

REFORMING OUR NATION'S HEALTH SYSTEM: LESSONS FOR THE PUBLIC HEALTH COMMUNITY



A Report from APHA's Summit on Health Reform

“That our generation is able to succeed in passing this reform is a testament to the persistence — and the character — of the American people, who championed this cause; who mobilized; who organized; who believed that people who love this country can change it.”

— President Barack Obama at the signing of the Patient Protection and Affordable Care Act



EXECUTIVE SUMMARY

On Nov. 6, 2010, hundreds of public health professionals from around the nation traveled to Denver to discuss the promise of historic changes to the U.S. health system and the role that public health will — and must — play if health reform is to fulfill its most fundamental goal: A nation in which all residents have access to the opportunities and advantages that afford good health and well-being.

Organized and hosted by the American Public Health Association in conjunction with its 138th Annual Meeting and Exposition, APHA's Summit on Health Reform welcomed more than 400 public health professionals and featured a diverse group of speakers, including some of the nation's top public health leaders and decision-makers. For the public health community, the health reform law is an opportunity to be embraced and enhanced, and the APHA summit was a chance for public health professionals to begin that journey as individuals, as colleagues and as a collective.

Topics of the summit included an overview of the landmark health reform law and its considerable prevention and public health provisions, lessons and experiences from states that have implemented their own versions of health reform as well as the role that top public health agencies, such as the Centers for Disease Control and Prevention, will have in realizing the goals of health reform. Also during the summit, attendees had the opportunity to gather in more intimate, detail-oriented break-out sessions. Such sessions covered public health's particular role in health reform and its implementation — such as education, outreach, and community- and population-based prevention — as well as the very real possibility that decision-makers may cut critical public health funding under the assumption that health reform is a substitute for a strong and resilient public health system.

The great opportunities and possible threats to public health in the face of health reform led to a common thread throughout the summit: That public health practitioners at all levels must have a place and a voice at the table. That the experiences and lessons of public health professionals as well as their longtime ties to the communities they serve are critical to realizing the promise of health reform. Like many times throughout public health history, summit attendees were called upon to add "advocate" to their resumes — to help protect public health's past and ongoing accomplishments and ensure public health concerns remain center-stage as the new law is implemented.

"It's not going to be enough to study health reform," said then-APHA President Carmen Nevarez as she welcomed attendees to the summit. "You're going to have to be activists. If we want to have any role in health reform in the next decade, we have to stand up, get going, write letters, call senators, call congressmen and congresswomen and really develop our agenda for public health, for prevention. Be very clear and as they say, vote early and vote often. Vote for public health and get out there and let them know what we stand for and why this is good for our country."



"It's not going to be enough to study health reform. You're going to have to be activists."

—Carmen Nevarez
APHA Past President

In March 2010, Congress passed and the president signed into law the Affordable Care Act, which puts in place comprehensive health insurance reforms that will hold insurance companies more accountable, lower health care costs, guarantee more health care choices and enhance the quality of health care for all Americans.

—www.healthcare.gov

THE NEW LAW OF THE LAND

50 million people in the United States were uninsured in 2009, a rise of 4.5 million from the previous year.

Seven months before APHA's summit and following more than a year of acrimonious debate and public wrangling, President Barack Obama signed the 2,409 page health reform bill — officially titled the Patient Protection and Affordable Care Act — into law.

The law — shorthanded to the Affordable Care Act — was nothing short of a re-ordering of national health priorities and the most significant transformation of the nation's health system since the advent of Medicare and Medicaid. While not perfect, it would add 32 million Americans to the rolls of the insured by 2014, and Medicaid eligibility would be expanded. Community health centers will see an \$11 billion infusion over the next five years, and private insurance plans and Medicare must offer first-dollar coverage of a range of prevention services.

The law includes broad and comprehensive provisions to improve and promote the health of every American. Specifically, children can no longer be denied coverage based on pre-existing conditions. Adults with pre-existing conditions are afforded new coverage options. Young adults are able to remain on their parents' policies until they reach age 26. New insurance plans and Medicare would cover, without cost-sharing, the most important immunizations as well as expanded preventive care for children and women.

Not only will health insurance and services be accessible to millions more, but increased prevention, wellness and public health initiatives were also codified into the law.

Lauded as "a new era for health care and public health in America," the law created a National Prevention, Health Promotion and Public Health Council, which was charged with developing a national prevention strategy, and a Prevention and Public Health Fund that will direct \$15 billion over 10 years to communities across the country. Programs to combat obesity and tobacco use, including smoking-cessation for pregnant women, will be enhanced, and community prevention grants will be made available to tackle a variety of local health issues, such as nutrition and injury prevention.

The imperative for reform is evident. U.S. Census Bureau figures reported a record 50 million people in the United States were uninsured in 2009, a rise of 4.5 million from the previous year. According to the Census, 16.7 percent of Americans were uninsured in 2009, a rise from 15.4 percent in 2008. Furthermore, fewer Americans — less than 56 percent — were covered through employer-based insurance, the lowest rate since 1987.

In addition, U.S. health care costs continue to skyrocket, and the nation's chronic disease and obesity rates show few signs of abating. According to some researchers, children today may face shorter life expectancies than their parents.

It was against this backdrop of impending change and formidable challenges that APHA convened its Summit on Health Reform.

For the summit's agenda and list of presenters, see page 24.

A NEW DAWN FOR HEALTH IN AMERICA

The hour was early and breakfasts were still being digested when Dr. Carmen Nevarez, then-president of APHA, opened the summit, rallying attendees and the public health community at-large to wed itself to history.

“The next two years are going to be very hard for us in public health,” Nevarez said. “Many forces are lining up to push prevention and prevention funding over into the background. Our job is to clearly communicate what we mean in prevention...to very precisely articulate why this is important to our country and to make sure that we are heard.”

Nevarez urged attendees to “find that part (of the health reform law) that really relates to your interest” and use your public health experience to help move the health reform agenda forward.

Diving straight into the specifics of the law, Howard Koh, assistant secretary for health at the U.S. Department of Health and Human Services, led summit attendees through an overview of the new health reform law and its public health provisions. While wider access to health insurance has been the highest profile aspect of the law, for many public health officials, the new opportunities to keep people out of the health care system are the most encouraging pieces of the legislation.

“The Affordable Care Act puts prevention front and center in the conversation,” he said. “Until now in the public debate, we haven’t heard much about preventive measures. This is the part that may have a tremendous legacy moving forward.”

Koh emphasized the law’s creation of a new National Prevention, Health Promotion and Public Health Council, which involves more than a dozen federal agencies and cabinet secretaries charged with developing a National Prevention and Health Promotion Strategy. The strategy is intended to help shape public health and prevention activities at all levels.

“New funding from the Prevention and Public Health Fund (\$500 million in 2010 and projected to grow to \$2 billion annually) will invest in new prevention activities across the country,” said Koh.

All new health insurance plans, Koh told the summit, must cover certain high-value and proven-effective preventive tests, including screening for breast, cervical and colorectal cancer, with neither co-pay nor deductible costs attached. Koh noted that studies show Americans receive only about half of the clinical preventive services currently recommended.

The new law will also help address racial and ethnic disparities in health access and disease rates and direct work to better understand and eventually break through the barriers to achieving health equity for all, Koh said. All federal health programs will be required to collect data on how women and minorities experience the health care system.

“As a clinician and a provider I have seen too often how disadvantaged populations carry too much of the burden of illness in this society,” Koh said. “As a Korean-American and son of immigrants, I feel like I have lived this story personally and professionally.”



The new law will help address racial and ethnic disparities in health access and disease rates and direct work to better understand the barriers to achieving health equity for all.

Health reform also tasks HHS with assembling a national strategy for quality improvement, including data collection. Koh said attendees should expect to see a more unified strategy on the topic as well as heightened efforts to ensure insurance premiums are used in the most efficient way, noting that large employer plans must devote at least 85 percent of their premiums to health and quality care.

To illustrate the impact health reform is already having, Koh presented a video about Gail O'Brien, who was diagnosed in March with high grade non-Hodgkin's lymphoma, a life-threatening illness requiring immediate treatment. Lacking insurance, she had to wait five months until health reform

provisions kicked in that allowed her to begin what has been reported to be successful treatment. In the video, President Obama is seen telephoning O'Brien, who told him, "If it wasn't for you, I wouldn't be here right now."

However, stories don't have to have immediate life-or-death implications to resonate with policy-makers, Koh noted.

"As a physician who has cared for patients for over 30 years I know health is a gift, and the only way to protect that gift is through the power of public health and the power of prevention," he said.

Implementing health reform, however, won't be easy.

"I know health is a gift, and the only way to protect that gift is through the power of public health and the power of prevention."

— Howard Koh, Assistant Secretary for Health
U.S. Department of Health and Human Services



“We are going to develop the first-ever national prevention strategy. We hope to move from a system of sick care to a system of prevention and wellness. ...We have to address those social determinants of health. Poverty and dropout rates are at least as important a health problem as smoking.”

—Regina Benjamin, U.S. Surgeon General



PRESCRIPTIONS FROM THE NATION'S DOCTOR

"We have to encourage each other, keep the perseverance going," Koh told attendees. "I'm convinced in the long run this is going to make a difference to millions and millions of Americans."

U.S. Surgeon General Regina Benjamin, often referred to as the nation's top "doc," followed Koh to discuss how health reform will advance and elevate prevention in health care. As surgeon general, Benjamin chairs the National Prevention, Health Promotion and Public Health Council, which was created with the passage of health reform and is charged with developing a national prevention strategy.

"We are going to develop the first-ever national prevention strategy," Benjamin said. "We hope to move from a system of sick care to a system of prevention and wellness."

The nation's 18th surgeon general, whose work in the field includes founding the Bayou La Batre Rural Health Clinic in rural Alabama, reinforced the concept that health reform encompasses far more than just having access to health care.

"We have to stop people from getting sick in the first place," she told summit attendees. "We have to address those social determinants of health. Poverty and dropout rates are at least as important a health problem as smoking."

Despite more Americans being covered by insurance and even with many preventive services provided with no co-pay or deductible, cost can still be a barrier to many.

Benjamin told the story of one of her patients, "a 40-something African American woman about that tall (extending

her hand below shoulder level)." The woman had been prescribed medication for back pain and when Benjamin saw her again, she asked if the medicine had helped. Her patient responded that she hadn't received the medicine yet, as she wasn't able to afford the co-pay until she received a paycheck later that week. In response, Benjamin said she dispatched a nurse to the pharmacist to get the medication, only to find her patient embarrassed for needing the help.

"I realized at that moment I had taken her dignity from her," Benjamin said. "I told her we have people who donate small pots of money and you can pay it back on Friday if you want to. Then she said, 'Oh, by the way, can I get a work excuse?' She said she had to go back tonight to strip the wax off the floors so kids can go to school in a clean place. It's people like her we advocate for."

Government, Benjamin noted, needs to make it easier for people to live healthier lifestyles. As part of that work, officials and health workers must address the social determinants that impact health. As public health has long known, good health often depends on a person's physical and social environment, and even factors that would seem to make little difference can have considerable impact. For example, Benjamin said, among the geriatric population, people tend to live longer if they live on a street with homes that are conducive to healthy lifestyles and developing a sense of community such as those with front porches.

"We can build safe parks where the sidewalks are there for people to walk," she said. "Those of us in public health know you take infrastructure for granted, but you need the infrastructure to get things going."



"We hope to move from a system of sick care to a system of prevention and wellness."

—Regina Benjamin,
U.S. Surgeon General

LESSONS FROM MASSACHUSETTS

Massachusetts health officials have several years of hands-on experience with health reform. The state enacted a comprehensive health reform package in 2006 with many of the same provisions — including mandatory insurance coverage — contained in the federal health reform law.

Based on what he has seen in his state, John Auerbach, commissioner of the Massachusetts Department of Public Health, told summit attendees how the simple act of enabling millions more Americans to get an insurance card will also aid public health goals. Now able to access the health care system before falling ill, Massachusetts residents are now receiving flu shots, being referred to preventive screenings such as colonoscopies and are offered help to quit smoking.

“There is a direct relationship between your health and having that insurance card,” Auerbach said. “People who lack insurance often sought care in the emergency department. If they were sick, or had an accident, their immediate needs were treated but they were less likely to get a flu shot.”

Auerbach said his state has seen dramatic differences between uninsured and insured populations who had seen doctors. Studies have shown that about 75 percent of insured patients received preventive services compared to about one-third of those who lack insurance. Those with insurance are also much more likely to see a dentist, but less than half without insurance do.

Health Reform: No Substitute For Public Health

While having health insurance is definitely a boost to overall public health goals, health reform can pose certain threats to public health as well. In particular, and especially

considering the current budget shortfalls in many states, policy-makers may make the assumption that health reform measures can fill in the gaps that arise from cutting public health funds and services. In response, public health officials need to be vigilant watchdogs against the perception that health reform is a substitute for public health, Auerbach stressed.

In Massachusetts, health reform was an expensive endeavor, and state officials looked for ways to save money, many assuming that with the implementation of the state’s health reform plan, some public health services were no longer needed. It’s a move that public health professionals need to be on guard for, Auerbach told the summit. Auerbach cited studies in Massachusetts that 25 percent of people with insurance said costs were still a barrier due to co-pays and deductibles.

“We had a \$50 million cut in childhood immunization because (legislators) assumed insurance would pay for it,” Auerbach said. “We had a women’s health network program for breast and cervical cancer screening for the uninsured. In the first year, the number plummeted because when they came in, we signed them up for insurance instead, but we found fewer of them going in for screening because of the deductible. In the (federal reform law), that program was protected without a deductible.”

Protect Public Health By Being At The Table

Public health officials have to be at the table when insurance companies are making determinations about coverage at the state level and must play a role in helping design new insurance packages and the services they offer, emphasized Auerbach. Public health has a unique perspective and



“There is a direct relationship between your health and having that insurance card,” Auerbach said. “People who lack insurance often sought care in the emergency department. If they were sick, or had an accident, their immediate needs were treated but they were less likely to get a flu shot.”

— John Auerbach,
Commissioner, Massachusetts
Department of Public Health

experience in promoting good health that can unfortunately be lost if no one is there to speak up for it.

“I say that after sitting at the table with insurers and recognizing there weren’t public health people talking about the importance of prevention and screening,” he said. “(Public health officials were) the only ones who talked about community health workers in terms of being part of the clinical care team, about substance abuse and mental health. We became the strongest advocates of understanding how co-pays and deductibles could concretely become obstacles to people accessing certain kinds of care.”

Within the context of health reform, trying new methods for delivering public health services can be vital in keeping costs down and in protecting key public health efforts. As reform brings health care to millions of additional people, it is inevitable that the discussion will turn to cost and results. They are questions that public health must be ready to answer, Auerbach said. It is up to public health to make the case — often an economic case — to justify its work.

“(I’ve) discovered people will only take me seriously if I talk about return on investment within a two-year period,” he said. “We can’t always demonstrate that but sometimes we can and (we) need to go out of our way to do those studies.”

In Massachusetts, Auerbach said insurers dismissed his recommendations on nicotine replacement therapy, arguing that the long-term effects and costs of smoking would be paid for by Medicare. In response, a study was conducted examining the difference between Medicaid beneficiaries who took advantage of nicotine replace therapy versus those who didn’t. After the first year, health researchers found statistically significant cost savings related to the prevention of myocardial infarctions and other medical conditions, Auerbach reported.

“I was able to go back to the table and say it’s not just Medicare that will be saving, you will save in two years and here’s some data that will be useful to you in terms of making those actuarial decisions that are going to be part of designing what the insurance packages include,” he said.

In the wake of health reform, public health also needs to “re-address our service model,” Auerbach said. For example, Massachusetts traditionally didn’t bill for tuberculosis services in public health clinics before the state’s health reform bill passed. However, Auerbach said, public health workers found that insured patients didn’t mind being asked for their insurance cards, as long as it was done in a sensitive manner. Patients knew they’d receive such services regardless of their willingness to present insurance coverage.

“We found the majority of patients are willing to have us bill third-party insurance, and we were able to diversify our funding base for the long term of some of these important services,” Auerbach said. “Historically, public health didn’t do that.”

Beyond health service delivery, public health professionals must also rethink exactly how public health fits into the new model for health reform. For years, Auerbach noted, public health was critical in filling the primary care gap, providing the immunizations, STD testing and tuberculosis screening that many were simply going without. But times are changing: As people who typically sought services under the public health system now have the coverage to seek out medical providers, should public health slowly transition out of its safety net role or develop its own systems to capture third-party reimbursement?

“We have to take this really seriously,” Auerbach urged the summit.

THE BREAKOUT SESSIONS: ORGANIZING FOR THE HEALTH OF THE PUBLIC

Following the summit's plenary sessions and keynote speakers, attendees had the opportunity to gather in more intimate breakout sessions led by a range of public health professionals, including state officials, public health professors and experts in public health advocacy. Topics ranged from promoting prevention to protecting effective public health programs, with all discussions taking place within the context of health reform, its opportunities and challenges. The following covers a portion of the diverse discussions that took place.

Show How Prevention Can Work — And Save Money

Prevention not only works to save lives, but it can save money — a proposal that the private sector is becoming more and more interested in as well, according to Jonathan Lever, vice president for health strategy and innovation at YMCA USA, who spoke during the summit's afternoon breakout session on "Achieving Prevention and Wellness."

In 2009, with funding from the Centers for Disease Control and Prevention, the YMCA of Greater Louisville, Ky., began offering the YMCA's Diabetes Prevention Program. Under federal health reform, the National Diabetes Prevention Program at CDC was funded at \$80 million.

"It's been proven to work and the YMCA has been proven to get 6 percent weight loss per participant, which is really key to prevent someone from getting diabetes," Lever said.

With additional support from CDC and UnitedHealth Group, the program has since expanded to nearly 20 additional YMCAs throughout the country and companies such

as Delta Airlines and KeyCorp are underwriting the costs of their employees' participation.

"This is completely paradigm-busting, the first time a major private payer is paying for prevention," Lever said. "It's group-based prevention and it's performance-based. If people don't lose the weight, the YMCA doesn't get paid. If participants lose more weight, the YMCA gets paid more. Everybody's interests are aligned and it's spreading at a ferocious speed."

Not only does the program speak to the benefits of prevention, it highlights the need for public health to branch out more often and partner with the private and nonprofit sectors. In fact, Lever cited an American Express survey released in November 2010 showing that 71 percent of respondents trusted nonprofits more than government or industry to address the most pressing needs of the day.

"Community-based organizations are the arms, legs and pulse of the community," he said. "As you think about where people live, work and play, they're often around the very community-based organizations you would want to involve in your work. They are very much born because of a need in the community."

Lever noted that because community-based organizations are often less encumbered by political constraints and less identified with a particular point-of-view, they are able to attain greater stability when mobilized around an issue. On the flip side, health departments are often restricted in their activities due to their ties to government.



Weight loss is key to preventing diabetes. With funding from CDC, the YMCA's diabetes prevention program achieves 6 percent weight loss per participant.



Community gardens not only improve access to fresh fruits and vegetables, they improve physical activity and increase social cohesion.

"(Community-based organizations) have the ability to advocate, have email lists, distribution lists, they can rally people up and get people excited," he said.

And sometimes they can get to the heart of the matter by aiming at the stomach.

"We can buy food for meetings," Lever said. "I am mystified at all these meetings I go to at dinnertime, lunchtime and you have to figure out how to have your own food. I say that with some tongue-in-cheek, but there is a spirit of hospitality that (community-based organizations) can bring that help facilitate relationships and help facilitate social cohesion."

Nonprofits can also lobby, he said — a crucial aspect of achieving public health goals that, many times, public health workers are unable to do because of their jobs.

"They can do things that you as health departments have more constraints around," Lever said. "Particularly when you're talking about policy, to have citizens be able to talk to legislators about specific bills is a real asset."

Tell The Story Of Prevention

When public health officials are attempting to secure funding and support for programs, real stories about how programs impact and affect real people can be more effective than reams of statistics, pie charts and power points, said Sanne Magnan, commissioner of health with the Minnesota Department of Health, during the summit's prevention-focused breakout session.

"We have to talk a language and connect to people in different ways to have them see themselves, their families, their friends and their neighbors in terms of prevention," Magnan said. "It takes both data and stories to help people

understand the full impact of health issues. Stories help illustrate facts and make them hit home in a different way."

For example, a staffer from the Minnesota health department, testifying before the state's legislature about obesity and tobacco trends, told a story about a community garden in Rochester. The testimony illustrated how the community garden not only improved access to fruits and vegetables, but brought people together in a community-wide effort. It helped legislators — those who hold the purse strings — identify more closely with a public health effort that could take years to produce the substantial, positive health data policy-makers often seek.

"When you listened, you could really see the community garden and you could see legislators making connections that helped them understand," Magnan said. "One influential legislator saw her family in the story and remarked, 'When my kids were growing up, we had a garden and I believe that is why they eat healthy.' She was the one who got us the \$47 million over two years (for the Statewide Health Improvement Program)."

Minnesota's Statewide Health Improvement Program (SHIP) was part of sweeping health reform legislation signed into Minnesota law in 2008. Public health was centrally involved in crafting the state's health reform efforts, however Magnan stressed language mattered when pitching public health programs.

"SHIP was originally called Statewide Health Promotion Program," she said. "To (state legislators) that sounded like trinkets and key chains so we changed it in the middle of the legislative session. We knew what it meant, but to policy-makers it sounded like trinkets."

“To achieve prevention and wellness, it is critical to work with partners. It is important to build collaborations and partnerships with natural allies.”

—Sanne Magnan, Commissioner, Minnesota Department of Health

Speaking their language can also mean incorporating policy-makers’ priorities as well. In Minnesota, she said, there’s a strong emphasis on personal responsibility. It was an issue public health workers took to heart.

“Instead of fighting that, we said, ‘Yes, there should be personal responsibility but there’s also community responsibility,’” Magnan said.

For example, people should take personal responsibility for their health by getting enough physical activity. However, the people that need it most may not live near gyms or can’t afford a membership. That’s why an individual-community partnership is necessary, said Magnan, pointing to the need to make streets safer for biking and walking and, in turn, increase the opportunities for physical activity for all.

Magnan also urged public health agencies to “work closely with your medical association and get upstream.” In Minnesota, the state’s Statewide Health Improvement Program stemmed from work that began with several initiatives,

including one that originated with the Minnesota Medical Association.

“To achieve prevention and wellness, it is critical to work with partners,” she said. “It is important to build collaborations and partnerships with natural allies. When it comes to tobacco cessation and community ordinances about smoking, for example, medical associations and providers are important allies to do prevention work.”

States such as Minnesota and Massachusetts that have experience with statewide health reform bills can offer lessons to state and local agencies as they implement federal health reform initiatives.

“The work we are doing to address the need for better quality and lower costs in health care is valuable experience that can be used by other states and the federal government to tackle the fact that we have a health care value problem in the United States,” Magnan said.

HEALTH REFORM: A BOON FOR COMMUNITY HEALTH CENTERS

Community health centers and their role in reaching at-risk populations was touched upon during the breakout session on “Valuing Clinical Programs.” The centers, one of the few remaining programs from President Lyndon Johnson’s War on Poverty, are poised to receive \$11 billion for expansion under federal health reform. Today, more than 7,900 community health centers serve more than 20 million patients and capacity is expected to double by 2015, according to the National Association of Community Health Centers.

Community health centers are typically located in high-needs areas and must provide a set of services that are comprehensive and open to all residents in the community where they are located regardless of a person’s ability to pay. The centers are governed by community boards, which, by statute, must have 51 percent of its members consist of those who use the centers for care. It’s a unique part of the centers’ governance, said Paul Melinkovich, community health services director at Denver Health, who spoke during the breakout session. Melinkovich noted that Denver’s community health centers were the third to open in the country.

“One in four (who receive community health center care) are low-income uninsured and a large number (are) farm workers, migrants and rural residents,” he said. “(The centers) vary considerably by location and have developed partnerships based on what exists in the community.”

In addition to medical services, Melinkovich said the centers provide HIV testing, breast and cervical cancer screening, immunizations, contraception services, dental services, behavioral health services and help people navigate the health care system. A significant number of community health center patients are living with chronic diseases. With the boost from health reform, community health centers are poised to play a huge role in bringing much-needed care and services to underserved populations.



Under health reform, Community Health Centers will play an even greater role in providing much-needed care to at-risk populations.

“Make sure you go out there and let the public know this great law passed and thank the legislators who did it. ... They’re human, they like a pat on the back.”

—Vincent DeMarco, President, Maryland Citizens Health Initiative



IT'S NOT JUST PREVENTION, IT'S POLITICS

Even as public health workers and advocates entrench themselves in the business of implementing the landmark law, the promise of health reform is not safe. More than two dozen states are suing to overturn the law and controlling members of Congress are working for its repeal. But, public health officials can employ a variety of strategies to counter opposition to health reform, said Vincent DeMarco, president of the Maryland Citizens Health Initiative and a speaker during the breakout session on “Addressing Education and Outreach.”

“Brag and thank,” DeMarco said. “Make sure you go out there and let the public know this great law passed and thank the legislators who did it. When we passed our health care expansion in Maryland in 2007, we bought a full-page (thank-you) ad. They’re human, they like a pat on the back.”

DeMarco urged summit attendees to get heavily involved in the regulation and implementation of health reform, calling on them to positively advocate and educate on behalf of the landmark law. In Maryland, he said, his organization ran ads educating readers on the hidden costs of uninsurance, highlighting the fact that as of 2008, insured families pay about \$1,000 a year in extra premiums to help cover the cost of uncompensated care.

TRANSFORMING COMMUNITY HEALTH

Community health and prevention are expected to receive huge boosts via health reform and its Community Transformation Grants. The grants are aimed at improving nutrition, increasing physical activity, promoting smoking cessation, advancing social and emotional wellness, and prioritizing strategies to reduce health disparities.

As public health advocates prepare to apply for such grants, they should pay close attention to how themes from the Communities Putting Prevention to Work Grants, which were included in the 2009 economic stimulus package, feed into the themes of health reform's Community Transformation Grants, said Regina A. Galer-Unti, a professor of public health at Walden University and speaker during the breakout session on education and outreach.

"If you're going to write a grant, look into those (stimulus) grants because they are precursors to these (new) grants," she said. "Obesity and tobacco are all that are being funded at the moment, but it's going to move out from there. Why are those the big movements? Because we know we can make some great systems change there."

Similar to the economic stimulus grants, grant writers seeking new health reform funds should stress the theme of local prevention education.

"If you don't make it local, we're going to lose the money and we're going to lose it fast," said Galer-Unti.

For example, in suburban Denver, the Tri-County Health Department is working with 15 school districts to promote healthy food and drink choices and physical activity. The effort includes partnering with LiveWell Colorado and PBS Channel 12 to develop and implement a social marketing campaign about the issues, convincing local restaurants to adopt a menu-labeling policy and creating sustainable community gardens in underserved areas to increase access to healthy food for low-income residents.

In addition to grant work, Galer-Unti stressed the need to educate the public about health reform's prevention provisions and their importance. She noted that congressional attempts have been made to re-appropriate — and essentially eliminate — the \$15 billion Prevention and Public Health Fund created by the health reform law. That's why it's essential that we start to educate people now, Galer-Unti said, and the way we start is by informing people about what prevention does, how it saves money and why it's important to communities.

"If we spend \$1 on prevention, we save about \$5.60 on health care costs," she said. "It's important that people you're near and dear to learn about this."



"If we spend \$1 on prevention, we save about \$5.60 on health care costs. It's important that people you're near and dear to learn about this."

—Regina A. Galer-Unti,
Professor of public health
at Walden University

EXPANDED PRIMARY CARE WORK FORCE

America's primary care work force will expand by an estimated 16,000 new physicians, nurses and physicians' assistants over the next five years due to the health reform law as well as the 2009 economic stimulus package, officially known as the American Recovery and Reinvestment Act of 2009. Included in the health reform law are up to \$1.5 billion for the National Health Service Corps by 2015, which would especially target the health needs of underserved communities.

"We have a national shortage of many kinds of workers, whether it's physicians, nurses, public health workers, pharmacists or the like," said Linda Rosenstock, dean of the UCLA School of Public Health, during the education and outreach breakout session.

Among other work force initiatives, health reform provides for the National Health Care Workforce Commission, which will make recommendations on national health work force priorities, goals and policies. It also authorizes the Public Health Workforce Loan Repayment program, which assists public health students or graduates working for federal, state, local or tribal public health agencies, Rosenstock told summit attendees.

"We have to take advantage of this window of opportunity to do some serious re-thinking about the way we're educating health professionals," Rosenstock said. "We need much more serious dialogue about inter-professional education. We need to be much more nimble and creative than we've been."

Rosenstock noted that while many such work force programs have been authorized by Congress, they've yet to be appropriated funds — "something we all need to be vigilant about," she said.



16,000

new physicians, nurses and physicians' assistants over the next five years will be added to America's primary care work force due to the health reform law as well as the 2009 economic stimulus package.

EDUCATING THE PUBLIC AND ENSURING EQUITY

“Who’s going to focus on the social determinants of health, physical determinants of health and economic determinants of health that account for most of the disparities if we don’t?”

—Jonathan Fielding
Director, Los Angeles County
Department of Public Health



Along with expanded insurance coverage, health reform also brings with it the opportunity to educate the public as well as policy-makers on the importance of public health and its work to elevate social justice and equity. Public health professionals, with their on-the-ground experiences and distinctive knowledge of the many contributors to good health, are uniquely positioned to lead such a movement, said Jonathan Fielding, director of the Los Angeles County Department of Public Health, who spoke during the summit’s breakout session on “Protecting Impacted Public Health Programs.” During the session, Fielding challenged public health officials to be steadfast.

“Who’s going to focus on the social determinants of health, physical determinants of health and economic determinants of health that account for most of the disparities if we don’t?” asked Fielding, echoing the earlier remarks of the surgeon general. “Who’s going to talk about social disadvantage? Who’s going to talk about the history of racism, economic discrimination? Those are health issues and they have bigger impacts on health and health disparity than all the health care in the world. Health care is very important, but it’s not the only important thing.”

Fielding called on attendees to make an effort to draw more attention to the impacts such determinants have on health status and tie such impacts to the larger economic strength and well-being of the nation. If we don’t do it, “we’re not doing our job as public health advocates,” he said.

PUBLIC HEALTH MUST CARVE OUT ITS ROLE

The increased number of insured Americans raises a number of issues for local public health departments as well, said Fielding. For example, if more people begin seeking out immunizations, public health should ensure it remains central to such efforts.

“We know the population, we should be part of this,” he said. “We can be more efficient at higher volume and we should get a contract to be part of this.”

Expanded health care access must also come with expanded education in order to reap positive health outcomes, such as educating families on the importance, safety and effectiveness of vaccines. As the health reform law directs more funds to immunization efforts and their proven success at preventing disease — such as authorizing states to purchase adult vaccines at federally negotiated prices and offering grants to improve vaccination rates — public health advocates must increase their educational outreach as well, Fielding said.

“There’s a lot of information that a lot of parents don’t get,” Fielding said. “(Some parents are) still concerned about (vaccines causing) autism and they haven’t seen the ravages of the diseases that we have vaccines to prevent. They don’t understand the importance, and that’s our job.”

Fielding also discussed the burgeoning use of electronic health records. The health reform law requires health plans to begin adopting and implementing secure methods for the electronic exchange of health records by 2012.

“Electronic health records is a huge area in itself and I don’t think we have near the set of standards and approaches,” said Fielding. “But there are a lot of different systems. How those are all going to work together to get a composite picture is the trick.”

For example, even though more opportunities exist for Americans to receive immunizations, such as at supermarkets and drug stores, it’s important they be part of the same health record registry, Fielding said, “otherwise we’re going to have all these duplications, all these questions about whether people have been immunized or not.”

“We’re going to get there but it’s going to be a lumpy set of standards because we haven’t mandated a particular system,” he said. “We’ve basically put a lot of money out and said, ‘Try different things.’”



The health reform law requires health plans to begin adopting and implementing secure methods for the electronic exchange of health records by 2012.

“There are those who will say we don’t need Ryan White [program] because by 2014, we will have health reform and that will be all we need. ...But I would beg to say differently.”

— Mildred Williamson,
Chief, HIV/AIDS Section, Illinois Department of Public Health

PROTECTING PUBLIC HEALTH PROGRAMS

Some vital public health programs may be at risk because of faulty assumptions that such services will now be covered by the expansions under health reform. Mildred Williamson, a public health social worker and chief of the HIV/AIDS Section for the Illinois Department of Public Health, pointed to the success of HIV/AIDS programs that assist people living with the disease as an example of a successful public health program that could now be at risk.

“There are those who will say we don’t need Ryan White (Comprehensive AIDS Resources Emergency Act) because by 2014, we will have health reform and that will be all we need,” she told attendees during the breakout session on “Protecting Impacted Public Health Programs,” referring to the federal program that helps low-income people living with HIV/AIDS. “But I would beg to say differently.”

By 2014, Williamson said, Medicaid expansions will go far in helping sustain and bring more people into such programs, but they are not likely to reach all at-risk populations, such as undocumented immigrants and people coming out of the prison system. Like many diseases, HIV/AIDS infection rates are impacted by a number of social determinants and policies. In turn, public health workers must advocate that health be considered during the development of all policies, especially those traditionally viewed as outside the public health arena.

“Immigration reform is a public health issue,” Williamson said. “Correctional health in general is a public health issue. People in facilities will be coming back to the community. From a public health perspective, we have studies that show when screening is reduced in jails, STDs and rape go right up in the community. We need to roll those studies back out and make the case with those policy-makers.”

DESPITE REFORM, MANY WILL REMAIN UNINSURED

Even though millions more Americans will be covered by insurance under the health reform law, many will still remain off the insurance grid. The Congressional Budget Office estimates that 23 million people will still be uninsured in 2019, said Williamson.

The remaining uninsured include immigrants who are not legal residents and therefore not eligible for Medicaid or federal subsidies to help them purchase insurance. Also among the uninsured will be those who are eligible for Medicaid but remain unenrolled, those who are exempt from the individual mandates for financial reasons, and those who choose to pay a penalty instead of purchasing health coverage.

"It is expected that many of the remaining uninsured will be low-income, so that the need for a strong network of safety net providers to care for these uninsured will continue," Williamson said.





(If) we don't begin to work together now to address the upstream causes of illness and disease, we are never going to be able to bail our way out of this overloaded boat. This is going to demand new kinds of partnerships between care delivery and public health.

—Carolyn Clancy, Director,
Agency for Healthcare
Research and Quality

SUCCESS INCLUDES NEW PARTNERSHIPS, NEW METHODS

At the closing session of APHA's Summit on Health Reform, attendees heard from leaders at some of the country's top public health agencies. Carolyn Clancy, director of the Agency for Healthcare Research and Quality, discussed the new opportunities that technology holds for reaching people where they live, work and play. She reminded attendees that as technology and new ways of communicating march forward, public health must be open to embracing and using them to promote health.

She also called on attendees to forge new partnerships with those in the medical field, as they are critical partners in efforts to prevent disease before it happens.

"(If) we don't begin to work together now to address the upstream causes of illness and disease, we are never going to be able to bail our way out of this overloaded boat," she said. "This is going to demand new kinds of partnerships between care delivery and public health."

Echoing those sentiments, Ileana Arias, principal deputy director with the CDC, said the Affordable Care Act "is a real opportunity to make the interaction between clinical and community health larger." She said CDC is leveraging resources and partnerships, and better aligning efforts to strengthen surveillance, epidemiology, laboratory services and its other work to better address the leading causes of death and disability.

The Health Resources and Services Administration, too, has realigned major parts of its organization in the wake of the new law. Administrator Mary Wakefield said it has redesigned its 10 regional offices to better deploy Affordable Care Act initiatives and expand its services. She reported that community health centers will be the target of its largest investments in the coming few years.

The opportunities to achieve long sought-after public health goals — such as the elimination of health disparities and health equity for all — seem even clearer on the horizon. But to achieve those goals, public health workers and advocates must ensure that their concerns remain at the forefront of discussion.

PUBLIC HEALTH IS THE CONSCIENCE OF HEALTH CARE

At the close of APHA's Summit on Health Reform, the message was clear: Public health must have a voice at the table if the success of health reform is to go beyond expanding insurance rates to making the United States a global leader in good health and prevention. The opportunities to achieve long sought-after public health goals — such as the elimination of health disparities and health equity for all — seem even clearer on the horizon. But to achieve those goals, public health workers and advocates must ensure that their concerns remain at the forefront of discussion.

"We in public health have a tendency to get kind of wonky and focus on the policy but not talk about our values, not talk about the principles of equity and social justice that drive this work," said Anthony Iton, senior vice president of healthy communities at the California Endowment and moderator of the summit. "We need to do it loud, need to do it in harmony and need to support our leaders."

The work to bring the benefits of health reform to the nation is just beginning. To build upon the momentum created during APHA's summit, the Association and its partners are holding the APHA Midyear Meeting: "Implementing Health Reform — A Public Health Approach" in Chicago from June 23–25, 2011. Topics during the June meeting will cover a wide range of public health issues related to implementing the new health reform law. The gathering will also offer public health professionals another opportunity to hear from experts in the field as well as a chance for attendees to share their own ideas, experiences and suggestions. For more details on the meeting, visit www.apha.org/midyear.

Before gathering in Chicago, however, there is much to be done at home. Like many advocates like to say, change starts with you. To help guide your efforts, below are some key action points from APHA's Summit on Health Reform. Please share them with your friends, families and colleagues. Together, we can transform the health of our nation.



To learn more about what the Affordable Care Act means for public health, prevention and wellness, visit www.apha.org/midyear.

PUBLIC HEALTH IN ACTION: KEY RECOMMENDATIONS FROM APHA'S SUMMIT ON HEALTH REFORM

ADVOCATE, EDUCATE AND COMMUNICATE CLEARLY: Find what relates to you most and help move the health reform and public health agenda forward. Make sure you can articulate the value of prevention and health reform to those who matter most, including the communities you serve as well as policy-makers. Tell real stories about real people — it's almost always more powerful than charts and graphs. Explain how prevention works and why it's important. Be vigilant against false descriptions of health reform and its impacts.

PROTECT PUBLIC HEALTH: Health reform is no substitute for a robust and well-funded public health system. Make the case for why public health is a critical partner in health reform and clearly explain why evidence-based public health programs are essential to ensuring health reform results in positive health outcomes. Remind policy-makers that even with reform, people will continue to face barriers to care and look toward public health to fill in the gaps.

ADAPT, ADJUST AND FORGE NEW PARTNERSHIPS: Reassess how public health delivers services in the context of health reform. Create new alliances — achieving prevention and wellness will require collaboration with a variety of partners, including the medical community and those in the private and nonprofit sectors. Forge relationships with lawmakers and support those who support public health.

ALL POLICY IS HEALTH POLICY: Good health is more than access to traditional health care systems, it's impacted by an array of social determinants that happen outside the doctor's office. Advocate for the consideration of health in all policy decisions.

COLLECT THE DATA, SHOW SAVINGS: Health reform is an expensive endeavor and policy-makers will be anxious for results. Adjust survey mechanisms to illustrate how health reform is having an immediate impact on health and, when possible, show how investing in prevention will save dollars in the short and long run.

SEIZE THE OPPORTUNITY: The health reform law includes a number of grant opportunities for improving community health and investing in prevention and public health. Stay up-to-date, go local and be ready to compete for funds.

COMMIT TO SOCIAL JUSTICE: Eliminating disparities, achieving health equity and addressing the social determinants of health are core public health goals that must be maintained.

CLAIM A SEAT AT THE TABLE: Public health officials must be part of the conversation when insurance companies are making determinations about coverage and designing new insurance packages under the health reform law. The unique perspective and experience of public health is essential to ensuring that good health — not only expanding insurance coverage — remains a central goal of reform.

AGENDA

Summit on Health Reform

Nov. 6, 2010

Denver, Colo.

The American Public Health Association's Summit on Health Reform convened more than 400 public health administrators; federal, state and local health officials; clinicians; public health practitioners; and others to discuss the implications of the new health reform law — the Patient Protection and Affordable Care Act — for the public health system. The summit was held the day prior to APHA's 138th Annual Meeting and Exposition in Denver, Colo.

Agenda

PLENARY SESSIONS

- | | |
|-------------------------|--|
| 8:30 a.m.-8:40 a.m. | <p>Opening and welcome
 Georges Benjamin, MD - Executive Director, American Public Health Association
 Carmen Nevarez, MD, MPH - President, American Public Health Association</p> |
| 8:40 a.m. -8:45 a.m. | <p>Introduction by moderator
 Anthony B. Iton, MD, JD, MPH - Senior Vice President of Healthy Communities, California Endowment</p> |
| 8:45 a.m. - 9:45 a.m. | <p>Understanding the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010
 Howard Koh, MD, MPH - Assistant Secretary for Health, Department of Health and Human Services</p> |
| 9:45 a.m. - 10:45 a.m. | <p>Advancing prevention: The National Prevention, Health Promotion and Public Health Council
 Regina Benjamin, MD, MBA - U.S. Surgeon General</p> |
| 10:45 a.m. - 11:00 a.m. | Break |
| 11:00 a.m. - 11:45 a.m. | <p>Lessons in implementing health reform: The Massachusetts experience
 John M. Auerbach, MBA - Commissioner, Massachusetts Department of Public Health, Executive Office of Health and Human Services</p> |
| 11:45 a.m. - 12:30 p.m. | Lunch |

CONCURRENT BREAKOUT SESSIONS: Part 1

Session 1:

Achieving prevention and wellness

Moderator: Jeff Levi, PhD - Trust for America's Health; Jonathan Lever - YMCA of USA; Sanne Magnan, MD, PhD - Minnesota Department of Health; Richard L. Vogt, MD - Tri-County Health Department

Session 2:

Valuing clinical programs

Moderator: Bobby Pestronk, MPH - National Association of County and City Health Officials; Ned Calonge, MD - Colorado Trust; Debra Brinson, MPA - Ingham County Health Department; Paul Melinkovich, MD - Denver Health and Hospital Authority

Session 3:

Addressing education and outreach

Moderator: Rob Gould, PhD - Partnership for Prevention; Vincent De Marco, JD, MA - Maryland Citizen's Health Initiative; Regina Galer-Unti, PhD - Walden University; Linda Rosenstock, MD, MPH - UCLA School of Public Health

Session 4:

Protecting impacted public health programs

Moderator: Paul Jarris, MD, MBA - Association of State and Territorial Health Officials; Jonathan E. Fielding, MD, MPH, MBA - Los Angeles County Department of Public Health; Gale D. Johnson, MPA - Wisconsin Department of Health Services; Mildred Williamson, PhD, MSW - Illinois Department of Public Health

CONCURRENT BREAKOUT SESSIONS: Part 2

Above sessions 1-4 repeated

CLOSING SESSION

3:30 p.m. - 4:30 p.m.

Where the rubber hits the road: Implementing health reform within HRSA and CDC/ATSDR

Ileana Arias, PhD - Principal Deputy Director, Centers for Disease Control and Prevention and Administrator, Agency for Toxic Substances and Disease Registry; Carolyn Clancy, MD - Director, Agency for Healthcare Research and Quality; Mary Wakefield, PhD, RN - Administrator, Health Resources and Services Administration

APHA

PROTECT PREVENT LIVE WELL

The **American Public Health Association**

is the oldest and most diverse organization of public health professionals in the world and has been working to improve public health since 1872. The Association aims to protect all Americans and their communities from preventable serious health threats and strives to assure community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States. APHA is committed to health equity and a healthy global society. The Association's broad array of public health professionals are champions of and advocates for healthy people and communities.

Credits

Writer: Mark Wolf

Editor : Kim Krisberg

Photos: iStockphoto, E-Z Event Photography, Indian Health Service