The Critical Role of Public Health Departments in Health Care Delivery System Reform

April 2014

Authors:

Dawn Hamilton
Margaret Kirkegaard
Jack Meyer

Mona Shah
Pat Terrell
Lori Weiselberg

Contributing Authors: Meghan Kirkpatrick, Barbara Leadholm, Diana Rodin
# TABLE OF CONTENTS

- Introduction and Statement of the Problem ................................................................. 3
- Bringing Local Health Officials into Key Decisions in the Health Care System ............... 4
- Redirecting Spending ..................................................................................................... 6
- Strategies for Bridging the Gap ................................................................................... 8
- Federally Supported Innovation Grants ........................................................................ 8
- Local Health Department Takes the Lead in Integrating Traditional Activities with Major Reforms in the Health Care Delivery System ......................................................... 11
- Linking Initiatives Addressing the Social Determinants of Health to Health Care Reforms ____ 11
- Providing Access to a Comprehensive Set of Health Services for the Uninsured through Non-insurance, Community-wide Programs Led by City Health Departments ...................................................... 13
- Opportunities and Constraints .................................................................................... 16
- ACA Provisions Provide Opportunities ........................................................................ 16
- Initiatives by Payers Can Make Positive Contributions .................................................. 17
- Work Force Development: Addressing a Major Constraint ............................................. 18
- Conclusion .................................................................................................................... 20
- Authors ........................................................................................................................ 21
INTRODUCTION AND STATEMENT OF THE PROBLEM

The purpose of this paper is to build a bridge that connects local and state public health officials with the leadership of hospitals, physicians and other providers, and public and private payers in an effort to improve the health of individuals and lower avoidable health care spending. This paper focuses on local reforms, including health care delivery system and community-based initiatives that factor in poor housing, long-term unemployment, inadequate nutrition, and other problems that clearly contribute to poor health but fall outside of the health care system.

The people who deliver and pay for health care do not often actively engage leaders in the public health community in key decisions involving local health reform. Similarly, people leading health departments and front-line public health professionals too often do not actively seek participation in discussions and planning about reforms within the overall health care delivery system.

A major premise of this paper is that the chasm between public health leaders and the key players in our health care delivery and finance systems limits the success of all parties. Significant improvements in health outcomes and successful control of the rise in health care spending will not occur unless the underlying drivers of poor health are addressed, including both the social and physical determinants of health, many of which are outside the boundaries of the health care system. This paper presents a variety of models for greater involvement of health departments in system-wide reforms at the community level.

Health reforms cannot fully succeed without a strong public health component. Seven in ten deaths in the US are related to preventable diseases such as obesity, diabetes, high blood pressure, heart disease, and in many cases, cancer. Some 75% of our total health care spending involves treating these types of diseases. In addition, chronic medical conditions associated with modifiable risk factors such as smoking, nutrition, weight, and physical activity represented six of the ten costliest medical conditions in the US, with a combined medical care expenditure of $338 billion in 2008.1 In contrast, approximately 3% of our total spending is for prevention.2

The Institute of Medicine (IOM) has delineated three types of prevention: universal interventions (affecting the population at large); selective interventions (targeted to groups at elevated risks); and indicated interventions (targeted to individuals with early symptoms). The IOM has emphasized the importance of true prevention, which occurs prior to the onset of a disorder, and mental health promotion—building healthy developmental and protective factors via supportive families, schools, and communities. Most mental, emotional, and behavioral (MEB) disorders have their roots in childhood and youth. Among adults reporting MEB, more than half report onset in

---

2http://www.apha.org/APHA/CMS_Templates/ChannelDefault.aspx?NRMODE=Published&NRNODEGUID=%7bD71F6AD2-E25B-460E-AFC0-29B4F741331%7d&NRORIGINALURL=%2fadvocacy%2fHealth%2bReform%2fPH%2bFund%2f&NRCACHEHINT=NoModifyGuest#PPHF1
childhood and adolescence. The annual quantifiable cost of such disorders among young people was estimated to be $247 billion in 2007.³

This paper begins by explaining the importance of bringing local and state health departments into the discussions and decision-making process regarding health care delivery and finance reforms. This is followed by a number of illustrations that feature health departments in leadership roles in community-wide health reforms that demonstrate promising efforts. Finally, this paper highlights opportunities for progress emerging from certain provisions of the Affordable Care Act and promising private sector initiatives.

**Bringing Local Health Officials into Key Decisions in the Health Care System**

A number of promising models of care and financing are emerging, including patient-centered medical homes (PCMH), accountable care organizations (ACOs), home and community-based care, and bundled and global payments. All deserve careful evaluation.

These health care reform initiatives all focus on better ways to deliver health care and better ways to pay for it. Public health can bring an important additional dimension to health policy by addressing social determinants of health and the forces that drive people into the health care system in the first place, in order to keep the population healthier. These forces include tobacco use, the national obesity epidemic, mental illness and substance abuse (sometimes leading to violence and suicide), persistent poverty, unsafe housing and homelessness, poor schools, insufficient attention to the impact of the built environment on population health, and environmental hazards that contribute to poor health. Local and state health departments can make important contributions to better population health and lower overall health spending through critical activities such as screening and treatment for communicable diseases; control of infectious disease outbreaks; environmental health surveillance; and population-based tobacco prevention.⁴

Local public health officials and leaders of community-based organizations can bring innovations to the table addressing these drivers of poor health and high spending, but only if they are invited into the decision-making process, and only if they accept, and even push for such invitations.

Not only is improving the health of the population one of the tri-partite goals of the Triple Aim,⁵ but addressing population health also serves as the foundation to the other two aims of controlling costs per capita and improving health care experience. To achieve the Triple Aim, the US must address the forces outside of the health care system that are driving high costs, poor quality, and adverse patient experiences. As noted by Michael Marmot and Richard Wilkinson, “Good health involves reducing levels of educational failure, reducing insecurity, and improving housing

---

³ Eisenberg, D and Neighbors, K (2007). “Economics of Preventing Mental Disorders and Substance Abuse Among Young People.” Paper commissioned by the Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions, Board on Children, Youth, and Families, National Research Council and Institute of Medicine. Washington, DC.

⁴ National Association of County & City Health Officials. [http://nacchoprofilestudy.org/chapter-6/](http://nacchoprofilestudy.org/chapter-6/)

⁵ The Triple Aim is a concept invented by the Institute for Healthcare Improvement and adopted by the US Department of Health and Human Services as an overarching goal for health policy. [http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx](http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx)
standards. Societies that enable all citizens to play a useful role in the social, economic, and cultural life of their societies will be healthier than those where people face insecurity, exclusion, and deprivation." By eradicating or improving the antecedents of injury and chronic disease, it is possible to reduce the need for future health care services.

Community-based prevention strategies complement and augment the impact of clinical prevention in three ways. First, because community-based interventions are implemented population-wide, they address the entire population and are not dependent on payer-source or access to the health care system; second, community interventions reach individuals at all levels of risk; and third, some lifestyle and behavioral risk factors are influenced by conditions not under an individual’s control. Community interventions can address these factors by, for example, providing safe parks and safe walking routes to school to improve the opportunities for exercise and physical activity; developing successful tobacco cessation programs; and conducting urban planning and public transportation development in a way that promotes walking, bike-riding, and other healthy activities.

Community-based prevention strategies also encompass initiatives aimed at increasing educational attainment and health literacy. People with greater educational attainment tend to have lower rates of several chronic diseases, including obesity, compared to people with lower education and income levels. In many poverty-dense regions, people are unable to access affordable healthy food, even when funds are available.

For example, men without a high-school diploma have a life expectancy that is 9.3 years less than those with a bachelor’s degree or higher; women without a high school diploma have a life expectancy 8.6 years less than those with a bachelor’s degree or higher. Further, over the 2005-2010 period, the prevalence of depression among adults 45-64 years of age was five times higher for those living in poverty (24%); three times higher for those with incomes between 100-199% of the poverty line (15%); and more than 1.5 times higher for those with family income between 200% and 399% of poverty (7%), compared with those with incomes at 400% or more of the poverty line (5%).

Additionally, over the 2007-2010 period, women 25 and over with less than a bachelor’s degree were more likely to be obese (39%-43%) than those with a bachelor's degree or higher education (25%), and in 2010, 31% of adults 25-64 with a high school diploma or less were current smokers, compared to 24% of adults with some college education and 9% of adults with a bachelor's degree or higher.

Interestingly, the reverse is also true. Students who weighed less than 5.5 pounds at birth, frequently leading to significant health problems, are about 33% more likely to drop out of high

---

school. High-quality early childhood education programs increase the likelihood of graduating from high school, as does intensive support to help children who struggle in elementary and middle school.

Redirecting Spending

Frequently, decisions are made about the health care delivery system in states and communities that generate hundreds of millions of dollars in new spending, but are not necessarily driven by the population’s need for services or community health improvement. This might involve building a new hospital in a community that is already over-bedded because it will be a “state of the art” hospital, or allegedly create jobs. It might involve investing in one, or even two, new proton beam therapy facilities, at a cost of $100 million or more each, when there is already ample capacity in the overall region and many of the costly and risky procedures that will be done lack a clinical evidence base. Hospitals continue to buy medical groups, frequently with contractual terms, rewarding these groups for fostering the growth in the volume of hospital services, even as evidence accumulates that a considerable number of ER visits, inpatient stays, and outpatient hospital visits are “ambulatory-sensitive,” meaning that they are avoidable with appropriate and timely care, particularly preventive and primary care. The medical malpractice system signals physicians to run more tests and perform more procedures. Of course, the fee-for-service payment system reinforces all of these volume-driven incentives.

Yet, long-standing, fee-for-service-based health care financing models will frequently fail to cover modest, well-targeted investments in efforts such as family preservation initiatives, promoting healthy diets, home visits to identify asthma triggers, and removing lead-based paint. Health care systems need payment reforms that reimburse and encourage such initiatives even though the savings they will generate are usually not realized quickly.

While the health care spending juggernaut rolls on, the forces that feed it are frequently overlooked. Some 88% of adult regular smokers started smoking by age 18. About 1,000 new kids become regular, daily smokers each day while another 4,000 kids try their first cigarette each day. A new report by the United States Surgeon General concludes that if current trends continue, 5.6 million American youth currently less than 18 years of age will die prematurely from smoking during their adult lives.

According to the Centers for Disease Control, the proportion of adults 20 years of age and older with Grade 1 obesity (body mass index [BMI] of 30.0-34.9) increased from 14% to 20% from 1988 through 2007-2010. The corresponding jump over this time span for those with Grade 2 obesity (BMI of 35.0-39.9) was from 5% to 9%, and the proportion with Grade 3 or higher obesity (BMI of 40 or higher) doubled from 3% to 6%. There is clear evidence that the sharp increase in obesity is connected to the rise in the incidence of diabetes and other chronic illnesses. High concentrations of

---

10 Centers for Disease Control and Prevention “Smoking and Tobacco Use” http://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/
12 National Center for Health Statistics, supra. p. 5.
polluted air lead to and exacerbate children’s asthma. Homeless people cycle through ERs and are frequently admitted to hospitals, then returned to the streets with no transitional housing assistance, and little, if any, resolution of the forces in their lives such as diabetes, mental illness, and substance use conditions that lead to the ambulance calls.

Given this backdrop, it is important to bring the leadership of local and state health departments to the table, especially as critical decisions are made about how to deploy resources. In fact, these officials could play a convening and facilitation role. For example, local and state health departments could educate a wide range of community leaders, including hospitals, health plans, and physician organizations, as well as business and labor, about the critical role that community needs assessments play in health care reform. In fact, the ACA requires all nonprofit hospitals to conduct a community needs assessment, which must include input from the local health department. As a result, county health departments are collaborating with local hospitals and conducting county-wide needs assessments in order to fulfill this requirement.

These needs assessments should precede, and may sometimes avert, commitments of resources to projects with very high price tags that do not meet critical community needs, and may, in some cases, exacerbate the misallocation of resources (e.g. when hundreds of millions of dollars are spent on a new hospital in a community that already has excess hospital capacity). At the same time the needs assessments could pave the way for comparatively lower cost investments for identified community needs (e.g. a smoking cessation program, a promising initiative to avoid obesity in children and youth, or a family preservation initiative for new mothers and their families).

A careful needs assessment, in conjunction with a careful mapping of the existing delivery system, can lead to an important “gap analysis,” uncover areas where resources are being duplicated, and identify opportunities to leverage existing community-based resources. For example, a community could discover a critical need for:

- new dental clinics for children;
- more language interpreters for community health centers;
- the recruitment of additional primary care physicians, nurse practitioners, social workers, and community health workers to bolster the primary care work force;
- support for a community mental health center that is losing staff;
- initiatives to increase access to prenatal care in the first trimester, or support for new mothers; and
- safe routes to school for children and safe places for them to play, exercise, learn healthy behaviors, and expand social supports.

Such programs carry price tags that are a tiny fraction of the resources thrown into enormously expensive investments inside the health care delivery system that lack an evidence base of clinical effectiveness.

In order to optimize population and public health outcomes and status, a “health in all policies” (HiAP) approach is needed. HiAP brings the impact on population health into a wide range of policy decisions in areas such as urban planning, new construction, public transportation, education, and
environmental safety. For example, the National Association of County & City Health Officials (NACCHO) launched the Environmental Public Health HiAP Program to increase awareness among decision makers about the environmental implications of community decisions, and to build the capacity of local health departments to be involved in cross-sector work.13

**Strategies for Bridging the Gap**

This section presents a series of strategies for integrating public health into reforms in the health care delivery and finance systems, and outlines a role for health departments in each example.

**Federally Supported Innovation Grants**

The federal government has articulated a vision for the future of US health care embodied in the Triple Aim, which, as mentioned earlier in this paper, is improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Anticipating that states would need resources to transform their delivery systems, the Center for Medicare and Medicaid Innovation (CMMI) created the State Innovation Models (SIM) initiative for states to promote planning, designing, testing, and supporting evaluation of new payment and service delivery models in the context of larger health system transformation. Six states received model testing awards of up to $45 million, three states received pre-testing awards, and 16 states received model design awards. City and state health departments are an important part of some of these models.

**Spotlight on: Oregon: Bringing Health Departments into Regional Governance of Resource Allocation**

Over the past two years Oregon has been engaged in a new approach to meeting the Triple Aim: the establishment of 15 regional Coordinated Care Organizations (CCOs), which are given the latitude to utilize public dollars in innovative ways to meet access, quality, and cost performance metrics. Each of the CCOs has a governance structure that is representative of all key stakeholders.

In addition to the traditional providers, the local public health departments are state-mandated members of the CCO. They play a critical role in assuring the integration of medical and behavioral health, and are leading the effort to meet performance indicators related to population health metrics. These metrics include immunization rates; penetration of chronic disease screening initiatives; initiation of prevention programs like smoking cessation; transforming public health and mental health clinics into patient-centered medical homes and health homes to expand access; and providing data to measure impact on the health status of the populations and communities served by the CCOs. The integration of local public health departments with health care providers is creating a new model for collaboration between two traditional approaches to health care normally operating in silos.

The introduction of public health metrics along with clinical prevention metrics will provide a more complete picture of population health and an improved benchmark against which to measure future progress. The linking of behavioral health providers with other medical specialists and primary care providers will increase the proportion of people with both types of conditions who

13 [http://www.naccho.org/topics/environmental/HiAP/](http://www.naccho.org/topics/environmental/HiAP/)
are properly served in the community, avoiding expensive inpatient stays in psychiatric facilities. This will yield savings to the state and the federal government, as well as for private payers.

**Spotlight on: Illinois: Building Regional Health Hubs**
The Illinois SIM leadership group, the Alliance for Health, developed an active planning process drawing on the expertise and input of multiple stakeholders to address population health and integrate population health improvement efforts within the health care delivery system. Both the Illinois Department of Health and local departments of health are integrally involved in the Alliance.

Through the planning process, four distinct values for population health improvement crystallized: health equity, integration, continuous learning, and sustainability.

In order to operationalize these four values, the Alliance for Health proposes to strengthen the public health infrastructure by creating Regional Public Health Hubs (Regional Hubs). The Regional Hubs will serve as a “nexus” between the Illinois Department of Public Health (IDPH), local health departments (LHDs), and communities. IDPH will serve as a “coach” and resource for the Regional Hubs by providing technical assistance, data analysis, and epidemiological expertise. Local health departments will play a key role in organizing communities and providing local expertise.

The Regional Hubs will connect with the Alliance’s ongoing planning processes and ensure that communities, LHDs, and health systems integrate their efforts for primary prevention and wellness promotion through the cycle of assessment, convening stakeholders, planning interventions, data collection, evaluation, and dissemination. As delivery systems transition from fee-for-service payment to shared savings and global payments, the value of community interventions to the health care delivery system will increase. The Illinois Alliance also emphasizes the benefit of community health interventions to employers, both by reducing health insurance premiums, and by increasing productivity. One of the innovations from subsequent model testing will be to calculate the return on investment associated with new interventions, and then develop a sustainable funding model, taking into account the value to all community stakeholders.

**Spotlight on: Michigan: Building Regional Hubs**
Through the State Innovation Models (SIM) planning grant received from CMMI, the State of Michigan has identified the integration of health care services and the traditional public health functions as a key element. Michigan’s State Health Care Innovation Plan (SHCIP) envisions five pillars undergirding health care reform:

1) Patient-Centered Medical Homes  
2) Accountable Systems of Care  
3) Community Health Innovation Regions  
4) Payment Reform  
5) Infrastructure

The Michigan SHCIP has identified a key role for Community Health Innovation Regions (CHIRs), which will encompass traditional public health entities and convene stakeholders across competitive entities, conduct community assessments, link people to needed services, establish
health policies and priorities, and spur integration of clinical, behavioral, and social services within accountable systems of care.

As the SIM process moves from the planning phase to the testing phase, Michigan is testing the theory that the CHIRs will be effective in bringing together public health, social services, and other community resources to reduce community risk factors and create a healthier community environment that will directly translate into lower health care spending. The state will be developing publically-reported community health dashboards and hold the health care systems and health plans accountable for reducing long-term community health risk factors by collaborating and supporting CHIRs. Part of the SIM test will be to evaluate whether the CHIRs can have a direct impact on health care costs, and therefore be allowed to participate in “shared savings” as a “three-share” model—providers, health plans, and the community.

The initial funding for the CHIRs will come from existing funds and resources as well as innovative approaches to using community development funds, tobacco tax revenues, or other special revenue sources. CHIRs are also expected to leverage non-profit hospital community benefit requirements and private foundation grants, and seek financial and non-financial support from providers and health plans that will benefit from the community health improvement efforts.

**Spotlight on: Lake County, IL: Improving Access to Specialty Care and Diagnostics and Improving Care Coordination**

Since 2003, spurred by the leadership of an Illinois State Senator, Lake County community leaders representing county and local government, the Lake County Health Department/Community Health Center, HealthReach (a free clinic), all five hospitals in Lake County, private health care providers, and local private foundations, have worked together to address unmet needs of uninsured, low-income residents of Lake County, particularly in the area of specialty care. The first initiative of this collaboration was a Specialty Care and Diagnostic Testing Program whereby each of the five hospitals agreed to an equitable dollar amount of in-kind specialty/diagnostic charity care annually, managed by the health department. The health department also expanded specialty care on-site at their multi-site FQHC, identified specialists in the community willing to take on a limited number of visits by uninsured patients, and provided case managers to connect uninsured patients to specialists.

More recently, the health department engaged HMA to meet with the five hospital CEOs to discuss priorities for their hospitals and interests in an expanded collaboration with the health department to improve care coordination. Based on themes from these discussions and interests of the health department, it was collectively decided to invest in population health management software for the purpose of creating an interface between the health department's FQHC and each hospital. The software would enable real-time alerts to the FQHC that their patients had either been seen in an emergency department, or had an inpatient admission in the county. The FQHC plans to contact these patients and ensure timely follow up with their Primary Care Provider (PCP), which is expected to result in reduced readmission rates. FQHC outreach to ED users to discuss same day/next day visit availability and telephone accessibility to a provider after hours is expected to more firmly establish patients in their medical homes, and reduce the number of low-acuity
emergency department visits. This initiative promises to be a win for the hospitals, the health department/FQHC, and most importantly, the patients.

**Local Health Department Takes the Lead in Integrating Traditional Activities with Major Reforms in the Health Care Delivery System**

Some local health departments are taking the lead in building community-wide collaboratives that guide a fundamental reorganization of the health care delivery system. A key element is building strong linkages between somatic health delivery and behavioral health services—including skilled nursing facilities—and bringing the traditional population health functions together with health care delivery reorganization.

**Spotlight On: San Francisco: Integrating the Health Care Delivery System within the Public Health Department**

The San Francisco Department of Public Health (SFDPH) is one of the few large urban health and hospital systems in the nation in which the medical delivery system operated by local government (hospital, clinics, skilled nursing facilities), behavioral health services (inpatient, outpatient, care management, residential mental health, and addiction programs), and population/public health are all under one department. With the help of HMA, SFDPH is taking innovative steps to coordinate their service delivery programs (both medical and behavioral health) into one integrated delivery system through the creation of the SF Health Network.

The integration of the delivery system services operated directly by SFDPH was seen as a critical first step; the collaboration with its own population health programs a second. However, the role of the public health system in “assuring the health of the public” is a larger charge than what can be accomplished within the public health system alone. Future efforts will be aimed at collaborations with other providers of care and with non-health elements within the City and County of San Francisco (i.e. education, economic development, housing). It was seen as critical, however, for the department to get its own “house in order” before involving the broader community.

The next step will be to build links between this integrated delivery system and population/public health. Several of the traditional public health categorical programs (maternal and child health, tuberculosis, and STD clinics) are being integrated into the delivery system network. There is interest in pairing the surveillance role of the public health unit (i.e. identifying problem areas for certain conditions) with delivery system interventions targeting these problems. The public health unit also offers the ability to better monitor overall health status impacts and provide feedback to the delivery system. Finally, the ability of the public health unit to address environmental health regulations offers further opportunities to collaborate.

**Linking Initiatives Addressing the Social Determinants of Health to Health Care Reforms**

Local and state health departments can play an important role in bringing important economic and social services normally viewed as well outside of health care into structural reforms within the health care delivery system. In particular, employment, housing, and nutrition services are now
being recognized as important contributors to better health. This approach features the co-location of these services within key sites in the medical delivery system such as clinics, ERs, and hospitals.

**Spotlight On: Hennepin County, MN: Bringing Employment Services, Housing, Nutrition, and Oral Health into Health Reform for Poor Childless Adults**

In Hennepin County, Minnesota (Minneapolis, St. Paul area), the Department of Health and Hennepin Health, a managed care organization serving poor childless adults in Medicaid, have formed a partnership with the North Point Health and Wellness Center, the County Human Services Department, and the Hennepin County Medical Center, to address a wide range of needs for this population.

Steps the county has taken to address the needs of the population include:

- The assignment of a single accountable individual to each of the members in the top 20% of health care utilizers who develops an individualized care plan, including behavioral and social needs. The individualized plans can include smoking cessation and oral health in addition to preventive and primary medical care.

- A county-operated intensive case management team assists patients with persistent and serious mental illness.

- An ER “in-reach” unit links high utilizers of the ER and other crisis services to primary care and non-emergency behavioral health services.

- A strong emphasis on averting care in high-cost settings, such as the ER and inpatient admissions, which is leading to savings. A portion of these savings is used to finance the types of housing and employment services described here, which would ordinarily fall outside of the Medicaid benefit package.

In addition, the county has conducted a survey of 1,200 people who are high-utilizers of care in high-cost settings and ascertained the “social determinants” of their health problems. The survey revealed that the leading causes of high care utilization are hunger and food inadequacy, persistent unemployment, a lack of access to medications, and complete social isolation.

The county is able to begin responding to these needs by taking a portion of the savings from ER diversion and other successful initiatives that are lowering hospital admissions and readmissions, and reinvesting them in supportive services that are rarely included in the medical model, including employment, nutrition, and housing services. Using a very innovative program called “Employment Pays,” Hennepin Health has formed partnerships with local employers to provide job opportunities for poor childless adults. Many participants have not worked in years and need mentoring and skill development to learn how to navigate the world of work. Once placed in a job, the person receives ongoing support from Hennepin Health.

Frequently, people using the Employment Pays initiative have utilized the chemical dependency treatment program at Hennepin Health to address addiction to drugs and alcohol. In addition, transitional housing services that help people find supported housing if they are either homeless, or

---

14 [http://www.hennepin.us/healthcare](http://www.hennepin.us/healthcare)
15 [http://www.hennepin.us/healthcare](http://www.hennepin.us/healthcare)
on the edge of becoming homeless, are available. The county has also hired community health
workers and placed them in “Health Care for the Homeless” locations, the county hospital, and
clinics. This holistic approach will first and foremost help the most vulnerable community residents
by going to the roots of the problems that are driving them into repeated encounters with the
health care system—ineffective housing, long-term joblessness, substance use, and mental illness.
Medicaid spending will also be reduced as fewer people cycle repeatedly through emergency
department visits and hospital stays.

Providing Access to a Comprehensive Set of Health Services for the Uninsured
through Non-insurance, Community-wide Programs Led by City Health
Departments

Two US cities, San Francisco and Washington, DC, began initiatives several years ago to establish an
insurance-like program to provide comprehensive health coverage to large numbers of uninsured
residents. These programs address the needs of people facing financial and other barriers to health
who were ineligible for Medicaid and other public programs. Both programs are led by the city
health departments.

The programs provide access, with very minimal cost sharing, to a wide range of health services,
including primary and specialty care physician visits, diagnostic testing and lab work, inpatient and
outpatient hospital services, and prescription drugs.

Prior to the enactment of ACA, when there was no discernible pathway to make many of these
services affordable for the uninsured (e.g. specialty care and diagnostics), these programs offered a
ticket to the mainstream health care system to low-income childless adults and many parents. The
programs responded to a critical need by filling the gap between primary care and inpatient care
and ED use. Prior to the programs the uninsured were going to a community health center where
the treating physician knew that they needed a set of diagnostic tests (e.g. MRI or CT scan, EEG) and
visits to specialist physicians, but that it was virtually impossible for the uninsured residents to
gain access to these services. Moreover, while uninsured patients might have received free samples
of drugs at a clinic, people who needed maintenance drugs for chronic conditions were handed
prescriptions that they simply could not afford to fill and refill. The programs in these two cities
opened the doors for tens of thousands of city residents to have access to a wide range of health
services that they would not have had otherwise.

Although substantial numbers of people are transitioning into Medicaid and insurance
Marketplaces, coverage initiatives are still vital. First, at this juncture in ACA implementation, more
than twenty states have decided not to move ahead with the ACA Medicaid expansion. In these
states, large numbers of poor and near-poor adults will remain uninsured. Second, even in states
that are implementing the Medicaid expansion, a substantial number of people are not eligible –
primarily undocumented people and documented immigrants who have not fulfilled Medicaid’s
five-year waiting period. States may allow foreign-born children and pregnant women to enter
Medicaid before the end of this five-year period, but not other adults. Third, many non-insurance
barriers to care impede access for low-income residents of a community, including language and
transportation barriers, and the fact that large numbers of health care providers do not participate in Medicaid.

**Spotlight On: San Francisco: Moving Toward Universal Coverage at the Community Level**

Healthy San Francisco (HSF) is a health care access program implemented by the San Francisco Department of Public Health in 2007. The goal is to provide a medical home for uninsured adults ages 18-64 living in the city, as well as access to affordable primary and specialty physician care, hospital, and behavioral health services, along with prescription drugs. While not an insurance program, HSF provides primary care through a group of medical homes located in San Francisco that include clinics affiliated with the San Francisco Department of Health; the San Francisco Community Clinic Consortium (SFCCC); the Chinese Health Care Association and Chinese Hospital; Kaiser Permanente; and a large private medical group. Each HSF enrollee chooses one of 30 participating clinics as a point of first contact for all of their basic medical care.

An evaluation of HSF conducted by Mathematica Policy Research found that:

- HSF participants are very satisfied with their health care, and fewer than one in ten report a delay in getting medical care or medications over the course of a year; for example, 93% had not delayed seeking care or filling a prescription at the time of renewal or re-enrollment.
- Almost half of HSF participants received at least one recommended preventive service during the first 12 months of enrollment.
- HSF participants show a steadily declining ED use over time; the majority of ED visits are emergent visits and most HSF enrollees do not have multiple ED visits; for example, of 60,008 HSF participants, 53,132, or 89%, had no ED visits in the first 12 months. Of the remaining people, 1,432 had an ED visit in the first month, but 834 of these visits were for emergent care. Of the 590 participants with a non-emergent visit, 342, or 58%, had no further visits to the ED during the year. This appears to show a quick “learning curve” and a positive change in patterns of utilization toward primary care settings for non-emergent care.
- HSF is associated with an observed decrease in potentially avoidable hospitalizations made by uninsured adults in San Francisco; HSF has used a number of programs, such as Strength in Numbers, which has increased glucose control and lowered cholesterol for participants with diabetes.16

The San Francisco Department of Public Health is now working on transitioning many covered under Healthy San Francisco into Medicaid and insurance exchange plans, while maintaining the program for the remaining uninsured.

---

**Spotlight on: The DC Health Alliance: Moving Toward Universal Coverage at the Community Level**

In 2001, the Department of Health in Washington, DC played a leadership role in establishing the DC Health Alliance, a program that provides access to a comprehensive package of health services to low-income residents of the District who are ineligible for Medicaid and CHIP. The financing for the Alliance emerged from the closure of DC General Hospital, which had been running consistent deficits and was subject to mounting evidence of serious quality and patient safety problems. The Alliance budget was in the range of $80-90 million per year, somewhat less than the estimated $90-$120 million spent by the city on DC General annually.17

Participants receive a card that provides payment not only to a broad network of community health centers, but also to office-based physicians in primary and specialty care, diagnostic testing, dental services, hospital care, and prescription drugs. Behavioral health services are not included in the Alliance benefit package, but are provided directly by an agency of city government.

By 2006 more than 30,000 residents of the city were in the Alliance, and at its peak, enrollment hit about 58,000, which represented at least three-fourths of the city's uninsured population. The program served all low-income residents, including undocumented immigrants, with the largest share of enrollment being poor adults without dependent children.18 A study of the DC Alliance conducted by RAND concluded the following:

- The proportion of adults in the city with continuous health insurance rose from about 79 percent in 2001 to over 86 percent in 2005.19
- Many providers across the continuum of care received payment for services that were previously uncompensated.
- Pharmaceuticals were made available and affordable to uninsured people enrolling in the Alliance. The District was able to use the Federal Supply Schedule (FSS) to obtain steep discounts that were comparable to those negotiated with pharmaceutical manufacturers by the US Department of Defense and the Veterans Administration.
- The Alliance program provided access to dental care for the uninsured, along with making more adequate payments to dentists and allied personnel than they might have received in the past. The higher payments enhanced the participation of providers in the program, thereby improving access to dental care.
- The Alliance identified the 50 patients with the greatest number of ER visits, which led to the development of individualized care plans for better managing their use of the system and their medical conditions.20
- In high-poverty zip codes, ambulatory-sensitive admission rates for children fell by half over the period from 2000 to 2004, before rising somewhat between 2004 and 2005. The proportion of low-income adults who were uninsured fell from over 25 percent in 2000 to

---

18 Meyer, Bovbjerg, Ormond, and Lagomarsino. Supra.
under 15 percent in 2006. There was also a noticeable decline in the percent of uninsured adults in the District of Columbia without a usual source of care, from 35 percent in 2001 to about 28 percent in 2006.21

This strategy of offering comprehensive health coverage—with the exception of behavioral health—outside of a standard insurance model to people generally excluded from public programs and ineligible for job-based insurance, reduced the uncompensated care burden on hospitals, particularly safety net hospitals, along with helping FQHCs and free clinics get more patients with a payment source. By reducing cost-shifting, it also likely lowered health care premiums.

OPPORTUNITIES AND CONSTRAINTS

There are a number of opportunities to capture funding streams and technical expertise to support local innovations that bring together public health and health care delivery and finance reforms.

ACA Provisions Provide Opportunities

Both ACA and private sector innovations offer several important approaches to increase the role of public health in the health care system. One significant accomplishment is the establishment of an $18.75 billion Prevention and Public Health Fund. These federal dollars must be used “to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public health care costs.” In February 2012 the size of the fund was quickly reduced when Congress enacted, and the President signed, legislation that removed $6.25 billion over nine years from the fund, using this money to pay for and offset the cost of other government programs.22 Despite this setback, this is still a significant investment in public health as a mandatory stream of funding.

ACA also established the National Prevention, Health Promotion, and Public Health Council. This Council involves 17 federal agencies, departments, and offices, and is chaired by the Surgeon General. The Council has issued a National Prevention Strategy, as required by the ACA.23 The Council includes departments such as the US Department of Housing and Urban Development, the Department of Labor, the Environmental Protection Agency, and the Department of Agriculture, among others, in recognition of the important role that housing, the work environment, clean air and water, and nutrition have on the health of our population.

Additionally, the ACA includes provisions that drive alignment between health plans and public health. All health plans, both inside and outside of health insurance exchanges, are required to cover preventive services with no cost sharing to patients. This means no copayments and

21 Lurie, supra.
22 American Public Health Association.
http://www.apha.org/APHA/CMS_Templates/ChannelDefault.aspx?NRMODE=Published&NRNODEGUID=%7bD71F6AD2-4E5B-460E-AFC0-29BF741331%7d&NRORIGINALURL=%2fadvocacy%2fHealth%2bReform%2fPH%2bFund%2f&NRCACHEHINT=NoModifyGuest#PPHF3
23 http://www.surgeongeneral.gov/initiatives/prevention/about/
deductibles for certain cancer screenings, childhood immunizations, HIV/AIDS screenings, and other types of preventive care. Greater use of preventive care will catch health conditions earlier, improving health status while reducing health care costs. A copayment of as low as $5-$10 can serve as a deterrent to seeking preventive care for lower-income people.24

The ACA also holds the potential to improve population health by disallowing insurance risk rating based on health status, and by allowing plans to adjust premiums for tobacco use, charging smokers premiums up to 1.5 times as high as premiums for non-smokers.

Other new programs established by the ACA include Community Transformation Grants that support community health and aim to reduce chronic disease risk factors. Grants include a program in Broward County, FL under which 700,000 residents in the county, or nearly four out of ten people, have an opportunity to increase their level of physical activity through initiatives that facilitate more walking and riding of bikes. In the Clover Park School District of Washington State, 11,000 students and all 1,500 staff have access to healthier food and beverage options in school vending machines that follow USDA guidelines.25

ACA also features the addition of an annual, free wellness visit and personalized prevention plan for people in Medicare; a requirement that restaurants with 20 or more locations post calorie information on their menus; and a new grant program that explores ways to encourage Medicaid enrollees to participate in programs that prevent chronic disease.

ACA also set up an $11 billion new investment in community health centers through establishment of the Community Health Centers Fund.

These components of ACA provide funding and reform strategies for local communities as they redesign their interventions to improve the health of the population.

**Initiatives by Payers Can Make Positive Contributions**

This section describes initiatives taken by insurers, employers, and the federal government that address integrating public health into the health care delivery system. US experience has shown that obtaining the direct participation in health reform of the major players in the health care system, in both the industry and in the purchasing community, can increase the odds of success in improving health outcomes and slowing the growth of spending. This includes the business community (e.g. large, self-insured employers and groups representing small firms) and representatives from the labor community. It also includes both commercial insurers and health plans sponsored by safety net provider systems.

Employers and health plans can benefit from investing in prevention and public health and are becoming increasingly engaged in providing public and population health programs. According to the Kaiser Family Foundation/Health Research and Educational Trust (HRET) 2013 Employer

---


http://www.researchgate.net/publication/20570401_The_effect_of_office_visit_copayments_on_utilization_in_a_health_maintenance_organization

Health Benefits Survey, employer-sponsored insurance covers about 149 million non-elderly people in the United States. The average yearly premium for a family coverage is about $16,000, and employers pay three-quarters of this amount. Not only do employers bear a large amount of health insurance costs, but poor health status decreases overall productivity by an estimated 5 to 10 percent. Thus, employers have a significant financial interest in promoting the health and wellness of their employees.

Worksite wellness programs have become popular among employers. A meta-analysis of the literature on costs and savings associated with worksite wellness programs found a decrease in health care costs of approximately $3.27 for every dollar spent, and a decrease in the cost associated with absenteeism of $2.73 for each dollar spent. In 2013, the US Department of Labor commissioned a study to assess workplace wellness programs and concluded that approximately half of U.S. employers offer wellness promotion initiatives. Interventions aimed at prevention by targeting employees with behavioral risk factors for chronic disease (lifestyle management) and at further prevention by improving disease control in employees with chronic conditions were most common. While there is evidence of a positive impact of employer-sponsored wellness programs, the impact is generally small (e.g. a weight reduction of only one pound, on average among participants in such programs). According to a 2013 study conducted by RAND for the US Department of Labor, fewer than one-half of employees (46%) get screenings or complete a health risk assessment (HRA) under employer wellness programs, and only a fifth or less of those indicated as needing help via the screenings and HRAs actually engage in fitness, smoking cessation, disease management, or weight loss programs.

Some employers are offering public transportation programs that increase activity levels rather than sitting in a car to commute to an employer site, offering healthier food options at the workplace, and developing physical activity and health education programs on site for employees.

It is important for local and state health departments to plug into the thinking and the programs sponsored by the employer and labor communities, academic health centers, community health centers, and the leading insurers. These are the organizations that are driving change in the health care system, and both local health departments and state health departments can add an important new dimension to their work that may otherwise be overlooked, particularly addressing the underlying drivers of poor health and high health spending that emerge from forces outside the health care system.

**Work Force Development: Addressing a Major Constraint**

The US does not have a health care work force that matches and meets the needs of an aging population with a high incidence of chronic disease, and a clear linkage of health problems with behavioral health, social, and economic problems. There is a surfeit of specialist physicians whose

---

27 www.prevent.org/downloadStart.aspx?id=18
28 Baicker K, Cutler D, Song Z, Health Aff February 2010 vol. 29 no. 2 304-311.
skills and training are excellent and critical, but in abundant and sometimes redundant supply. There are shortages of primary care physicians, nurse practitioners, physicians’ assistants, and nurses. In addition, the health care community frequently falls short in linking critically important professionals such as nutritionists, social workers, psychologists, pharmacists, and other key players who can help meet the complex medical and social needs of people who are high-cost users of the health care system. Community health workers can complement the work of all of these health and social service workers.

Increasing the use of community health workers (CHWs) —community members with public health-oriented training focused on helping others improve and maintain their health—shows promise for improving population health. There are a number of successful models in the U.S. and internationally for deploying CHWs, including as extensions of hospital or clinic systems, as employees of community-based organizations, or in organizations that are dedicated to CHWs, that integrate their role with both the health system and community organizations.31

City Health Works in New York provides a good example. This is a network of CHWs whose responsibilities include early risk detection, self-management support in community settings, and primary care coordination.32 There could also be substantial overlap between Navigators trained to assist people with coverage options under the ACA and CHWs, creating an opportunity to address prevention and drivers of health when people gain insurance coverage and access to care. Sustainable financial support, variation in CHW roles, and formal recognition among states are continuing challenges that a public health approach to delivery system reform could help address.

The ACA created a number of opportunities to expand the use of CHWs, but funding for some of these programs is uncertain. State-based and local delivery system reform efforts can consider opportunities to include CHWs, and explore other ways to involve staff of community-based organizations to help address public health priorities. CHWs can bridge the gap between health care services and public health by providing education, motivation, and outreach.

Success in meeting the needs of vulnerable populations would be enhanced by relaxing rigid scope-of-practice laws that restrict the ability of various mid-level providers to practice up to the limits of their licenses. This includes dental therapists, nurse practitioners, and other professionals who can help meet the need for more preventive services.

---

32 Ibid.
CONCLUSION

The US has embarked on a fundamental transformation of our health care system, and faces a deep chasm between the worlds of public health improvement and the delivery and financing of health care. There is ample evidence of excessive spending in our health care system—with one estimate of wasteful spending amounting to $750 billion a year—with little accountability for cost and quality outcomes. Many of the forces driving people into the health care system emerge from factors largely outside of that system, including health behaviors, poor nutrition, poverty, homelessness, and long-term unemployment.

As community leaders strive for fundamental reforms inside this health care system, they would greatly benefit from the direct participation and leadership of local and state public health departments. Bringing the public health community into health system restructuring aimed at improved health outcomes and lower spending will create a more comprehensive and swifter transformation of the health care system, and greatly increase the odds of sustainable success.

---

33 Institute of Medicine. "Best care at lower cost: the path to continuously learning health care in America." September 6, 2012. The estimate of $750 billion in annual waste is comprised of: $210 billion in unnecessary services; $190 billion in excess administrative costs; $130 billion in inefficiently delivered services; $105 billion in prices that are too high; $75 billion in fraud; and $55 billion in missed prevention opportunities. http://www.nap.edu/download.php?record_id=13444.
Dawn Hamilton’s combined health care and legal expertise make her an invaluable asset to clients who are developing and implementing transformative strategies to meet health reform requirements and improve health care systems, outcomes, and status.

Adept at analyzing the impact public policy and law have on organizations, Dawn is skilled at conducting health care research and needs assessments. She understands the complex dynamics of the changing health care landscape and knows how to help clients successfully navigate the health reform era. From implementing integrated delivery systems and innovative models of care, to provider workforce issues and patient-centered and population-focused health care, Dawn is well-versed in the issues facing publicly financed health care and the organizations that operate in that realm.

Dawn came to HMA from the University of Maryland, School of Public Health where she managed several projects, including a comprehensive public health impact study that involved multiple government, public health, private sector, and community stakeholders. She also developed innovative methodologies to conduct community health needs assessments for two Maryland hospitals, something now required of all non-profit hospitals under the Affordable Care Act.

Previously, Dawn worked as a consultant for several years at Hamilton Dynamics, Inc., a company she founded. She focused on health care management, strategic planning, and risk management. Dawn also has experience working as a health care attorney for a large California law firm, where she represented regional and state health care systems, providers, and health care plans.

Dawn received her JD from the University of San Diego, School of Law and a bachelor’s degree from Columbia University. Dawn also received a Master of Science in Health Administration from the University of Maryland.
Dr. Margaret Kirkegaard provides client consulting focusing on physician engagement in health care reform, medical education, community health and medical care integration, primary care development and transformation, population-based health care delivery and underserved and vulnerable populations. Dr. Kirkegaard has particular expertise in the implementation of the patient-centered medical home model. For over six years, she served as the Medical Director of a state-wide, start-up primary care case management program for 1.8 million Medicaid clients. She was responsible for network development, physician recruitment and practice transformation to the medical home model for 5700 primary care providers and 2300 specialist providers. During her tenure, the program developed multiple clinical quality management tools and a pay-for-performance program and achieved provider approval and client satisfaction ratings over 90%.

Prior to her work in Medicaid, Dr. Kirkegaard held several academic positions teaching in both graduate and undergraduate medical education institutions. In 2005, she was selected from among nominees from all American medical schools for the National Golden Apple Teaching Award sponsored by the American Medical Student Association.

Dr. Kirkegaard is a board certified family physician. She received her M.D. from the University of Minnesota and completed her Family Medicine residency at Hinsdale Family Practice Residency. She holds a Masters of Public Health with a concentration in Health Policy and focus on Quality Improvement.

As a third-generation family physician with over twenty years clinical experience, Dr. Kirkegaard continues to teach medical students and residents and provide clinical care to patients at the Hinsdale Family Medicine Residency. As an advocate for underserved and vulnerable patients, she has also been a long-term volunteer at local free clinics serving uninsured patients.
Jack A. Meyer, PhD, is a Managing Principal with Health Management Associates (HMA) in HMA’s Washington, DC office. In this capacity, Dr. Meyer is conducting health care research, policy analysis, and strategic planning for grant-making foundations, health industry leaders, and state and federal agencies. From 2006 to 2013, he was also a Professor in the School of Public Policy and the School of Public Health at the University of Maryland.

General areas of recent and current work include:

- Analysis and strategic planning on ACA implementation
- Research to determine the complex medical needs of lower-income populations and the design of care management programs to meet these needs
- Analysis of the ingredients of hospital quality and patient safety
- Review of promising models of health care delivery system reform at the local level


Prior to joining HMA in 2006, Dr. Meyer was the founder and President of the Economic and Social Research Institute, a non-profit organization conducting research and policy analysis for grant-making foundations. He began his career in the federal government and has spent sabbaticals working at the Organization for Economic Cooperation and Development (OECD) in Paris, France and the UCLA School of Public Health.
Mona Shah has an extensive background in a wide range of health policy issues including the Affordable Care Act, Medicaid, Medicare, public health, and women's health. She has in-depth government relations experience and has unique insight into how health policy is developed and implemented at the national level.

Prior to joining HMA, Mona served as staff director for the U.S. Senate Subcommittee on Children and Families on the Committee on Health, Education, Labor, and Pensions. As part of this role, she was also Senior Health Policy Advisor to Sen. Barbara Mikulski.

Mona drafted several sections of the Affordable Care Act, including sections on quality, improving patient safety, women's health, health care workforce, and delivery systems. She was the staff author of the women's preventive health amendment which guarantees women access to preventive care with no copays and no deductibles.

Mona also spent considerable time working on legislation and appropriations issues related to pharmaceuticals and medical devices, cancer, wellness, HIV/AIDS, bioethics, and preventive health. Her committee had jurisdiction over all bills that fell under the Food and Drug Administration (FDA), Centers for Disease Control (CDC), National Institutes of Health (NIH), Health Resources and Services Administration (HRSA), and Agency for Healthcare Research and Quality (AHRQ).

In addition to developing, negotiating, and analyzing health policy, Mona organized congressional hearings, engaged with stakeholders and advocacy groups, built coalitions, developed communications strategies, and has spoken at numerous public events and roundtables.

Prior to her work in the Senate, Mona served as a law clerk in the HHS Office of the General Counsel, Public Health Division, and has represented AIDS patients as a student attorney. She was also the recipient of an Albert Schweitzer Fellowship, where she made site visits to Medicaid patients in Baltimore City to ensure their access to health care.

Mona earned her JD with a Certificate of Concentration in Health Law from the University of Maryland School of Law. She received both her Masters of Public Health in Health Policy and Management and Bachelor of Science in Human Biology and Anthropology from Emory University. She is admitted to practice law in California and Maryland.
Patricia R. Terrell is a managing principal with Health Management Associates, where she directs a practice concentrating on the restructuring of health care systems and the establishment of multiple provider integrated delivery systems focused on the care of under-served populations. She is also the Executive Director of HMA’s Accountable Care Institute. Since joining HMA in 2003, Ms. Terrell has led multi-disciplinary teams to work with public and private health care systems, provider consortia, foundations, and state and local governments to address the clinical, structural, financial, and governance issues related to the development of more effective and integrated delivery systems. During her time with HMA, this work has been done in San Francisco, Los Angeles, New Orleans, Chicago, Phoenix, Dallas, Portland and other communities.

Previously, Ms. Terrell spent twelve years as the deputy chief of the Cook County Bureau of Health Services in Chicago, one of the largest public hospital systems in the country that includes one major tertiary and teaching hospital, a community hospital, a long-term care and rehabilitation facility, a network of thirty primary and specialty care outpatient centers, the county’s public health department, a correctional health center, and an innovative public/private model outpatient treatment and research center devoted to infectious diseases. Ms. Terrell was also the president of a health policy consulting group, concentrating primarily on Medicaid expansion and reconfiguration of public and private safety net institutions, including hospitals, community health centers, and public health services, and was a founding member and first executive director of the Chicago-based Health and Medicine Policy Research Group and managing editor of its national journal.
Lori Weiselberg provides consulting in the areas of health system development and public health initiatives. Her primary interests include prevention of chronic disease, optimizing chronic disease management, quality improvement in primary care, and the design and implementation of coordinated, integrated delivery systems with the patient-centered medical home as a central component.

Lori is currently supporting health systems in the transition of primary care practices to patient-centered medical home models of care which focuses both on planned patient visits and population health management.

Prior to joining HMA, Lori conducted research and directed learning collaboratives to improve the quality of chronic disease care for a large public hospital system in Chicago. She also directed a federally-funded area health education center (AHEC), improving access and quality of primary care in New York City (NYC). As an independent consultant, she collaborated with the NYC Department of Health on the design of a childhood asthma initiative. She also promoted a comprehensive school health program for the Wisconsin Department of Public Instruction.

Lori holds a master’s degree in public health from the University of Michigan and a bachelor’s degree from Cornell University.
Health Management Associates (HMA) has amassed a wealth of on-the-ground experience that is important to share more widely as the nation undergoes the dramatic changes anticipated over the next several years. To that end, it is forming the Accountable Care Institute (ACI). The ACI will:

- provide a venue in which to share experiences and best practices from across the country related to the development of community-specific integrated delivery systems, new financial strategies to incentivize value, and innovative partnerships between providers and payers to ensure effective care for the unique populations they are both trying to serve;
- develop and offer resources to others to help spread lessons learned in the development of these new approaches to the delivery of accountable care;
- facilitate the training of new leaders in health system change; and
- translate delivery system lessons learned on the ground into policy and policy into change at the delivery system level, whether financial, legal, clinical or organizational.

Over the past decade, HMA has been assembling a growing practice of senior health care clinicians and administrators, finance experts, behavioral health professionals, managed care leaders, long term care innovators and others committed to developing new approaches to delivering health care services, particularly to populations and communities that have traditionally been under-served. HMA has worked for large health systems, consortia of providers, individual hospitals and ambulatory providers, states and counties, foundations and managed care plans to assess current delivery of care, plan new approaches and assist in implementation. This work has been growing in volume as the country has started to seriously grapple with how to assure access and quality—and the improvement of health status—while rolling back the cost trajectory which is universally agreed to be unsustainable. Expertise in integrated and accountable care as it applies to the delivery of care to those funded by public dollars is in demand; it is anticipated that the ACI will provide a vehicle for meeting that demand.