THE HEALTH CARE SECTOR:

Affordable Care Act Opportunities to Improve Public Health

Produced by Health Resources in Action for the Maricopa County Department of Public Health (MCDPH)

Background

The federal **Patient Protection and Affordable Care Act (ACA)** represents a major expansion and regulatory overhaul of the U.S. health system that aims to increase the rate of insurance coverage, contain the unsustainable rise in health care costs, and improve health care quality and outcomes through a number of mechanisms that are currently being rolled out over the course of several years. Through the ACA, an estimated 1.3 million currently uninsured Arizonans are expected to enroll in either the Arizona Health Care Cost Containment System (AHCCCS, Arizona's Medicaid system) or private insurance exchanges through an Insurance Marketplace. While insurance coverage and subsequent demand for primary care and prevention services are anticipated to rise, approximately 650,000 Arizonans will remain uninsured and will continue to rely on safety net providers as well as public health services.

With the ACA's emphasis on expanding health care access, improving quality of care and health outcomes, as well as promoting the role of prevention and population health in controlling costs, there are many opportunities for public health to help shape the development of a more effective health system in Arizona. To that end, the Maricopa County Department of Public Health (MCDPH) commissioned a number of reports and briefs that will help them better understand what opportunities they have for supporting health care providers, payers, and businesses as they collectively seek to navigate a new and effective health system landscape.

This brief is intended for the health care sector to highlight new opportunities to partner with health departments to foster of a healthier population and more effective health system. A longer technical report, available from MCDPH, goes into greater detail about all of these subjects.

New Context for Improving Population Health

NEW MODELS OF CARE PROMOTED UNDER THE ACA OFFER OPPORTUNITIES FOR COLLABORATION AND COORDINATION

These models, such as health homes*, accountable care organizations (ACOs), and community health teams (CHTs), will need help and technical assistance to:

- Incorporate prevention strategies and services to improve population health;
- Integrate medical, mental health, and dental care to improve care coordination and quality while controlling costs;
- Use multi-disciplinary coordinated care teams to avoid costly medical care;
- Monitor and address disparities and provide culturally appropriate services; and,
- Address how new reimbursement systems, such as bundled or global payment systems, can achieve the Triple Aim: better care, improved population health, and lower costs.

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Health homes are patient centered systems of care that facilitate coordination of primary and acute medical services, behavioral health care, and long-term community based services and supports. The model expands on the traditional medical home model by building linkages and enhancing coordination and integration of medical and behavioral health care to better meet the needs of people with multiple chronic illnesses.[1]

INCREASED FOCUS ON PREVENTION AND OUTCOMES WILL REQUIRE PLANNING AND RESOURCES, INCLUDING:

- Greater demand for preventive services, such as screenings and immunizations, since co-pays and deductibles will be waived for these services and fully paid for by insurance;
- Increased need for primary care and community health providers;
- Increased need for monitoring, facilitating and supporting the reduction of preventable hospitalizations which is incentivized through the Hospital Readmissions Reduction Program; and,
- More funding opportunities, through new Centers for Disease Control and Prevention (CDC) and Center for Medicare and Medicaid Innovation (CMMI) grants, to connect clinical services to community resources and that bring together multi-sector collaborations to prevent and reduce chronic disease through policy and systems change. In addition, there will be federal grants and programs to strengthen the health care and public health workforce to align with ACA goals.

EMPHASIS ON POPULATION HEALTH ASSESSMENT AND IMPROVEMENT WILL REQUIRE COLLABORATIVE PLANNING

New IRS regulations, under the ACA, require non-profit hospitals to develop Community Health Needs Assessments (CHNAs) and Community Health Improvement Plans (CHIPs) every three tax years that must involve public health and community partners. Community benefits dollars must be both responsive and accountable to these identified community needs. Some states impose additional requirements on tax-exempt hospitals for their community benefit expenditures.

Strategies for Coordinating Health Care and Community Resources

CREATE LINKAGES BETWEEN CLINICAL PRACTICE AND THE COMMUNITY

A starting point for collaboration could be for public health to conduct an assessment of health care providers' knowledge of community prevention resources and strategies[2] which could help identify the needs, gaps, and opportunities for moving forward. Another approach is to engage clinical providers, using their patient intelligence or their knowledge and data about patient beliefs and health status, to inform community policy prevention efforts like addressing junk food in schools or smoking in multi-unit housing. There are many opportunities to create linkages, including:

- Increasing clinical awareness of community based programs related to fitness, healthy foods, tobacco cessation, and wellness resources (e.g. gyms, farmers markets, group sessions);
- Forming partnerships between a health clinic and the health department to operate primary care and traditional public health clinics jointly[3];
- Locating a public health professional in or near providers' practices where there is high need;
- Developing tools and databases to assist care providers in referring patients to community agencies for health education and counseling;
- Initiating case management programs that incorporate public health staff and primary care providers to proactively improve chronic disease care and self-management;
- Training medical students and physicians in specific population health skills and/or creating internships in health departments for physicians-in-training;
- Involving providers on public health planning groups, policy committees and needs assessments;
- Developing and disseminating evidence-based tools and guidelines for providers[3]; and,
- Utilizing public health and community-based programs to decrease readmission rates.

PROMOTE COMMUNITY HEALTH WORKERS (CHW) TO ADDRESS DISPARITIES AND PROMOTE LINKAGES

MCDPH can work with providers and community agencies to strengthen the role of CHWs to help patients navigate new health systems and improve access to culturally appropriate care. The health department can collaborate to assure a pipeline to an effective CHW workforce through training and hiring of CHWs in key positions.

LINK HEALTH CARE PROVIDERS TO COMMUNITY PREVENTION AND DISEASE MANAGEMENT PROGRAMS

In particular, MCDPH can provide or increase the supply of chronic disease management programs and training, often utilizing CHWs. MCDPH can partner with providers to offer targeted programs like Chronic Disease Self-Management or proven asthma or maternal child health home visiting programs.[4] Access to non-medical services, such as housing, food, and electricity, are important determinants of health, and providers should be aware of the community services that are available to support patients. MCDPH can work with providers to develop systems for easy referral of patients to community and governmental resources in Maricopa County to address these conditions.

WORK WITH PAYERS TO ALLOW AND SUPPORT NEW MODELS OF COMMUNITY CARE

Currently, many fee-for-service payers do not recognize or reimburse for the community health supports that will become necessary to maintain a healthy population, reduce disparities, and avoid expensive preventable medical care. Recognizing that not all patient care will be provided in the context of clinical systems, payers will need to reimburse for prevention oriented services such as patient self-management education sessions, home visits, and services from non-traditional providers such as CHWs. Public health will need to make the business case to payers in this regard.

Public Health and New Models of Care

SUPPORT COMMUNITY FOCUS OF ACCOUNTABLE CARE ORGANIZATIONS (ACO) AND HEALTH HOMES

It is critical that public health experts are at the health care institutional planning table to help familiarize them with relevant resources and prevention strategies. Public health can foster community centered and accountable care networks that are positioned to effectively address population health using public health strategies such as promoting community engagement. Public health can also recommend incorporating relevant metrics of social determinants of health, and offer evidence-based community prevention strategies.[5]

JOINTLY CREATE COMMUNITY HEALTH TEAMS (CHT)

CHTs provide a unique way to link healthcare providers and community based providers to support patients in their homes and community. In Vermont, CHTs support provider practices across the state, and are responsible for care coordination, outreach, and population management, counseling, and integration with supportive resources. They include nurse coordinators, CHWs, social workers, behavioral counselors, and public health professionals. The cost of the CHTs is covered by Vermont's three major commercial insurers and Medicaid.[6]

CREATE A COMMUNITY CENTERED HEALTH SYSTEM

Facilitate multi-sector partnerships which broaden the health home model to address changes to the environment that improve population health. This model begins with using data to understand social, economic, and community conditions driving health outcomes; using a geographic information system to identify trends and "hot spots"; working with community partners to coordinate activities; acting as health advocates to influence policies; using community outreach, including CHWs, to mobilize patients; and, developing model organizational practices.[2]

The Akron Accountable Care Community (ACC) is an example of this model. The ACC measures success via three factors: improved health of the whole community, cost effectiveness, and cost savings in the health care system. To address the high prevalence of Type 2 diabetes in the community, the ACC brought together hospitals and health care providers, public health agencies, employers, the Chamber of Commerce, universities, housing and transportation groups, economic developers, faith-based organizations, and others. Some of the ACC's activities combine intensive clinical programs, including self-management and prevention with community initiatives such as community gardens.[7]

Workforce Training and Development

ENSURE HEALTH CARE PROVIDERS HAVE POPULATION HEALTH COMPETENCIES

At a national level, agencies are exploring the creation of an inventory and clearinghouse of population health skills needed by health care professionals to meet desired population health outcomes such as those identified in Healthy People 2020.[8] MCDPH, with schools of public health, can train providers and provide them with population health competencies.

PROMOTE EQUITY

MCDPH and community partners can help providers understand the data on health inequities and best strategies to reduce disparities and improve health outcomes for all populations. The ACA established requirements for collecting and reporting data on race, ethnicity, sex, primary language, disability status, and sexual orientation.[9] MCDPH can have an important role in analyzing this data on a local level and sharing it with local health care organizations that can help target disparities. Arizona's REACH Program has worked to identify gaps and make plans to address inequities, and the Arizona Department of Health Services Health Disparities Center provides a number of resources that address disparities reduction at the community level. These programs will be important partners in understanding disparities and targeting the conditions which contribute to them.

SUPPORT HEALTH LITERACY

Limited health literacy disproportionately affects lower socioeconomic and minority groups. Low literacy affects people's ability to search for and use health information and services, adopt healthy behaviors, and act on important public health alerts. MCDPH has a strong history of serving these target populations and can provide the types of information and languages that are necessary, accessible, and culturally appropriate.

Joint Health Assessments, Data, and Planning

LEAD THE USE OF DATA TO IDENTIFY COMMUNITY HEALTH ISSUES AND DETERMINE APPROPRIATE INTERVENTIONS

Health departments have an important role in using Health Information Technology (HIT) to identify preventable diseases, as well as hospital admission and high cost "hot spots". MCDPH can convene academic, health, and community partners for a "hot spot" analysis of costly preventable health conditions.[10] HIT systems and electronic health records (EHRs) have great potential for the collection and analysis of health data and interactive communication among providers, health departments, and community providers. Health care systems and MCDPH should collaborate to invest in, and/or apply for, funding to create an adequate infrastructure that maximizes population health planning and connects different sources of data so they are interoperable and available in real-time, which can permit vital new capabilities to identify health trends.[4] In addition, Arizona should investigate the use of an All-Payer Claims Database, as many other states have, to monitor quality, costs, and outcomes from both public and private payers.

HEALTH INFORMATION EXCHANGE (HIE)

The capability to exchange timely patient health information across systems is important, allowing health care providers to share information with community agencies that are supporting the same patients and leading to more seamless care.

This is critical for community providers that wish to participate with ACOs and other models providing a continuum of care. Establishing HIEs requires extensive resources and planning, and MCDPH can bring together health care providers and community organizations to define the required capabilities.

In North Carolina, a multi-stakeholder taskforce recommended a new statewide HIT system that would accomplish: consumer acceptance; privacy and security; health care delivery adoption of EHR; improved population health; and, multi-stakeholder guidance.[11] MCDPH could play an important role in facilitating such a process.

JOINT PLANNING EFFORTS

MCDPH can promote various health care institutions to work together to jointly plan and focus resources to target high need populations, identify priority health drivers and indicators, and high cost health priorities through the required CHNA and CHIP processes for nonprofit hospitals. Unfortunately, many hospitals are working independently even though they serve common neighborhoods and populations. MCDPH can help them work together to achieve collective impact by agreeing on measures and interventions to more efficiently and effectively improve population health outcomes and reduce health spending.

In Vermont, public health and health care cost containment leaders are exploring the creation of a Vermont Population Health Working Group which would, among other things, recommend coordinated population health indicators. MCDPH can convene such a group to promote a coordinated approach to public health and health system planning and performance measurement.

CHAMPIONS AND NEW FUNDING FOR PREVENTION

Health care providers and leaders can be among the most effective champions for prevention and public health. In collaboration with other organizations, health care providers can have a strong voice in advocating for public health funding that will foster prevention and health improvement. In Massachusetts, public health, health access, faith-based advocates, CBOs, as well as business and municipal leaders came together to call for the creation of a new Prevention and Wellness Trust Fund as part of a health care payment reform law. These funds will be used for programs to stem chronic illnesses such as diabetes, asthma, and heart disease that are fueling the growth of medical costs. The funds for The Trust will be paid for by a surcharge on insurers and larger hospitals.[12] Under the expansive prevention program, communities, health care providers, regional planning agencies, and health plans can apply for grants to address preventable illnesses. Up to 10% of the $60 million dollars over four years are designated to help employers launch work-based wellness programs. More information can be obtained from the MA Public Health Association which led the legislative effort, at www.mphaweb.org.

Health Care Organizations as Employers

PROVIDE AND PROMOTE PREVENTIVE BENEFITS TO EMPLOYEES

As employers, health care organizations face the same financial pressures as other employers and must struggle with what kinds of insurance to provide. Health care organizations can contribute to promoting health by negotiating insurance benefits that cover robust preventive services and promoting them to employees. Health departments can advise on evidence-based coverage, using the CDC's Guide to Clinical Preventive Services.

OFFER STRONG EMPLOYEE WELLNESS PROGRAMS AND A HEALTHY WORKPLACE

Health care providers can implement evidence-based changes to create a healthy workplace, such as creating opportunities for physical activity, offering healthier food in cafeterias and vending machines, and establishing smoke-free outdoor policies. In addition, health care providers can develop worksite wellness programs in partnership with MCDPH as part of the Healthy Arizona Worksites Program. The health department can recommend best practices using the U.S. Guide to Community Preventive Services and their National Healthy Worksite Program. Healthier worksites send important health messages to patients, as well.

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