the public's health." The Journal of Law, Medicine & Ethics 39(3): 414-424, Pande, A., Ross-Degnan, D., Zaslavsky, A., and Salomon, J. (2011). "Effects of Healthcare Reforms on Coverage, Access, and Disparities: Quasi-Experimental Analysis of Evidence from Massachusetts." American Journal of Preventive Medicine 41(1): 1-8, Paradise, J. (2011). Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants. Washington, D.C., Kaiser Commission on Medicaid and the Uninsured, HRSA. (2015). "Shortage Designation Homepage." Retrieved January 14, 2016, from http://www.hrsa.gov/shortage/.

Guided Practice 4: Maternal and Child Health

This guided practice was developed in partnership with the National MCH Workforce Development Center. The center aims to create a continuum of learning and engagement opportunities for state and territorial Title V practitioners and maternal and child health (MCH) graduate and undergraduate students to develop the competencies required of contemporary public health leaders to implement the Affordable Care Act (ACA) and other health system transformations. The center's key areas of focus are access to care, change management, systems integration, and quality improvement. The center's definition of health transformation is broad and applies to all states and territories as they respond to various forms of health system reform:

> *Health transformation shifts the emphasis of health care from disease management to prevention and population health management, while improving access to affordable health care; develops an interprofessional/interdisciplinary approach to health care; integrates primary care, specialty care, and public health; develops efficient health systems that better incorporate ongoing quality improvement; and drives partnerships across sectors to optimize the well-being of maternal and child health populations.*

This module is designed to assist state and territorial Title V agencies as they plan and implement health programs in an environment of health transformation.

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STEP 1: Define a question.

How can Title V professionals identify and monitor improvements to maternal and child health outcomes resulting from health system transformation?

STEP 2: Collect information about your question related to the ACA and other health system transformations.

OVERVIEW

The ACA provides numerous opportunities that Title V can use to improve maternal and child health. Opportunities include, but are not limited to, access to affordable health insurance, coverage of preventive care services, support for care coordination efforts, and community benefit requirements. By increasing access to affordable health insurance, women and children who were previously un- or underinsured have increased access to appropriate health care services. The requirement for insurers to cover (with no cost-sharing) certain designated preventive services for women and children further encourages and allows the public to access and utilize appropriate health care services.

The ACA also provided prompting and funding for innovative care coordination and financial savings models such as Accountable Care Organizations (ACOs), medical homes, home visiting programs, and community health workers, all of which have the ability to directly serve and improve maternal and

child health needs. Additionally, the law created enhancement of community benefit requirements for hospitals, which can address and serve maternal and child health at the community level. Although the ACA provides many opportunities to improve maternal and child health, certain systemic gaps remain. Thus, Title V programs can embrace the new opportunities while nonetheless remaining aware of a continued need to fill those gaps.

INSURANCE ACCESS

One of the main goals of the ACA was to increase the public's access to affordable health insurance. The ACA seeks to accomplish this goal by expanding Medicaid eligibility to those at or below 138% of the federal poverty limit (FPL), extending and strengthening Children's Health Insurance Program (CHIP), creating health insurance Marketplaces for the purchase of affordable health insurance, creating requirements for employer-sponsored insurance, and removing the ability of insurance companies to deny insurance coverage due to pre-existing conditions. One way Title V programs can get involved in the area of insurance access is by working with state and local partners to increase uptake of new insurance options while still supporting direct services for those unable to obtain affordable insurance.

In June 2012, the Supreme Court determined that the ACA's Medicaid expansion provision is optional for states, rather than mandatory. To date, 31 states have chosen to expand Medicaid for U.S. citizens and documented immigrants at or below 138% FPL. In nonexpansion states, adults (including single or married women) at or below 138% FPL must obtain insurance by other means, either through employers, health insurance Marketplaces, in the private market, through parents' insurance (if under 26 and a student), or remain uninsured. However, in all states, pregnant women and children who meet the state's income and immigration requirements will still have Medicaid as an option. Additionally, the ACA provided federal funding for CHIP until 2015, and then maintains the program by increasing the match rate starting in 2015.

The ACA's "no wrong door" initiative requires that state Medicaid departments coordinate with health insurance Marketplaces to ensure that new applicants are directed to the appropriate insurance access point.

The ACA's health insurance Marketplaces serve as an additional market where the public may purchase health insurance meeting minimum coverage, cost, and provider network requirements. The federal government provides a sliding scale of subsidies to customers, depending on their income level. However, undocumented immigrants, who make up an estimated 3.5% of the nation's population (11.2 million persons in 2012),[61] may not access the subsidies. Although there are network adequacy requirements for health insurance plans to be sold on the Marketplaces, many, due to cost and contracting, may not have as robust a provider and specialist network as plans obtained in the private market or through employers. Parents of children and youth with special health care needs (CYSHCN) or others requiring particular specialist care may need to pay special attention to this when purchasing a plan. The ACA also requires that starting in 2016, any employer with 50 or more employees (100 or more employees in 2015), must either offer health insurance to their employees, provide them with a stipend to purchase insurance on the Marketplaces, or face tax penalties.

Prior to the ACA, pre-existing condition exclusions often created a significant barrier to insurance access in the private market. Pre-existing conditions such as pregnancy, cancer, or genetic birth defects would automatically trigger denial of an application for insurance, leaving the person to seek Medicaid (if within the income limits), forgo care, or cover the costs on their own. Now, under the ACA, pregnant women may purchase insurance to help pay for prenatal care and labor and delivery costs. CYSHCN with genetic birth defects may also better access critical and often costly health care.

COVERAGE OF PREVENTIVE HEALTH SERVICES

Another significant way the ACA impacts maternal and child health is by requiring that insurance cover (with no cost-sharing to the patient) certain preventive health services for women and children. Annual well-woman exams, critical to reproductive health, are now covered at 100% and include such services as cervical cancer screening, sexually transmitted disease screening and counseling, and contraceptive methods counseling. Additionally, the law requires coverage for key pre- and perinatal health services, crucial to the prevention of birth defects and other childhood illness, such as gestational diabetes screening, folic acid supplements, tobacco use screening, interventions, expanded counseling for pregnant users including lactation support and counseling, and breast-feeding equipment.

The ACA's coverage provisions also provide an opportunity to identify and treat certain disorders earlier among children by requiring that insurance cover all 31 newborn screenings on the Recommended Uniform Screening Panel (if one's state does not already require testing for all of them). Additionally, all costs for services associated with well-child visits must be covered by insurance, including physical exams, immunizations, hearing and vision screenings, and developmental and behavioral screenings. However, it is important to note that until, or unless, they make a significant change to their benefits or costs, grandfathered plans are exempt from these coverage requirements. Title V programs could educate the public about the availability, and encourage use, of these no-cost services, as well as inform the public about the continued costs of these services under grandfathered plans.

CARE COORDINATION AND COMMUNITY BENEFIT

The ACA also supports a number of promising care coordination initiatives that could help to improve maternal and child health. Key initiatives include ACOs, medical homes, home visiting programs, and use of community health workers (CHWs). ACOs are collaborations of hospitals, doctors, and other health care providers who have committed to taking responsibility for the cost, quality of care, and health outcomes of a particular patient group. They work to "improve care transitions, ensure patient safety, enhance the patient and caregiver experience, improve health outcomes, and help patients achieve wellness goals",[62] as well as improve efficiency and quality of care (for example by eliminating unnecessary duplication of services and medical errors).

An ACO's payment structure is formatted so that when it delivers high-quality, cost-efficient health care, the provider members share in the savings to health care costs, either through reimbursements or other incentive payments. ACOs may be tailored to deal with a specific maternal or child population or illness. For example, there are ACOs that include well-child visits, asthma control, or prenatal care in their outcome measures. The ACA also created a specific Pediatric ACO demonstration project, which authorized participating states to recognize pediatric medical providers as an ACO for purposes of receiving incentive payments for Medicaid or CHIP savings and positive outcomes. Although CMS and state Medicaid programs have been some of the big ACO funders thus far, ACOs are not limited to government payers — private insurance companies have also been very active in creating ACOs with partnering physicians and hospitals.

The ACA's Medicaid Health Homes program, supported by federal planning grants, has created a State Plan option to provide health homes for Medicaid enrollees with chronic conditions. The program seeks to encourage provider-family partnerships in order to provide coordinated, quality care, efficiently utilize resources, and minimize costs. Individual states determine the program's payment methodology and may tier payments to reflect the severity or number of patients' chronic conditions and the specific capabilities of the health home. Health homes have been particularly useful for coordinating the care of children with special needs, as well as pregnant women to decrease the prevalence of and costs associated with negative birth outcomes. Colorado's Title V program played an instrumental role in creating, with legislative backing, CYSHCN health homes for their Medicaid population.

The ACA also provides direct community supports for maternal and child health through the Maternal, Infant, and Early Childhood Visiting Program (MIECVP), nurse home visiting services, and CHWs. Multiple state agencies and programs such as public health, Medicaid, and Title V programs, as well as local actors, should join together to take advantage of these opportunities. MIECVP offers federal grants to states to strengthen Title V activities, improve coordination of maternal and child health services in at-risk communities, and provide comprehensive maternal and child health services to improve outcomes for at-risk families. The ACA also established optional State Plan coverage of "nurse home visiting services" under Medicaid and CHIP.

In states that have added this option, nurse home visiting programs can apply for authorization and be reimbursed by Medicaid for their services. CHWs are another type of health worker who work within communities and can influence maternal and child health. CHWs typically live within or are otherwise closely tied to the communities they serve and act as a liaison between health and social services and community members, facilitating access to services and cultural competency. The ACA has promoted the use of CHWs in multiple ways, including establishing a CHW grant to promote the workforce, authorizing community transformation grants that can support CHWs, and encouraging CHW reimbursement under Medicaid.

The ACA also created a new requirement that in order for nonprofit hospitals to retain their 501(c)(3) tax-exempt status, every three years they must conduct a community health needs assessment (CHNA) that contains an implementation strategy for improving the health of their surrounding community. The community benefit requirements also specify that nonprofit hospitals allow for greater transparency in their decision-making processes and include more community input, particularly from low-income, minority, and underserved community members. Many hospitals' CHNAs have already included maternal and child health data in their assessments, goals, and programs within their implementation strategies and are utilizing state and local public health and Title V program expertise. Additionally, through the new CHNA requirements, hospitals are now incentivized not only to invest in programs providing direct health provisions but also to invest in multisector community partnerships and activities such as workforce development, built environment and housing, education, and economic development.

Now that the final regulations on CHNA have been released and hospitals are required to solicit and utilize input from a governmental public health department of their choice, LHDs should reach out to area hospitals and demonstrate their value and common community health goals in order to position themselves as that partner.

As a Title V professional, how does your situation relate to what is described above about the ACA? Enter your observations in the open entry area below. Some questions are provided to get your thinking started.

QUESTION 4: How can Title V professionals identify and monitor improvements to maternal and child health outcomes resulting from health system transformation?

- How does your situation relate to what is described above in the ACA?
- Are you providing direct services now or should it be a part of your strategy to provide them over the next three to five years? 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 maternal and child health?

Your Observations:

STEP 3: Think About the Feasible Options and Select One to Begin the Analysis.

There could be many ways for Title V professionals to identify and monitor improvements to maternal and child health outcomes resulting from health system transformation. 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:

"How can Title V professionals leverage ACA opportunities to broker improvements for the well-being of mothers and children, including those with special needs?"

Four options, based on the Maternal and Child Health Pyramid of Health Services, 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.

[63] The conceptual framework for the services of the Title V Maternal and Child Health Block Grant is envisioned as a pyramid with four tiers of services and levels of funding that provide comprehensive services for mothers and children. The pyramid also displays the uniqueness of the Maternal and Child Health Block Grant, which is the only federal program that consistently provides services at all levels of the pyramid.

1 | **Option 1:** Continue to provide direct health care services to women and children, including children with special health care needs.

Evaluate your capacity to provide direct health care services for the MCH population. Think about your opportunities around serving as a medical home particularly for underserved subpopulations and providing health-related services, including prevention, primary care, and specialty care services, when needed. Additionally consider how to sustain these efforts, such as newly added insurance options resulting from health reform.

EXAMPLE:

[64] Rhode Island developed a health home state plan amendment that establishes existing Comprehensive Evaluation Diagnosis Assessment Referral Re-evaluation (CEDARR) Family Centers as health home providers for children with special care needs. Although CEDARR Family Centers have supported families of children with special care needs and provided direct therapeutic services since 2001, the ACA's home health funding allowed for enhanced screening of secondary conditions (e.g., obesity and depression), additional reimbursement to primary care providers to participate in care planning, information technology improvements, and better communication between the centers and Medicaid managed care plans. Rhode Island created operational protocols to define collaborative roles for home health providers and health plans.

2 | **Option 2:** Work across agency boundaries to provide access to enabling services.

Assess your capacity to provide or facilitate services for the MCH population that enable their access to care. Think about your opportunities regarding enabling services, including financial access, cultural acceptability, accessibility of primary care, specialty care, and rehabilitation services. Specific services may be translation services, respite care, health education, and case management coordination with Medicaid.

EXAMPLE 1:

[65] Starting in July 2013, Colorado Medicaid's Accountable Care Collaborative (ACC) incorporated well-child visits (children under 18) as one of their four key performance indicators to measure improvement among members. In fiscal year (FY) 2013-14, the ACC performance measure focused on children ages 3-9 years. The ACC currently serves about 60% of state Medicaid clients. In addition to their regular Medicaid benefits, ACC members belong to a Regional Care Collaborative Organization (RCCO), which helps to coordinate their care, connecting them with primary care medical homes, specialists, and community resources. RCCOs and primary medical care providers that demonstrate regional improvement in well-child visits are able to share in quarterly incentive payments. The Colorado ACC has already produced positive outcomes for FY 2013-14: the program's net savings was approximately $31 million, and about half of all ACC children received a well-child visit.

EXAMPLE 2:

[66] North Carolina has implemented a Pregnancy Medical Home program that is open to all health care providers that will provide comprehensive, patient-centered care to pregnant women enrolled in the state's Medicaid program. This Pregnancy Medical Home program offers reimbursement to providers for prenatal risk screening and collaborates with local health departments by providing case management support to pregnant women through pregnancy care managers employed by the departments.

3 | **Option 3:** Facilitate efficient and effective provision of integrated population-based services.

Explore your involvement in the direct management of population-based services and programs, coordination with other agencies and organizations (universities, managed care organizations, physician groups) in the provision of these services, and funding mechanisms for these services. Population-based services provided for Title V population groups include screenings, immunizations, oral health, and outreach efforts.

EXAMPLE:

The ACA makes children's oral health care an "essential benefits package" that is offered in state health insurance marketplaces. By 2017, oral health will be considered an essential benefit for all coverage, inside or outside the marketplace system. Additionally, the law requires the Secretary to establish a five-year, evidence-based public education campaign to promote oral health, including a focus on early child hood caries, prevention, oral health of pregnant women, and oral health of at-risk populations.[67]

The Georgia Oral Health Coalition (GOHC), formed by the Georgia Department of Public Health, works to prevent oral disease among Georgians. The coalition has been instrumental in addressing oral health infrastructure and policy for the state due to the collaboration between partners such as: public health, dental associations, pediatric associations, schools, and health educators. The GOHC educates stakeholders on oral heath literacy, disseminates oral health information, promotes oral health surveillance activities, reviews access to dental services, and supports policy for positive dental service activities.

In August 2012, GOHC hosted an oral health summit with national, state, and local speakers. Once information on service offerings was collected, the low-income oral health services were mapped and placed on the coalition's website under "Access to Care". Medical practices, facilities, and individuals seeking oral health services can now easily locate free or reduced oral health services across the state.

GOHC was strengthened by early wins that demonstrated the critical role it played in dental health policy. Now, policy-related work has been initiated in several areas including: public health dental hygiene supervision, as well as Medicaid reimbursement for medical practices for oral screenings, anticipatory guidance, and fluoride varnish applications.[68]

4 | **Option 4:** Take or assume a leadership role in building and developing supportive infrastructure for systems serving mothers and children.

Examine your capacity to promote comprehensive systems of services through infrastructure building. Think about how local delivery systems meet the population's health needs. Assess your role in planning, evaluation, and research; policy development; workforce development; the monitoring of continuous quality improvement; and the development and implementation of standards of care.

EXAMPLE:

[69] Under the ACA, charitable hospitals with 501(c)(3) status are required to complete CHNA and adopt implementation strategies to improve community health. State and local public health agencies are also required to complete community health assessments and develop community health improvement plans in order to be accredited. These requirements can provide the opportunity for win-win collaborations between public health and hospitals.

In Venango County, Pennsylvania, the University of Pittsburgh Medical Center (UPMC) Northwest partnered with state agencies and clinics, university researchers, community health care providers (including Title V clinics), and other community partners on their CHNA and implementation plans. The CHNA identified maternal and infant health as one of its three key areas for intervention. The CHNA found that Venango County had lower rates (than the state and nation) of first-trimester prenatal care and higher rates (than the state) of smoking during pregnancy. The UPMC Northwest CHNA maternal and infant health implementation strategies, developed with the hospital and its partners, include hospital-based educational classes (on childbirth, infant care, breast-feeding, and sibling interaction), community clinic programs (on nutritional counseling, transportation assistance, parenting classes, and substance abuse prevention), and a home visiting program for at-risk families.

Which of the four options presented above is the most appealing to you as a Title V professional as you think about your organization over the next three to five years? Why? Enter your observations in the space below.

QUESTION 3: How can Title V professionals leverage ACA opportunities to broker improvements for the well-being of mothers and children, including those with special needs?

CHOOSE ONE preferred option:

- [ ] **OPTION 1:** Continue to provide direct health care services to women and children, including children with special health care needs.
- [ ] **OPTION 2:** Work across agency boundaries to provide access to enabling services.
- [ ] **OPTION 3:** Facilitate efficient and effective provision of integrated population-based services.
- [ ] **OPTION 4:** Take or assume a leadership role in building and developing supportive infrastructure for systems serving mothers and children.

Why is this option your preferred choice as you think ahead three to five years?

STEP 4: Apply Adaptive Actions

The ACA presents many 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 staff, community-based organizations, hospitals, large and small provider practices, and large and small employers.[70] Eight priority strategic actions emerged from the work that can be applied here to help you think about challenges with which you are faced.

INFLUENCING DECISIONS

Many decisions for implementing health reform continue to occur at the state level. Although many of those decisions have been made over the past few years, there is still 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 who understand more about the law and its potential impact on public health have the opportunity to educate others. The opportunity exists for public health, as a leader, to play a role in convening stakeholders to 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 effects of the health reform law continue to unfold and the impacts will not be known for several years, public health leaders are faced with a daunting prospect of continuing to have to make decisions without complete information. In addition, they are acutely aware that the provisions of the law itself might change over time. 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 future scenarios and then using them as a foundation for planning; pursuing good ideas, even in the absence of certainty; 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 law, 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. Adaptive thinkers must seek out the latest — even imperfect — information related to the challenges they are facing. Sources of information related to the ACA include the Federal Register, national association websites, www.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 even more important.

CREATING NEW PARTNERSHIPS

New partners are critical to the success of health reform. Some of the partnerships needed to implement health reform 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, ideally, will not directly benefit from the partnership.

BUILDING WORKFORCE CAPACITY

The elimination of copays, deductibles, and coinsurance for many preventive services will likely drive demand for providers in both the public health and private health care workforces. Particularly for the public health workforce, this will depend on the various health reform opportunities public health agencies pursue.[71] 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, technology training and education, and better utilization of the current workforce, including reorganizing provider teams and considering new types of providers.

BUILDING INFORMATION TECHNOLOGY CAPACITY

The ACA will further stimulate demand for electronic health records and other health data that require complex data-sharing systems. Information technology (IT) needs and requirements vary across institutions and reflect the idiosyncratic nature of organizations. The most likely IT capacity needs related to the ACA will involve designing or purchasing 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.

BUILDING CARE COORDINATION CAPACITY

The ACA has 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 administrative requirements, be able to link different types of care, 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 might identify and monitor improvements to maternal and child health outcomes in the context of the ACA, 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 maternal and child health, which strategic actions would you consider implementing and why? Record your answers in the table below.

QUESTION 4: How can Title V professionals leverage ACA opportunities to broker improvements for the well-being of mothers and children, including those with special needs?

CHOOSE ONE preferred option:

- ☐ **OPTION 1:** Continue to provide direct health care services to women and children, including children with special health care needs.
- ☐ **OPTION 2:** Work across agency boundaries to provide access to enabling services.
- ☐ **OPTION 3:** Facilitate efficient and effective provision of integrated population-based services.
- ☐ **OPTION 4:** Take or assume a leadership role in building and developing supportive infrastructure for systems serving mothers and children.

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 the question? • Who can you engage to influence those decisions?	

EDUCATING OTHERS: • Who needs to know about how the particular challenge relates to health reform or health transformation? • What are the facts? • How will you communicate them?	
PLANNING UNDER UNCERTAINTY: • What are the most likely future scenarios given what you know, and how can you use them as a foundation for planning?	
STAYING ABREAST OF NEW INFORMATION: • How will you systematically learn of changes related to the ACA and health transformation? • What partnerships can you leverage to do this?	
CREATING NEW PARTNERSHIPS: • What new partnerships might advance the strategy? • Who can serve as a neutral convener of these new partnerships?	
BUILDING WORKFORCE CAPACITY: • Will you need new types of professionals to achieve your goals? • How can you ensure there will be sufficient workforce capacity?	

BUILDING IT CAPACITY: • What sort of IT capacity will you need to achieve the 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 needed? • What professional certifications will be required?	

STEP 5: Create an Implementation Plan

The last step in thinking adaptively about questions related to health reform and health transformation is to create a plan in order to move into action. Thinking about three fundamental components will help you gain clarity about what is feasible: staffing, budget and funding strategy, and a management plan.

STAFFING

The staff responsible for program implementation and the partners who provide program guidance are key to 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 you want to initiate. Most likely, you will want someone from outside the organization to facilitate the conversation.

Some questions that may help you think about staffing include these:

- What expertise is needed to initiate this activity?
- Can some of the activities be absorbed by partners?
- Can any activities be undertaken by volunteers rather than paid staff?
- What paid staff will be necessary to initiate the activities?
- Who will employ the staff?
- Are there any union bargaining rules that must be considered?

BUDGET AND FUNDING STRATEGY

Having a clear idea of the cost of building or sustaining the activities is an essential part of the implementation planning process. You may want to project the costs for a minimum of three years to obtain a complete picture of the total cost of the activity, including one-time cash expenditures, ongoing operational expenses, etc. Developing a line item budget for each activity is necessary for determining the 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 and supporters for the 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. Remember that many activities are sustained through partnerships. As a part of the sustainability planning process, you should discuss the role that partners can realistically play in the long-term support of the actions.

MANAGEMENT PLAN

How you manage new activities and the staff and partners who will undertake them is an important part of the implementation plan. Some questions that will help you start thinking about a management plan include these: What has worked well in managing the current activities and relationships? What could be improved? What management functions will be required of the 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 existing 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 3: How can Title V professionals leverage ACA opportunities to broker improvements for the well-being of mothers and children, including those with special needs?

Staffing

- What expertise is needed to initiate this activity?
- Can some of the activities be absorbed by partners?
- Can any activities be undertaken by volunteers rather than paid staff?
- What paid staff will be necessary to initiate the activities?
- Who will employ the 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 the possible funding sources?
- What community partners can be approached for direct or indirect support?

Management Plan

- What has worked well in managing current activities and relationships?
- What could be improved?
- What management functions will be required of the 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 staff or undertaken by partners?

Guided Practice 4: Bibliography

[61] Pew Research Center. (2015). 5 facts about illegal immigration in the U.S. Retrieved February 25, 2016, from http://www.pewresearch.org/fact-tank/2014/11/18/5-facts-about-illegal-immigration-in-the-u-s/.

[62] White SE, and Taylor LB. (2012). "Accountable Care and Data Analytics Emerging in Healthcare." J AHIMA. 83(11): 56-58.

[63] HRSA. Maternal and Child Health Programs. Retrieved February 25, 2016, from http://www.mchb.hrsa.gov/programs/index.html.

[64] NGA Center for Best Practices. (2013). Effect of Provider Payment Reforms on Maternal and Child Health Services. Retrieved February 25, 2016, from http://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/effect-of-provider-payment-refor.html.

[65] Colorado Department of Health Care Policy & Financing. (2014). Accountable Care Collaborative News and Fact Sheet. Retrieved February 25, 2016, from https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%20News%20Release%20and%20Fact%20Sheet%20-%20November%203,%202014.pdf, Colorado Department of Health Care Policy & Financing. (2013). Provider Bulletin. Retrieved February 25, 2016, from https://www.colorado.gov/pacific/sites/default/files/Medicaid%20Program%20News%20and%20Updates%20(B1300339,%20July%202013)_0.pdf.

[66] NGA Center for Best Practices. (2013). Effect of Provider Payment Reforms on Maternal and Child Health Services. Retrieved February 25, 2016, from http://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/effect-of-provider-payment-refor.html.

[67] Oral Health Watch. The Affordable Care Act and Oral Health. Retrieved January 19, 2015, from http://www.oralhealthwatch.org/policy-center/healthcare-reform-and-oral-health/.

[68] The Practical Playbook. Georgia Promotes Oral Health. Retrieved January 19, 2015, from https://practicalplaybook.org/success-story/georgia-promotes-oral-health.

[69] UPMC Northwest. (2013). Community Health Needs Assessment and Community Health Strategic Plan. Retrieved February 25, 2016, from http://www.upmc.com/about/community-commitment/Documents/northwest-community-health-needs-assessment.pdf.

[70] GHPC. (2001). Health Reform, From Insights to Strategies, A Variety of Perspectives. Atlanta, GA, Georgia State University: 44.

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