IMPLEMENTING HEALTH REFORM:
A PUBLIC HEALTH APPROACH

A Report from APHA's 2011 Midyear Meeting
June 23–25, Chicago
“We know that preventing disease before it starts is critical to helping people live longer, healthier lives and keeping health care costs down. Poor diet, physical inactivity, tobacco use and alcohol misuse are just some of the challenges we face. We also know that many of the strongest predictors of health and well-being fall outside of the health care setting. Our housing, transportation, education, workplaces and environment are major elements that impact the physical and mental health of Americans.”

— Dr. Regina Benjamin, U.S. surgeon general and chair of the National Prevention, Health Promotion and Public Health Council, in an introductory message included in the country’s very first National Prevention and Health Promotion Strategy, which was released in June 2011
The history of public health in the United States is packed with prized and hard-fought gains in the health of individuals, families and entire communities. At the same time, the field’s uphill struggles only underscore the substantial failings of a health system built almost entirely on a foundation of treatment, instead of prevention. For public health practitioners working to fill the widening cracks in a crumbling system, the evidence for change is clear: record numbers of uninsured, rising rates of preventable chronic diseases, out-of-control health spending and dire warnings that today’s children may have shorter life expectancies than their parents.

Fortunately, with the 2010 passage of the Patient Protection and Affordable Care Act, public health practitioners have a number of new tools at their disposal as well as a momentous opportunity to transform the way good health is delivered and sustained. How to wield those new tools and opportunities as well as the law’s landmark investments in prevention and public health was the exclusive focus of APHA’s 2011 Midyear Meeting, which was held June 23–25 in downtown Chicago. This report chronicles the myriad discussions that took place among the meeting’s hundreds of attendees and highlights the central themes and recommendations that came out of the three-day event.

Throughout the meeting, a few central threads became apparent. Among the most notable thread was the need for public health practitioners to firmly claim their place at the health reform table and give voice to the effectiveness of prevention and its critical role in achieving health reform’s top measure of success: a healthier population. Another common thread was the call to defend proven public health programs. In other words, to make the case that while health reform is a positive step forward, it is not a substitute for a strong, resilient and well-funded public health system — that public health’s focus on the social and environmental factors that contribute to poor health and disease is essential if health reform is to truly succeed.

Health reform offers great prospects for moving closer to and achieving long-held public health goals. At the same time, the field of public health must adapt and be responsive to a changing health care landscape to take full advantage of such opportunities and reap the greatest rewards. The chance to broaden the nation’s view of what it takes to attain good health for all is before us; it is up to public health to take the reins.
The historic health reform law also contained landmark public health and prevention provisions — an acknowledgement from the highest levels of government that connecting patients and doctors is only one component of an effective health system. These provisions helped solidify the critical role that public health and prevention should — and must — have if health reform is to achieve its ultimate goal: a healthier America.
For public health practitioners, the March 2010 signing of the Patient Protection and Affordable Care Act not only launched a long-awaited national commitment to expanding access to affordable health insurance. The historic health reform law also contained landmark public health and prevention provisions — an acknowledgement from the highest levels of government that connecting patients and doctors is only one component of an effective health system. These provisions helped solidify the critical role that public health and prevention should — and must — have if health reform is to achieve its ultimate goal: a healthier America. They also recognized that improving health and preventing disease is indeed a community affair and will require a frank examination of the social and economic factors that shape a person’s risk for disease, disability and premature death.

Bringing these provisions to life was the exclusive focus of a three-day meeting that welcomed more than 600 public health practitioners from all corners of the nation and disciplines of public health. Organized and hosted by the American Public Health Association, “Implementing Health Reform: A Public Health Approach” convened in the windy city of Chicago from June 23–25, 2011, and featured presentations from the nation’s top public health decision-makers, advocates, researchers and leaders. It also provided a forum for public health practitioners to swap best practices, share experiences and discuss ways to help reframe the national health reform discussion from one that seems entirely focused on costs to one that highlights the value of investing in prevention and community health.

Sessions at the APHA Midyear Meeting ran the gamut, covering topics such as the technical and fiscal impacts of the health reform law, promoting prevention, strengthening the public health workforce and protecting proven public health programs. Attendees had the chance to not only attend the larger general sessions, but could pick from a variety of smaller sessions where they could gather and discuss issues in more intimate settings. Many speakers reported health reform-related success stories already unfolding on the ground, while others discussed the ups and downs of reorganizing local public health services to better fit a changing health care landscape. Unfortunately, the news wasn’t all positive. In addition to the opportunities that health reform holds for public health and prevention, it also poses hidden threats.

At the top of that list is the notion that health reform is a substitute for a strong, well-funded public health system — it’s a notion that is regrettable seeing the light of day and helping to chip away at already struggling public health programs at the federal, state and local levels. While new prevention funding created via the health reform law is now filling many public health budget gaps, those new monies are by no means permanent. And if they go away, it could be a huge setback for public health in America. So, like at many events organized by APHA, attendees in Chicago were called upon to become champions for health and prevention. To collect the critical data, seek out the stories that illustrate prevention in action, and speak for public health values — values that stem from knowing that good individual health is rooted in good community health.

“We’re here today to do something different,” said APHA Executive Director Georges Benjamin during the meeting’s opening session. “This is not a health care meeting. This is not a health insurance meeting. This is a population-based health meeting through the lens of public health for us to address the population needs of our nation. There are many, many, many things that are much better done as a collective.”
In March 2010, President Barack Obama signed the Patient Protection and Affordable Care Act into law. The law sets forth broad changes in the health system and is expected to bring tens of millions more Americans into the health insurance fold—a move that will go far in reducing the nation’s uninsured rolls, which hit a record 50 million Americans in 2009.

On the insurance side, the law created a number of new rules. For example, insurance companies are now prohibited from discriminating against people with pre-existing medical conditions; children can stay on their parents’ insurance plans until age 26; and new insurance plans must cover certain preventive services. The law also expanded Medicaid eligibility and authorized cost-sharing changes under Medicare. Every state is also required to develop and implement state-based health insurance exchanges, which are intended to be centralized, competitive marketplaces where residents and small businesses can shop for and buy affordable health insurance plans. The law requires such exchanges be up and running by 2014, and in states where local legislators refuse to participate, federal officials will step in and create an exchange for them.

On the prevention and public health side, the law created the landmark $15 billion Prevention and Public Health Fund, money from which will go to states over 10 years to support and invest in proven community health efforts. In fact, millions of dollars have already started flowing to the local level. For example, in Alabama, monies from the Prevention and Public Health Fund are going to support efforts to prevent tobacco use and exposure to secondhand smoke; promote healthy eating; support walkable communities; strengthen public health laboratory capacity; widen HIV prevention and screening efforts; and invest in efforts to evaluate, streamline and strengthen overall public health capacity. Also created via the Prevention and Public Health Fund was the federal Community Transformation Grants program. The program presents an opportunity for communities around the nation to address the root causes of disease and poor health—also known as the social determinants of health—and tailor solutions to fit the diverse needs and values of individual communities.

In addition, the health reform law created the National Prevention, Health Promotion and Public Health Council, which is chaired by the U.S. surgeon general and charged with developing a nationwide prevention strategy. The very first National Prevention and Health Promotion Strategy was released in June 2011.

The Prevention and Public Health Fund is the country’s first mandatory stream of funding to support public health. However, Congress does have the ability to eliminate the fund or divert its monies to non-public health activities. Though unsuccessful, members of Congress have already attempted to eliminate the fund entirely.
In the early afternoon of Thursday, June 23, in a meeting room of a downtown Chicago hotel, hundreds of public health practitioners gathered to kick off the APHA Midyear Meeting. After welcoming remarks from Illinois Gov. Pat Quinn, APHA President Linda Rae Murray as well as local health officials, Celinda Lake took to the stage of the opening session to bring attendees good news on the public’s opinion of prevention.

A political strategist and president of the polling firm Lake Research Partners, Lake presented research on public perceptions of prevention and community health and discussed ways that public health advocates can bridge the communication gap between notions of individual responsibility and collective action. While the public supports community prevention efforts, they also respond positively to teamwork—“people want a partnership,” Lake said.

“We need to include individual responsibility with community responsibility but talk about making healthier choices easier for families,” she said.

According to the polling data Lake presented, Americans strongly support prevention and believe it should be a higher priority for the nation. The majority of those polled believe the country is doing quite poorly in areas of health and prevention, giving the nation a grade of “C” or “D.” The majority also supports making resources available to aid community prevention efforts, which were described as activities that make it easier for people to make healthy choices and maintain good health. However, the public was more divided as to who bears the responsibility for health and prevention. While a majority responded positively to ideas that communities can help make healthy choices easier and that “we are all in this together,” more than 30 percent agreed that becoming healthier is the responsibility of each individual. Not surprisingly, support for community action dropped if it included an increase in taxes.

“Of course in this economy, in some ways, it’s reasonable to be tax sensitive,” Lake said. “People are concerned about spending taxes in this area. But they are still very, very supportive of investing resources.”

The polling data also illustrated useful demographic differences and provided insight into the types of community-based interventions that garner the most positive responses. For example, when taxes are not mentioned, women support community health efforts versus individual responsibility by almost 20 percentage points over men; when taxes come into the picture, the gap narrows. Hispanics and blacks support investing in community prevention by nine to 15 percentage points over whites. In terms of efforts, specific community actions such as smoking bans, food labeling and making school lunches healthier reaped strong positive support, while actions such as restricting tobacco and junk food advertising and creating safe walking and biking areas garnered slightly less support. Overall, community interventions that tested most favorably were those that targeted children and those that produced multiple benefits—in other words, efforts that use limited resources in a fashion that results in more than one positive outcome.

Lake noted that messaging is key: “Frame the overall goal of community prevention as making good, healthy choices easier. We can bridge the values of individual responsibility and collective action by framing this as a matter of individual choice that the community can play a role in making easier.”

“The great news is it’s your time,” Lake said. “It may seem in many ways like it is the toughest of times, but actually there is really an emerging public consensus here that needs to be nurtured, needs to be educated and needs to be tapped into. The biggest thing I would say is we need to define what community prevention is for people. We need to start this locally at the grassroots; it will be something that will trickle up rather than trickle down.”
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—Celinda Lake, president of Lake Research Partners
LESSONS FROM A LEGISLATOR

Moving from persuading the public to support community prevention to persuading policymakers, former Michigan Gov. Jennifer Granholm took to the opening session stage to talk about her experiences and to call on attendees to make their voices heard.

Granholm began by discussing the cost differences between the U.S. health system and other developed nations. Since the United States spends the most on health care when compared to its global counterparts — with health care spending accounting for 16 percent of the U.S. GDP — than surely the United States has some “fantastic health care outcomes, right,” she asked. The answer, as public health practitioners are already aware, is no.

“This is an example of a U.S. policy that has resulted in almost absurd outcomes,” Granholm said. “If you asked any business person...if you give them a graph of that data with the U.S. as an outlier in all the negative senses on the key factors, they would say fire the person in charge of that system, right? So, why then I wondered is fixing this thing so darn hard?”

In fact, the current health situation seems like the perfect opportunity to look toward other nations for practices that could be adopted to fit American life. Unfortunately, that might mean more government and public sector involvement — a solution that does not fit well into the current political environment, Granholm said, noting that “we are so afraid of government...that we are willing to tolerate illogical results.”

“Other countries are actively engaging in policy and public-private partnerships and trying to do what they can to serve their citizens,” Granholm said. “If you look at other countries, they don’t have this weird aversion to government helping citizens. They’re willing to allow their governments to make their citizens’ lives better.”

Health care, Granholm said, is a competitiveness issue. Several years ago, she noted, Ontario began manufacturing more automobiles than Michigan for the first time ever. The automobile makers were not moving to Canada because of lower tax rates, smaller government or less regulation; they were going because of health care costs, she said.

“We in America have decided to put that burden on the private sector, whereas other countries share that burden,” she said.

It’s time for public health to raise its voice, Granholm said, calling on attendees to help “stage a big intervention on America.” Be creative, call policymakers out by name and send individual letters — “lots of people making lots of noise is powerful,” she said.

“You radicals, you public health aficionados, you activists,” Granholm told audience members. “You are all founders of the world and I exhort you to go out and stage an intervention to make the world a better place.”
With long-time and trusted ties to the communities they serve, public health practitioners will be key in communicating the value of health reform’s prevention and public health provisions to the public. To do so, the public health community must first understand how the public views prevention and how they believe it fits into their lives. According to session presenter Bob Crittenden, executive director of the Herndon Alliance, good policy makes no difference at all if you don’t have the public behind your efforts. A good first step toward gaining that support is finding a consistent story, Crittenden said. Data may be a compelling factor within public health circles, but it won’t make the sale among the public. Instead, public health advocates and their partners need to agree on a public health narrative that complements long-held American values, such as personal responsibility.

“We have to start deciding what is our [public health] story; what are we trying to sell the American people,” Crittenden said. “It’s not just good data or good facts or a better life. We have to have a story, a narrative.”

Crittenden advised that the public health community build narratives around two central themes: personal responsibility and children. He also advised that public health advocates tap into long-held notions of the “American dream.” In other words, frame health reform as a policy that will create opportunities for the nation’s middle-class and working families. In addition, find trusted community messengers, such as small business owners, to help relay positive messages about community health and search out “strange bedfellows” to support the cause.

“When I say ‘don’t go this alone,’ I mean it,” said session moderator Rob Gould, executive vice president and managing director of Brodeur Worldwide. “I really believe there’s a tremendous opportunity for us to move this ball forward if we really pool our knowledge and resources and get on with the collaboration just among ourselves and then reach out to others.”

Session presenter Joe Marx, senior communications officer at the Robert Wood Johnson Foundation, noted that influence happens with the help of good stories, compelling data and trusted influencers. Marx pointed to the release of the foundation’s County Health Rankings, which ranks each county within the 50 states according to health outcomes and various health factors, as an example of effective messaging. Thanks to a comprehensive communications campaign that deliberately framed the discussions around the release of the rankings, the media coverage went beyond the data to become a robust conversation of how to improve health and address the social determinants of health, Marx said.

**Steps for action:**

- Agree on a public health narrative, speak to community values and use messaging that recognizes the role of personal responsibility
- Recruit trusted community messengers and non-traditional public health partners to advocate for community-based prevention
PUBLIC HEALTH AND QUALITY CARE

Improving quality of care throughout the health system, within both clinical and public health settings, is a major directive of the new health reform law and a critical goal to work toward as millions more Americans become insured. Achieving improvement in quality of care will require new partnerships, new ways to measure performance and a broader view of what is required to sustain good health.

“We really need to work together — the health care delivery systems, the public health system, the public sector, policy-makers, schools, businesses...we need to work together and focus on health, which is a very different focus than what the health care delivery system has been focused on up to this point,” said Bonnie Zell, senior director of population health at the National Quality Forum.

Zell said her organization is transitioning from a complete focus on health care to one that includes public health too, which is “really going to change the conversation.” In fact, the health reform law directed federal officials to develop a national strategy to improve the delivery of health care services, patient health outcomes and population health. In March 2011, the U.S. Department of Health and Human Services released its National Strategy for Quality Improvement in Health Care, of which a top priority is supporting proven community health interventions. The strategy’s inclusion of community health will help compel health care delivery systems to join forces with new partners in their communities, Zell said.

“Now, it may not sound revolutionary to this group, but the fact that the health care delivery system is talking about population health is a big deal and it really has a lot of implications,” Zell told session attendees.

As more Americans become insured and seek out primary care services, community health centers will play a key role in meeting increased demand. Currently, the nation’s almost 1,300 community health centers provide care for about 20 million Americans, and the health reform law is expected to bring 32 million more Americans into the insurance fold. To meet the growing need, the health reform law included an $11 billion trust fund for community health centers — an investment that could double the number of centers, according to session presenter Lee Francis, president and CEO of Erie Family Health in Illinois. However, that expansion is in jeopardy. To make up for severe cuts in annual federal funding for community health centers, policymakers have borrowed from the trust fund, which Francis described as a “cycle of borrowing from the future.” He said that the issue of sustainability will be a crucial one for community health centers in the coming years.

Quality improvement efforts are taking hold within the public health field as well, with the movement toward public health accreditation taking the lead. Terry Cline, state health officer with the Oklahoma State Department of Health, discussed his state’s accreditation experience with session attendees, noting that the health reform law offers unique opportunities to transform and change the way public health does business. Oklahoma was chosen as one of eight state health departments to serve as beta testing sites by the Public Health accreditation Board, which is developing a voluntary accreditation program for state, local, territorial and tribal public health departments. Accreditation — the three main components of which are conducting an assessment, creating a health improvement plan and developing a strategic plan — will go far in strengthening public health infrastructures, Cline said.

“I believe it is a very, very valuable tool; maybe one of the most important things to happen to public health, certainly in my own lifetime,” Cline said.

Steps for action:

- Engage local health care delivery systems in population-based efforts and collaborate with clinical partners
- Seek out opportunities to employ public health quality improvement strategies, such as public health accreditation
Integrating new technologies into public health systems will be key to the field’s continuing success. While much of the health reform funds for implementing health information technologies are being directed toward the clinical sector, the re-energized focus on technology is proving a boon for public health as well.

“We have to become a different entity than what we are now,” said William Pilkington, CEO and director of public health at Cabarrus Health Alliance in North Carolina. “As long as we stay focused on the same old ideas that we had in the ’60s and ’70s, we’re not going to be able to fit into this new world of high-tech information and fast-moving data collection.”

According to session presenter Chesley Richards, of the Centers for Disease Control and Prevention’s Division for Healthcare Quality Promotion, some of the top issues for the public health field are how practitioners can use health information technology to enhance surveillance, improve prevention activities and strengthen efficacy.

“These are real opportunities to be able to respond much quicker than we have in the past,” Richards said.

The burgeoning electronic health records movement holds promise as well, he said. With billions in federal funds going to support the implementation of such technology, there is great potential for those in public health to use the data to populate health information exchanges in support of population-based interventions. As patients become savvier with electronic health records and other forms of health information technology, the potential for digital interaction is new territory for many in public health, Richards noted. One big question should be how to use such systems to push out timely information to residents and promote healthy behaviors. As an example, Richards cited efforts such as Text4Baby, which sends out maternal and child health information via text messaging.

Of course, with new technologies come new dilemmas. Issues of confidentiality, data ownership and how such data is used and accessed are questions that still need to be addressed. In addition, just having the technology is not enough. Although new technologies are bringing an “avalanche” of new information into public health departments, workforce shortages may stunt an agency’s ability to respond, Richards noted. It’s another compelling argument to partner with the private health care sector.

“Let’s learn together,” said session presenter William Hacker, commissioner with the Kentucky Department for Public Health. “We need to be able to steer the private health care sector to be willing to share some of their information and take on some public health goals as their responsibility.”

A health information exchange has been up and running in Kentucky since 2010, Hacker said, and is already seeing a return on investment. In fact, the public health agency has received testimonials from physicians reporting that the health information exchange has prevented the duplication of medical tests — an outcome that Hacker noted can help curb health care spending.

“Go back home and tell all the skeptics who say it ain’t going to work that it is — we’re doing it,” Hacker told attendees. “It’s not easy and you’ve got to have some really talented people, but this is reality and it’s not going to go away.”

Steps for action:

- Get involved in the growing health information technology movement and look for ways technology can enhance population health
- Look for opportunities to use technology to bring health education directly to the people
FISCAL IMPLICATIONS OF HEALTH REFORM

The health reform law may have come with billions in new dollars for public health and prevention, but it by no means solved the field’s chronic funding problems. Worries that funds from the new Prevention and Public Health Fund would supplant — instead of enhance — current public health funding levels are unfortunately being realized. It’s a critical issue, as monies from the fund are now bridging serious public health funding gaps. If a congressional attempt to eliminate or re-direct fund dollars were successful, it could be a devastating blow.

“There is nothing mandatory about this money,” said session presenter Paul Jarris, executive director of the Association of State and Territorial Health Officials. “We can not take this for granted. We will lose it if we take it for granted.”

While the Prevention and Public Health Fund was created as a mandatory funding stream — in other words, the funds do not have to be authorized via the federal appropriations process — there is nothing to prevent policymakers from attempting to change that, Jarris said. In addition, when the same public health program is eligible for both mandatory and discretionary federal funds, it almost always means the discretionary funding stream will get cut — and that’s exactly what’s happening. For example, from 2010 to 2011, the federal immunization grant program known as section 317, which provides funds for immunization operations and infrastructure, received a boost from the Prevention and Public Health Fund. However, the program’s base funding was slashed by $71 million dollars. So while on the surface it looks like the program is receiving more money, its capacity is now firmly dependent on new and uncertain health reform dollars, Jarris said. At the end of the day, public health programs and infrastructure are getting less money, not more, he said.

To overcome such funding challenges, the public health sector must leverage its resources to “help the clinical sector create healthier people and then share in some of that savings...if we ignore the clinical sector, I think we’re in big trouble,” Jarris said.

According to Paul Kuehnert, executive director of Illinois’ Kane County Health Department, the fiscal reality check has already begun. Though health reform holds opportunities for local public health, such as an expanded role in insurance enrollment and outreach, it presents formidable challenges too, namely whether providing direct health services is still a viable option for local public health agencies, Kuehnert told attendees. To meet such challenges, Kuehnert’s health department, which had experienced a 10 percent decline in revenues, has undergone a complete restructuring to zero in its focus on population health, transferring direct client services to federally qualified health centers and reducing staff.

“We really have to look at integrating the new public health accreditation standards and really look hard at how we are organizing ourselves as local and state health departments,” Kuehnert said.

Steps for action:

- Be prepared to compete for new health reform funds and look for innovative ways to adapt to changing budget realities, such as strengthening coordination with the clinical sector
- Collect the data and stories that illustrate the positive health outcomes of investing in public health programs and infrastructure
SEEKING COMMON GROUND: VIEWPOINTS ON IMPROVING HEALTH

The second day of APHA’s Midyear Meeting kicked off with a lively debate on the best ways to improve community health. The Friday morning session illustrated that while improving Americans’ health is a common thread among public health practitioners, opinions do differ on what methods are best and whether the health reform law is a good fit.

Session speaker John McDonough, director of the Center for Public Health Leadership at the Harvard School of Public Health, noted that while the health reform bill that finally became law may not be perfect, it was the best version with a chance of passing through Congress. In fact, it is probably one of the single most important pieces of legislation to address public health, prevention and wellness, he said, noting that for the first time there is an “attempt on the federal level to elevate and create a health-in-all-policies approach.” Still, the fate of many public health endeavors is being caught up in a larger debate over the role of government, McDonough warned.

“In so many ways, this is the best of times and also in so many ways, this is the worst of times,” he said. “We are right now potentially in the midst of the largest assault on public health in our nation’s history in terms of what’s being discussed and considered in Washington, D.C....Everything the government does...is in that bullseye.”

McDonough said that when there is no common ground to stand on, that’s when elections matter. The fate of the health reform law, he said, will fundamentally be decided during the 2012 presidential election.

Julie Eckstein, vice president of the Center for Health Transformation, told attendees that while she disagrees with parts of the health reform law, she is “thrilled that health is finally on the radar screen.” Eckstein said one area that most agree on is the need to ensure and create a culture of health in our communities. She also called on attendees to find common ground in the need to break down the system silos that can stunt exchange and collaboration. Another important issue is realigning payment incentives within the health delivery system to produce desired health outcomes.

“I don’t know anyone who’s against health reform,” she told attendees. “We have a health crisis and we have a health care crisis. Both of those demand reforms in our industries, in our lack of systems. So when I hear people say that there are those that are against health reform, I don’t think that’s accurate. I think the difference is in what models, what forms of health reform do you support and which ones should move forward.”

Session speaker Oliver Fein, a professor of clinical public health at Cornell University, called on attendees to become advocates for a vision that goes beyond the health reform law, namely a single-payer health system. Key principles of national health care would be universal access with automatic enrollment, free choice of providers, the elimination of financial barriers, coverage of comprehensive benefits and public financing. Fein argued that such a system is affordable, as it would eliminate much of the administrative costs that come with a for-profit insurance system.

“Without single-payer, the public health system is constantly trying to catch up, trying to plug the holes left in the health care system,” he said.
Become advocates for a vision that goes beyond the health reform law, namely a single-payer health system. “Without single-payer, the public health system is constantly trying to catch up, trying to plug the holes left in the health care system.”

—Oliver Fein, MD
Professor of clinical public health at Cornell University
Implementing health reform will take a robust and well-trained health workforce, of which public health practitioners play a key role. Unfortunately, the public health field is experiencing worrisome trends: A recent survey from the National Association of County and City Health Officials found that 29,000 local health department jobs have been lost since 2008. Luckily, innovative initiatives are creating ways to support public health workforce development.

At CDC, funding authorized via the health reform law is supporting a range of workforce programs that are already helping to fill critical workforce gaps. Such funds are enabling CDC to expand its public health fellowship programs, increase epidemiology and laboratory capacity, and transform how it provides training to the public health community, according to John Lisco, deputy director of the agency’s Scientific Education and Professional Development Program Office. Lisco noted that CDC fellows provide critical surge capacity to local and state public health agencies. For example, in 2010, Epidemic Intelligence Service fellows conducted more than 290 outbreak investigations, he reported.

Health reform funds are also supporting CDC’s online training program. Billed as a one-stop shop for online training with almost 300 learning products, the CDC Learning Connection site has received more than 41,000 visits since its launch in 2010.

“With health reform funds, we’re able to more aggressively address gaps and restrain growth in health care costs largely through more and better prepared staff,” Lisco told session attendees.

The ability to better tackle health inequities is another anticipated outcome of workforce activities. The need to address “equity is paramount, it’s more important than ever,” said session presenter Brian Smedley, vice president and director of the Health Policy Institute at the Joint Center for Political and Economic Studies. According to Smedley’s presentation, more than 30 percent of direct medical care costs for blacks, Asians and Hispanics between 2003 and 2006 were excess costs linked to health inequalities. It’s not enough to simply have an insurance card for residents living in medically underserved communities, he said. Thankfully, the health reform law is attempting to put more resources where they’re needed, such as expanding community health centers and incentivizing health professionals to serve in areas with provider shortages. Also, for the first time ever, the health reform law requires those receiving federal funds to uniformly collect data on race, ethnicity and primary language and encourages data collection for population subgroups as well — it’s a huge step toward health equity, Smedley said.

“This is not a time for us to be sitting there and waiting to see what happens,” said session presenter Cynthia Lamberth, associate dean for workforce development at the University of Kentucky College of Public Health. “This is a time for reinvention of what we do to serve our communities and there needs to be a lot of planning.”

Steps for action:

- Take advantage of workforce development resources and initiatives
- Be flexible and start planning: Health reform changes will likely lead to shifting demands for public health services
ACHIEVING PREVENTION AND WELLNESS

As health reform moves the U.S. health system from one focused on treating illness to one focused on sustaining good health, evidence-based prevention and health promotion efforts will take center stage. Leading this movement is the nation’s very first National Prevention and Health Promotion Strategy, which was released in June 2011 and created at the directive of the health reform law.

With U.S. Surgeon General Regina Benjamin at the lead, the strategy was developed with input from 17 federal agencies. It lays out a national vision for health and public health priorities, including healthy community environments and the elimination of health disparities. For Larry Cohen, founder and executive director of the Prevention Institute, the “national strategy was a dream come true.”

“We’re on a wave and we need to push that wave,” Cohen told session attendees. “We really need to maintain our role as advocates, we need to push the agenda and we need to do the work.”

A bigger question, however, is can “public health fully deliver on this promise of prevention,” asked session presenter Judith Monroe, deputy director of CDC’s new Office for State, Tribal, Local and Territorial Support. To make that promise a reality, Monroe’s office is focusing on improving public health performance via the National Public Health Improvement Initiative, which began last summer with funding support from the Prevention and Public Health Fund. In summer 2010, Monroe reported, the initiative funded 76 state, local, territorial and tribal agencies and organizations with the goal of improving performance management capacity in ways that ultimately lead to better health outcomes. Some successes so far: an increase in evidence-based policies, laws and regulations; an increase in the adoption of best practices that improve system efficiency; and improvements in staff and resource distribution.

“If we don’t have this operational capacity out there, we don’t get the big dividends that pay off on the other end,” Monroe said.

The positive impacts of investing in prevention are already evident. In Washington’s King County, funds from Communities Putting Prevention to Work, an initiative created by the 2009 federal economic stimulus bill, is reaping success in creating community conditions in support of tobacco control and active living, according to session presenter Ryan Kellogg, program manager of Healthy Eating/Active Living at the Department of Public Health Seattle-King County. Some successes include the adoption of smoke-free housing policies by the county housing authority, the launch of sugary beverage education campaigns, and the inclusion of health considerations in countywide planning processes. Kellogg called on attendees to think about “sustainability from day one” as public health agencies move forward with the Community Transformation Grants created under health reform.

“It’s really trying to turn the tide and look at balancing community-based priorities with our sector-based approaches,” Kellogg said.

Steps for action:

- Rally around the first national prevention strategy and use it to facilitate better collaboration both within and outside the public health field
- Utilize public health performance improvement strategies to help deliver on the promise of prevention
Thanks to health reform, millions more Americans will now have access to timely and affordable preventive services — a huge step forward for efforts to sustain good health, promote early detection and avert preventable disability and mortality. In addition to widening access to such services, integrating clinical and population health models will help sustain good health far into the future.

Work to make such integration a reality is already happening, with federal agencies helping to lead the way. Session presenter Sarah Linde-Feucht, acting chief public health officer at the U.S. Health Resources and Services Administration, noted that prevention is the bridge between public health and primary care. Among the HRSA-led work supported via health reform includes an expansion of the National Health Service Corps to provide care in medically underserved areas; funds to widen access to in-home maternal and child health services in at-risk communities; and investments to address shortages in primary care — an effort that Linde-Feucht described as a “subset of building the public health workforce.” In addition, health reform also authorized $50 million in annual funds from 2010 through 2013 to build capacity at school-based health centers. Linde-Feucht also noted that HRSA and CDC initiated a study at the Institute of Medicine to examine ways to improve population health via the integration of public health and primary care. The final study, which will include actionable recommendations, is due in summer 2012.

In Delaware, efforts to bring together population health and clinical care are already seeing success. Session presenter Deborah Chang, vice president of policy and prevention at Nemours, an integrated health system, told attendees about her organization’s experience in transitioning to a broader focus on population health. To develop its new model, the system decided to zero in on child health and obesity, expanding its focus from the 50,000 children who use Nemours’ pediatric care system to every child in the state. Realizing that health care alone won’t solve the childhood obesity problem, the new approach took on policy, practice and environmental change. In working with more than 200 community partners, the Nemours initiative successfully advocated for policy changes within schools, childcare and health care settings. For example, licensed childcare centers in the state are now required to provide a minimum amount of physical activity and must limit TV time.

“It is about individual responsibility, but you also need the environment to support these changes and that’s why policy change is so important,” Chang said.

**Steps for action:**

- Engage and partner with the clinical sector to improve both patient and population outcomes
- Educate clinical counterparts on the role of social determinants in sustaining good health
Health reform on its own can hardly meet its goals of a healthier population without the unique training, perspectives and efforts of a well-supported public health workforce and its focus on the prevention opportunities that happen outside the doctor’s office.

**PROTECTING IMPACTED PUBLIC HEALTH PROGRAMS**

Health reform isn’t a substitute for a strong public health system. In fact, health reform on its own can hardly meet its goals of a healthier population without the unique training, perspectives and efforts of a well-supported public health workforce and its focus on the prevention opportunities that happen outside the doctor’s office. Unfortunately, many policymakers disagree, with proven public health efforts reporting severe funding cuts. In turn, public health practitioners must make persuasive cases for necessary programs, advocate for better policy and find new ways to sustain good health.

In the area of immunization, the health reform law is likely to improve access and help lower costs, according to session presenter Alexandra Stewart, assistant research professor at the George Washington University School of Public Health and Health Services. For example, insurance plans participating in state-based health insurance exchanges will be required to cover recommended vaccines with no cost-sharing and state Medicaid plans will be incentivized to cover vaccines at no cost to patients. The reforms are good news; however, coinciding state budget cuts to public health programs could mean continuing immunization coverage gaps, Stewart said. For example, Alaska legislators recently eliminated funds for adult vaccines, and North Carolina legislators eliminated the state’s universal childhood vaccine program. Stewart called for new public health partnerships to ensure immunization coverage, pointing to community health centers, which in 2009 administered 3.7 million non-flu vaccines to about 2.6 million patients.

Some diseases don’t have specific language in the health reform law and therefore the continued path to success is a bit more challenging, said session presenter Gail Bolan, director of CDC’s Division of STD Prevention. Even though sexually transmitted diseases cost the nation upward of $17 billion annually and some STD rates are on the rise, almost 70 percent of state and local STD programs experienced funding cuts and reduced services from 2008 to 2009, Bolan said. To protect the gains made so far and continue moving forward, Bolan called on attendees to work with partners to leverage prevention efforts and share best practices. She said public health will play a key role in assessing and assuring coverage and quality of STD prevention services, noting that many vulnerable populations will still seek out safety net services.

“We in the field have to be very proactive and have to have metrics and ways that we educate people about our safety net needs,” she said. “We’ve got to be able to answer that political question, which I call the ‘so what’ question: ‘If this goes away, so what?’”

**Steps for action:**

- Measure your progress and use the data to defend critical public health programs
- Seek out clinical and non-traditional public health partners to help fill gaps created by budget cuts
HEALTH REFORM IN ACTION: IF YOU BUILD IT, THEY WILL COME

As of June 2011, more than 5 million Americans with traditional Medicare coverage had taken advantage of preventive services such as mammograms and prostate cancer screenings now offered at no cost thanks to the health reform law. The uptake in such services means that 16 percent of Medicare beneficiaries are now visiting their doctors with “timely prevention and wellness on their minds,” according to Caya Lewis, chief of staff at the Centers for Medicare and Medicaid Services, who was the keynote speaker during Friday’s afternoon general session on “Putting It All In Perspective: Public Health, Health Care and Quality.”

The positive Medicare data is just one illustration of how policy change can promote prevention and ultimately save lives. And even though CMS’ charge is primarily as an insurance provider, Lewis said that public health and prevention have become a daily part of the conversation at the agency. Lewis said much of CMS’ work is being guided by a three-part aim: better care for individuals, better health for populations and reducing costs through quality improvements. They are goals that Lewis urged attendees to rally around.

“High-quality care doesn’t mean the most expensive care; it means reliable care, person-centered care,” she said. “Prevention efforts are critical to CMS carrying out its three-part aim.”

Other Medicare changes enacted by health reform include free annual wellness visits as well as rebates to help beneficiaries navigate the so-called “donut hole” in Medicare’s prescription drug plan. The donut hole is the gap between initial drug coverage and catastrophic coverage during which beneficiaries must pay all costs out of pocket. The health reform law also removed patient cost sharing for the Welcome to Medicare Exam for new beneficiaries. As of May 2011, CMS recorded a 26 percent increase in the number of beneficiaries taking advantage of the welcome exam when compared to May 2010. CMS is also working to encourage patients to take advantage of new services. For example, the Medicare handbook sent to beneficiaries now features a handy checklist of preventive services, Lewis said.

Lewis said that with the release of the National Prevention and Health Promotion Strategy, the agency is looking forward to finding new ways that Medicare and Medicaid can help realize the strategy’s goals.

“We know that focusing on prevention and improved quality just makes plain common sense,” she told attendees. “We have a lot to look forward to…and we’ll continue to need your help along the way.”

— Caya Lewis, chief of staff at the Centers for Medicare and Medicaid Services
As of June 2011, more than 5 million Americans with traditional Medicare coverage had taken advantage of preventive services such as mammograms and prostate cancer screenings now offered at no cost thanks to the health reform law. The uptake in such services means that 16 percent of Medicare beneficiaries are now visiting their doctors with “timely prevention and wellness on their minds.”
Among the running themes throughout the APHA Midyear Meeting was that simply having an insurance card does not equal access to medical care. While the health reform law is expected to make real inroads in current uninsured rolls, gaps will remain, said session presenter Eduardo Sanchez, vice president and chief medical officer of Blue Cross Blue Shield of Texas. For example, he said, the law does not meet the needs of the nation’s millions of undocumented residents — a shortsighted move that will affect public health efforts to maintain overall community health and prevent the spread of communicable diseases.

Access to preventive care will depend on more than obtaining insurance coverage, Sanchez said. Issues such as transportation and language will remain barriers, and so enabling residents to avail themselves of newly covered prevention services will require public health input, he said. While managed care organizations will likely focus on delivering clinically based preventive services, they can still be strong partners in strengthening community-based efforts as well, Sanchez said, pointing to tools such as the federal “Guide to Community Preventive Health Services” as a way to create better linkages between clinical care and population health.

Sanchez noted a number of risks in shifting from an employer-based insurance system to an individual one. One risk is a low rate of health literacy that will make it difficult for individuals to shop for and purchase insurance in an informed way. Also, public health practitioners face the risk of losing workplaces as a leverage site to do population-based health interventions, he said. At the end of the day, focusing on public health funding must be a priority, Sanchez said, noting that new prevention and public health funding gains made under health reform are systematically being canceled out by cuts in state, local and federal budgets.

Session presenter Emily Stewart, director of public policy at Planned Parenthood, discussed access issues affecting women’s health. On the plus side, health reform eliminated the discriminatory practice of insurance providers charging women higher rates than men and allowed states to expand family planning services under Medicaid. And in August 2011, HHS announced guidelines requiring new insurance plans to cover birth control with no co-payments.

Not surprisingly, the debate over abortion took center stage in the run up to health reform and threatened its passage. The final compromise that made it into law requires that insurers offering abortion coverage collect two payments from beneficiaries — one to cover abortion and one to cover all other services — to ensure that no federal subsidies be used to provide abortion. Advocates such as Stewart worry that the rule is so burdensome it might deter insurers from covering abortion services at all. Also, states are allowed to ban abortion coverage in their state health insurance exchanges, Stewart noted.

The health care delivery system isn’t strong enough to meet growing demand, especially for women’s health, Stewart told attendees. For example, the National Health Service Corp does not send professionals to serve at Planned Parenthood and other federally funded family planning centers, as they don’t meet the definition of a primary care provider — a notion that many American women would disagree with, Stewart said.

Steps for action:
- Educate policymakers and the public that having insurance does not always equal access to care
- Help make it known that well-supported public health interventions will still be important, especially in medically underserved communities
The overwhelming majority of employers agree that there’s a link between an employee’s health and productivity and view health benefits as an investment in human capital.

ASSURING POPULATION HEALTH: ADVOCATING FOR PREVENTION AND WELLNESS

Most Americans support prevention and wellness activities, however getting them to participate in such activities is another story. The health reform law provides new avenues for public health practitioners to integrate prevention into local health systems and partner with one of the main purchasers of health care: employers.

Session presenter Rob Restuccia, executive director of Community Catalyst, a national health advocacy organization, called on attendees to advocate for the integration of evidence-based prevention practices into health delivery systems, noting that the health reform law provides a number of incentives for clinical providers to push prevention. Other openings for public health input include the state-based health insurance exchanges as well as accountable care organizations, which are groups of health providers that work together to curb health care costs and improve quality of care. Both enterprises are just beginning and are ripe for public health interaction, he said.

“We need to think about the new allies that we have,” Restuccia said. “These new allies are critical in how we move forward.”

One such ally will be employers. U.S. employers spend billions of dollars on health care every year and they have a real interest in how the health system functions, said session presenter Larry Boress, president and CEO of the Midwest Business Group on Health. Employers aren’t involved in health care because of altruism, Boress noted, but for business reasons — they realize the benefits of keeping people healthy and productive. According to a survey conducted by the Midwest Business Group on Health, the overwhelming majority of employers agree that there’s a link between an employee’s health and productivity and view health benefits as an investment in human capital. Most employers say they’re staying in the health care game despite new individual insurance options created via health reform, Boress said.

Also, most employers believe that prevention is key and many are creating financial incentives for employees to get and stay healthy, Boress noted. Reform, he said, is a team sport. For example, Boress’ organization is working with the Illinois Department of Public Health to reduce preventable preterm births.

“View the employer community as part of the solution,” he said. “You have to commit to looking at employers not as funding sources, but as partners. Reach out to them, invite them to participate.”

Steps for action:

- Use medical payment incentives and new insurance mechanisms, such as state health insurance exchanges, as leverage points for prevention
- Take the lead in mobilizing organizations and communities, including the business community, around prevention
Advocacy can be a sticky subject for many public health practitioners, particularly for those who are public employees. Luckily, there are a variety of ways you can drive home messages of prevention and connect in memorable ways to community members as well as policymakers.

"Now more than ever, we need to do all we can," said session moderator Tom Quade, deputy director of Ohio’s Akron City Health Department. “And in order to do all we can, we need to know all we can in terms of advocacy.”

Echoing a major theme throughout the Chicago meeting, session presenter Chuck Alexander, senior vice president for public health at Burness Communications, called on attendees to be aware of the language and messaging they use outside of public health circles. Avoid jargon, tailor your message to your audience, use “people” speak instead of “brand” speak, and show instead of tell, Alexander said. For example, instead of using the phrase “increasing physical activity,” talk about “more P.E. in schools” or “safer parks to play in.”

Messages that strongly resonate often focus on children, their health and their futures, Alexander said. Also, don’t assume your audience automatically knows what prevention entails. Make sure to describe what prevention means for people’s lives, he said.

“We’ve got to bring it down to where (people) live, to who they deal with, to the neighborhoods they walk in every day,” Alexander said.

Part of that communications work is having a story to back up your message, said session presenter Elizabeth Wenk, vice president for public policy at Burness Communications, who added that “your work is about more than data points, it’s about real people.”

“Stories stick with people,” she said. “Our parents didn’t put us to bed at night reading a census book.”

Having worked on Capitol Hill for many years, Wenk said that policymakers remember compelling stories and will often use them to describe the issues they care about. She advised attendees to keep the story short, easy to understand and focused on a specific message. In terms of lobbying, Wenk listed a number of ways to advocate without breaking any rules, such as calling for the enforcement of existing laws, using the media to reach community members and developing non-partisan analyses, such as health rankings. She also called on attendees to coordinate with outside advocacy groups that are often able to speak more freely.

“Think about how you’re bringing all your partners, your coalitions together to really try to drive the policy change that you want to see,” Wenk said.
As public health practitioners receive funds via the health reform law and begin work to implement its prevention goals, it’s critical that policymakers hear about the difference it’s making in the lives of their constituents.

LEGAL CHALLENGES TO HEALTH REFORM: AN UPDATE

The promise of health reform is far from certain — especially if the legal challenges to the landmark law end up on the winning side.

Within hours of the law’s signing, lawsuits were filed challenging its authority — “it was like an epidemic,” said session presenter Jane Perkins, legal director at the National Health Law Program. More than two-dozen lawsuits have been filed against the health reform law, and officials in 26 states have joined together to overturn the health reform law on grounds that it is unconstitutional. Decisions in the cases have been a mixed bag, with most siding with the law and others striking down certain provisions of the law or ruling that the entire law be voided. It is likely the U.S. Supreme Court will have the final say.

The basis for the lawsuits vary, such as allegations that the law infringes on health privacy, that it turns Medicaid into a wholly federal program, and that its individual insurance mandate violates the Constitution’s commerce clause, which addresses Congress’ authority to regulate interstate commerce.

Regardless of a state’s involvement in the lawsuits, however, nearly every state is moving forward to come in compliance, including setting up state-based health insurance exchanges, which are due to be up and running by 2014.

“I think that 2014 is approaching and the law is the law right now,” Perkins said. “As we get more and more parts of it implemented and it touches more people’s lives, it can get more traction.”

With debates over the nation’s economy eclipsing all conversations in Washington, D.C., spending cuts are becoming a top priority — and the Prevention and Public Health Fund has a “major bullseye on it,” said session presenter Rebecca Salay, director of government relations at Trust for America’s Health. As public health practitioners receive funds via the health reform law and begin work to implement its prevention goals, it’s critical that policymakers hear about the difference it’s making in the lives of their constituents.

“The more you do to make it real, the better,” she said.

Steps for action:

- Make sure policymakers know the impact of new prevention and public health funds
On the third day of APHA’s Midyear Meeting, the message was clear: Health reform offers enormous potential to change the trajectory of the nation’s health and is already changing American lives for the better. At a time when one in five U.S. children lives in poverty and many researchers predict that today’s children may not live as long as their parents, it would seem that health reform would be more of a breath of fresh air rather than the highly charged, divisive debate that it has become.

For closing session speaker Lawrence Wallack, dean of the College of Urban and Public Affairs at Portland State University, the health reform discussion represents a much older debate that is deeply embedded in the American psyche: individualism vs. community.

Referencing author Robert Bellah, Wallack noted that America is home to two languages: one of rugged individualism and open markets, and the other of community and social solidarity. The language of community may be the second language of American society, but “it is the first language of public health,” he said. And herein lie public health’s strengths and weaknesses, Wallack said. While public health is a field committed to community and social justice, it often fails to communicate those values effectively within an individualistic, market-dominated context.

“How do you balance the responsibility of the individual with that of the state,” Wallack asked. “It’s a healthy argument, it’s a productive argument, it’s a passionate argument and it’s a never-ending argument. It’s an argument that is at the core of our public health profession.”

Today’s public policy decisions are rooted in such narratives and will determine the social, health and economic problems of tomorrow, he said. In fact, in the debate over health reform, such narratives often trump even the most compelling data and facts. For example, Wallack said, proponents of reform have taken up the question of controlling health care costs. For opponents, there can be no better question that will occupy the so-called “do-gooders,” he said. While proponents believe there is an answer that will finally win the argument, the reality is that the only solution acceptable to the opposition won’t even solve the problem. At the end of the day, “reformers are trapped in their own question,” Wallack said.

“We believe deep down that the facts will set us free and that data will win the day,” he said. “Facts, while they do matter...they matter less than we think.”

On the other side, health reform opponents are occupied with entirely different questions — questions about freedom and the role of government. And in an argument of costs vs. freedom, freedom likely wins, Wallack said.

“It’s not about what words say, it’s about what words mean and what values the phrases evoke,” he said.

In his closing remarks, Wallack called on attendees to begin making arguments about what kind of country we are and what kind of values guide us. The real issue, he said, is how we define fairness. How do we create messages that reflect public health values?

“If we believe in public health and social justice, then we need to say so,” Wallack said. “Each of us needs to speak our values so others understand that our well-being is rooted in the community that we all create together.”

“Facts, while they do matter... they matter less than we think.”
Health reform offers enormous potential to change the trajectory of the nation’s health and is already changing American lives for the better. At a time when one in five U.S. children lives in poverty and many researchers predict that today’s children may not live as long as their parents, it would seem that health reform would be more of a breath of fresh air rather than the highly charged, divisive debate that it has become.
Prevention is an American Value

The APHA Midyear Meeting covered a wide swath of the health reform landscape, zeroing in on the great opportunities for public health as well as the unfortunate threats. Implementing the provisions of the historic law is no easy task. Luckily, the American public is by our side, with the great majority believing in the power of prevention and the value that it brings to our lives and communities. That notion of value must be kept at the forefront of the national discussion and it is up to public health practitioners, researchers and advocates to help find the real-life stories that will resonate in the public’s mind and create the momentum to ultimately turn the tide in public health’s favor. Creating the opportunities for better health and well-being is a difficult endeavor and one that will truly require a team effort.

“We’re clearly at a crossroads; both our opportunities and our challenges are arguably at the height of all time,” said U.S. Assistant Surgeon General James Galloway during the meeting’s closing session. “There is no greater time for us to stand together for the health of our families, our friends, our colleagues, our communities and our nation. We have inherited the nobility of those great men and women who proceeded us: the responsibility for social justice across the nation and across the world. And I believe we’re up to it.”

Get involved today in APHA’s efforts to create the healthiest nation in one generation by visiting www.apha.org/advocacy/activities. In addition, below is a list of some of the top actionable recommendations that came out of APHA’s 2011 Midyear Meeting. Please share them with your colleagues, friends and families. The nation’s health landscape is changing and it’s vital that public health be in the driver’s seat.

For more details on APHA’s 2011 Midyear Meeting as well as future meetings, visit www.apha.org/meetings.

“There is no greater time for us to stand together for the health of our families, our friends, our colleagues, our communities and our nation. We have inherited the nobility of those great men and women who proceeded us: the responsibility for social justice across the nation and across the world. And I believe we’re up to it.”

—James Galloway, U.S. Assistant Surgeon General
PUBLIC HEALTH IN ACTION: KEY RECOMMENDATIONS FROM APHA’S 2011 MIDYEAR MEETING

TALK ABOUT VALUE: Talk about the value of public health and prevention in ways that resonate with your community’s values and needs. Avoid scientific jargon, tailor your message to your audience and zero in on efforts that people care about, such as children’s health. Bridge the gap between individual responsibility and community health by talking about the need to make healthy choices easy, affordable and accessible for all.

PARTNER, PARTNER, PARTNER: In a time of limited public health budgets, it’s critical to seek out new ways to partner with clinical and non-traditional public health partners in the public and private sectors to promote evidence-based prevention, reap positive health outcomes and curb health care costs. Everyone has a stake in promoting and improving population health.

DEFEND PUBLIC HEALTH: Deep federal, state and local budget cuts are jeopardizing public health capacity, threatening hard-fought public health wins and weakening the public health system’s ability to respond to emerging threats. While monies from the Prevention and Public Health Fund are helping to fill gaps, those new funds are under threat of being eliminated as well. And since the funds are not being used as intended — in other words, health reform funds are supplanting, not expanding, current public health and prevention funding levels — any new initiatives are not only far from sustainable, they’re being set up for failure. To help stop this trend, collect the data and find the stories to make the case for a robust and well-funded public health system as well as a dedicated funding stream for prevention. Remind policymakers that having an insurance card doesn’t always equal access to care and that many residents will still look to public health for services and population-based programs.

AIM TO DO BETTER: As the health care landscape changes, so too must public health. In a new health era in which efficiency and competency will be key, it’s vital to seek out opportunities to improve public health performance, strengthen the public health workforce and maximize return on investment.

GET WITH TECH: New investments in health information technology and electronic health records present promising opportunities for public health to reach residents with vital health information, strengthen its ability to respond to threats and bolster ties with the clinical community.

SPEAK SOCIAL JUSTICE: Social justice values are at the heart of the public health profession. Continue to shine a light on ethnic and racial health inequities and advocate for resources, policies and funds that bring the opportunities for good health and well-being to all. Explain that good health requires not only access to care, but targeting the social determinants of health.

MAKE YOUR VOICE HEARD: Public health must be at the table as states move forward to implement insurance reforms. The true measure of health reform’s success will be in the health of the population. Public health experience and knowledge are key to ensuring that good health is a driving factor as the nation moves toward reform.
AGENDA

APHA Midyear Meeting
Implementing Health Reform: A Public Health Approach
June 23–25, 2011
Chicago, Ill.

The American Public Health Association’s 2011 Midyear Meeting welcomed more than 600 public health practitioners, researchers and advocates to engage in extensive conversations around the role of public health in implementing the Patient Protection and Affordable Care Act and the opportunities the law presents for improving health and preventing disease.

THURSDAY, JUNE 23

1 p.m.–2:30 p.m.
Opening General Session: The Public Health Context for Health Reform
Georges Benjamin, MD, FACP, FACEP (E), Executive Director, APHA; Celinda Lake, president, Lake Research Partners; Terry Mason, MD, interim chief executive officer, Cook County Health and Hospital System; Bechara Choucair, MD, commissioner, Chicago Department of Public Health; Jennifer Granholm, JD, former governor of Michigan; Linda Rae Murray, MD, MPH, president, APHA, and chief medical officer, Cook County Department of Public Health; Pat Quinn, governor of Illinois

2:30 p.m.–3 p.m.
Refreshment Break

3 p.m.–5 p.m.
Concurrent Breakout Sessions
How Does the Public Describe Public Health?
Moderator: Robert J. Gould, PhD, executive vice president and managing director, Brodeur Worldwide; Bob Crittenden, MD, MPH, executive director, Herndon Alliance; Joe Marx, senior communications officer, Robert Wood Johnson Foundation

Public Health and Quality Care
Moderator: Christina Welter, DrPH, MPH, deputy director, Cook County Department of Public Health, Illinois; Terry Cline, PhD, state health officer, Oklahoma State Department of Health; Lee Francis, MD, MPH, president and CEO, Erie Family Health, Illinois; Mary Mincer Hansen, PhD, RN, director of the Masters of Public Health Program and adjunct associate professor, Department of Global Health, Des Moines University; Phyllis D. Meadows, PhD, MSN, RN, associate dean for practice, Office of Public Health Practice, and clinical professor of health management and policy, University of Michigan School of Public Health; Bonnie Zell, MD, MPH, senior director, Population Health, National Quality Forum
Technology Implications of Health Reform
Moderator: Edward Mensah, PhD, associate professor and director of Health Informatics Graduate Program, University of Illinois-Chicago School of Public Health; William Hacker, MD, FAAP, CPE, commissioner, Kentucky Department for Public Health; William Pilkington, DPA, director of public health and CEO, Cabarrus Health Alliance, North Carolina

Fiscal Implications of Health Reform
Moderator: Diane Canova, JD, vice president, Policy and Programs, Partnership for Prevention; Michael Botticelli, MEd, director, Bureau of Substance Abuse Services, Massachusetts Department of Public Health; Kenneth Coleman, MA, director, School-Based Health Centers, St. John Providence Health System, Michigan; Paul E. Jarris, MD, MBA, executive director, Association of State and Territorial Health Officials; Paul Keuhnert, MS, RN, executive director, Kane County Health Department, Illinois

Welcome Reception

FRIDAY, JUNE 24

Continental Breakfast

Morning General Session: Seeking Common Ground: Various Approaches to Improving Population Health
Moderator: Susan Dentzer, editor-in-chief, Health Affairs; Oliver Fein, MD, professor of clinical public health, Department of Public Health, Weill Medical College, Cornell University; Julie Eckstein, MBA, center for Health Transformation; John E. McDonough, DPH, MPA, professor of public health practice, director of the Center for Public Health Leadership, Harvard School of Public Health-Landmark Center

Concurrent Breakout Sessions: The themes of the morning and afternoon sessions are the same, however the speakers and presentations varied

Developing the Public Health Workforce
Morning session
Moderator: Paul E. Jarris, MD, MBA, executive director, Association of State and Territorial Health Officials; Patricia Drehobl, MPH, RN, associate director for policy, Scientific Education and Professional Development Program Office, Centers for Disease Control and Prevention; Brian Smedley, PhD, vice president and director, Health Policy Institute, Joint Center for Political and Economic Studies; Cynthia D. Lamberth, MPH, CPH, associate dean for workforce development, University of Kentucky College of Public Health
Afternoon session
Moderator: Paul E. Jarris, MD, MBA, executive director, Association of State and Territorial Health Officials; Sarah Linde-Feucht, MD, acting chief public health officer, Health Resources and Services Administration; Brian Smedley, PhD, vice president and director, Health Policy Institute, Joint Center for Political and Economic Studies; Cynthia D. Lamberth, MPH, CPH, associate dean for workforce development, University of Kentucky College of Public Health

Achieving Prevention and Wellness

Morning session
Moderator: Adewale Troutman, MD, MPH, MA, CPH, director, Public Health Leadership and Practice, University of South Florida; Larry Cohen, MSW, founder and executive director, Prevention Institute; Janet Collins, PhD, associate director for program, Centers for Disease Control and Prevention; Judith Monroe, MD, MPH, deputy director, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention

Afternoon session
Moderator: Adewale Troutman, MD, MPH, MA, CPH, director, Public Health Leadership and Practice, University of South Florida; Ryan Kellogg, program manager, Healthy Eating/Active Living, Department of Public Health Seattle-King County; Stephen A. Martin Jr., PhD, MPH, chief operating officer, Cook County Department of Public Health, Illinois; Karla Sneegas, MPH, executive director, Indiana Tobacco Prevention and Cessation Program; Mildred Thompson, MSW, senior director, PolicyLink

Connecting Public Health and Clinical Prevention

Morning session
Moderator: James Galloway, MD, FACP FACCC, FAHA, assistant U.S. Surgeon General, acting U.S. Health and Human Services regional director and regional health administrator, Region V, Chicago; Deborah Chang, MPH, vice president, Policy and Prevention, Nemours; Sarah Linde-Feucht, MD, acting chief public health officer, Health Resources and Services Administration; Chesley Richards, MD, MPH, director, Office of Prevention Through Healthcare, Centers for Disease Control and Prevention; Fred Volpe, MPA, project officer, Drug-Free Communities Program, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration

Afternoon Session
Moderator and panelist: David Fukuzawa, MS, program director, Kresge Foundation; Rishi Manchanda, MD, MPH, founder, National Physicians Alliance; Deborah Klein Walker, EdD, Abt Associates

Protecting Impacted Public Health Programs

Morning session
Moderator: Diane Canova, JD, vice president, Policy and Program, Partnership for Prevention; Robyn Gabel, state representative, Illinois’ 18th District; Lynn Bethel, MPH, RDH, director, Office of Oral Health, Massachusetts Department
of Public Health; Rachel Iverson, MA, associate director, Tobacco Control Program, New York State Department of Health; Sheri Scavone, PT, EHSA, New York State Department of Health

**Afternoon session**

*Moderator:* Diane Canova, JD, vice president, Policy and Program, Partnership for Prevention; Gail Bolan, MD, director, Division for STD Prevention, Centers for Disease Control and Prevention; Christopher Brown, MPH, MBA, assistant commissioner, STI/HIV Division, Chicago Department of Public Health; Alexandra Stewart, JD, assistant research professor, George Washington University School of Public Health and Health Services

12:30 p.m.–1:15 p.m.

**Lunch**

1:30 p.m.–2:45 p.m.

**Afternoon General Session: Putting It All In Perspective: Public Health, Health Care and Quality**

Georges Benjamin, MD, FACP, FACEP (E), executive director, APHA; Caya Lewis, MPH, chief of staff, Centers for Medicare and Medicaid Services

3 p.m.–5 p.m.

**Breakout Sessions**

The afternoon session themes were a repeat of the day’s earlier sessions, but with different speakers and presentations. For a list of speakers, see the previous breakout session listings.

**SATURDAY, JUNE 25**

7:30 a.m.–8:30 a.m.

**Continental Breakfast**

**Concurrent Breakout Sessions**

**Assuring Access: Advocating for Coverage**

*Moderator:* Matthew Marsom, director, Public Health Policy and Advocacy, Public Health Institute; Jim Duffett, MA, executive director, Campaign for Better Health care; Eduardo Sanchez, MD, MPH, vice president and chief medical officer, Blue Cross Blue Shield of Texas; Emily Stewart, director of public policy, Planned Parenthood Federation of America

**Assuring Population Health: Advocating for Prevention and Wellness**

*Moderator:* Larry Cohen, MSW, founder and executive director, Prevention Institute; Rob Restuccia, MPA, executive director, Community Catalyst; Larry Boress, MPA, president and CEO, Midwest Business Group on Health; Gerry Thomas, MPH, associate director, Community Initiatives Bureau, Boston Public Health Commission

**Engaging Policymakers and Other Leaders: How Public Employees Can Advocate Effectively for Public Health and Prevention**

*Moderator:* Tom Quade, MPH, MA, deputy director, Akron City Health Department, Ohio; Chuck Alexander, senior vice president for public health, Burness Communications; Elizabeth Wenk, vice president for public policy, Burness Communications
Legal Challenges to Health Reform: An Update

Moderator: Gene W. Matthews, JD, director, Southeastern Regional Center, Public Health Law Network, University of North Carolina Gillings School of Global Public Health; Michael Gelder, senior health policy advisor to Gov. Pat Quinn, Office of the Governor, Illinois; Rebecca Salay, MSC, director of government relations, Trust for America’s Health; Jane Perkins, JD, legal director, National Health Law Program

10:30 a.m.–noon

Closing General Session: Where Do We Go From Here?

Georges Benjamin, MD, FACP, FACEP (E), executive director, APHA; James Galloway, MD, FACP FACC, FAHA, assistant U.S. Surgeon General, acting U.S. Health and Human Services regional director and regional health administrator, Region V, Chicago; Lawrence Wallack, DrPH, dean, College of Urban and Public Affairs, Portland State University
THANKS!

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