

Northwest Public Health

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States of Reform: Public Health and Health Care Transformation in the Northwest

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WHAT DOES THE ACA MEAN FOR OUR REGION?



IN THE YEAR SINCE the last issue of *Northwest Public Health* appeared, the US health care system marked a historic transition: implementation of the Affordable Care Act (ACA). This issue is devoted to that transition and what it means.

Our state did well. By the end of the enrollment period on March 31, Washington Healthplanfinder reported that 146,497 state residents had signed up for private health insurance through the state's health insurance exchange, 268,367 newly eligible people had enrolled in Medicaid, and 135,485 people previously eligible for Medicaid but not enrolled had signed up. An additional 408,086 people had re-enrolled in Medicaid. This totals over 950,000 enrollees, of whom over 550,000—8 percent of the state's population—were newly insured. We should celebrate this achievement.

The ACA centers on health care delivery, but it is highly relevant to public health as well. It encourages the integration of public health with clinical care—an opportunity recognized and seized by many public health leaders (such as Washington's Secretary of Health, Dr. John Wiesman). Federal funds have been allocated to prevention. Hospitals are required to provide community benefit, which often entails working “upstream” from the point of care. Insurance plans are required to cover preventive services. Again, we should celebrate these and similar provisions.

I am proud that the UW School of Public Health has fully engaged these opportunities, through our teaching, research, and service. You can read about some of these efforts in this issue. In brief:

- Professor Doug Conrad is leading a team, including students Jeremy Snider, Megan Shepherd-Banigan and Ian Randall, in collaboration with Public Health - Seattle & King County, that is monitoring the impact of the ACA on the health of King County.
- Professor Anirban Basu is leading UW-SHARE, a mail survey of 40,000 randomly selected Washington State households that aims to understand how the ACA affects Washington residents.
- Aaron Katz, Patricia Lichiello, and John Hall are conducting a qualitative state-level field network study of ACA implementation.

UW students have also played an important role in ACA implementation. Associate Dean Mark Oberle led an effort, across the Health Science schools, to facilitate this student activity. Read “The Invincibles” on page 22 of this issue for more about how UW students have contributed to ACA implementation in our state.

Finally, UW SPH faculty have served in various capacities related to ACA and health reform: Doug Conrad on the Washington Health Benefits Exchange, Jack Thompson and Tao Sheng Kwan-Gett on the state Public Health - Health Care Delivery System Partnership workgroup, Mark Oberle on King County's Health Reform Leadership Circle Executive Committee.

And as this issue of *Northwest Public Health* went to press, Ron Sims, former King County Executive and Chair of the UW SPH Dean's Council, was named chair of the Health Benefits Exchange Board by Governor Inslee.

We will be drawing lessons from the first year of the ACA for years to come. For now, several conclusions suggest themselves:

- Bold, transformative public policy is possible, even in an era of political paralysis. And this policy can improve life for millions of people. Courage and perseverance are essential.
- While thoroughgoing reform, such as a single-payer system, might secure universal, affordable, high quality health care, partial reform that is politically more feasible can still yield important benefits. Compromise is sometimes necessary.
- In our nation, faith in collective solutions—in government—is fragile, and can be badly shaken by poor performance, such as the botched rollout of Healthcare.gov. Government must deliver services efficiently and well.

I hope you enjoy the fascinating mix of articles in this issue, and I hope they provide useful information as you work to advance the health of the public.

A handwritten signature in dark ink, appearing to read "Howard Frumkin".

**Howard Frumkin, Dean
UW School of Public Health**

PUBLIC HEALTH PROVISIONS OF THE ACA



States are given flexibility to create innovative health care payment systems that incentivize disease prevention and community-based interventions.



Through the Prevention and Public Health Fund, federal agencies award grants to states to develop transformative strategies for public health.



Community Transformation Grants awarded by the Centers for Disease Control and Prevention support disease prevention efforts by community-based and nonprofit organizations.



Nonprofit hospitals are required to conduct community health needs assessments every three years to maintain their tax exempt status.



Federally Qualified Health Centers will receive \$11 billion in new funding to enhance and expand care for underserved populations.



Private insurance, Medicare, and Medicaid are required to cover preventive services such as annual checkups and personalized prevention plans.



States are given funding for community-based interventions such as community health workers, home visiting programs, and school-based health centers.

AS PUBLIC health transforms itself, so does *Northwest*

Public Health. Just as the Affordable Care Act calls for public health to create new collaborations, *Northwest Public Health* is reaching out to new audiences.

After more than 10 years as a peer-reviewed journal for public health practitioners, we are becoming a magazine. You will still find the same regional perspective and the same dedication to the art and science of public health practice. But you'll also find some exciting additions that we've made in response to last year's readership survey. Our new "Regional Round-Up" features developments from state, local, and tribal public health. The "Making a Difference" section gives a sampling of the cutting-edge work done by the diverse disciplines at the University of Washington School of Public Health, including biostatistics, environmental health, epidemiology, global health, and health services. Opinion pieces and profiles share the passions and stories of personalities in public health. Infographics present public health data in a lively visual format. Feature articles invite you in with quotes, stories, and conversational prose. We hope you find this new format compelling, whether you are a public health veteran, or simply someone who shares our commitment to improving the health of communities.

We would like to keep improving what we do. Please let us know what you liked, what you didn't like, and what you'd like to see in future issues. E-mail us at nph@u.washington.edu, or fill out our reader survey at www.nwpublichealth.org/survey.

**Tao Sheng Kwan-Gett, Editor-in-Chief
Northwest Public Health**



First Steps and Second Chances

by Loreen Nichols

Multnomah County Health Department administers two programs that demonstrate how innovative health care delivery models can be applied to urgent public health problems.

HAVEN WHELOCK was co-ordinating a syringe exchange in Portland, Oregon, when a terrified participant ran into her office.

Someone had overdosed on heroin. Wheelock grabbed her naloxone kit and ran three blocks to where a man was blue and unresponsive in the February chill. She performed rescue breathing and injected naloxone into the man's shoulder. By the time the ambulance arrived, the man was alert and asking, "What happened?"

Opiate overdose is a major public health problem in Oregon. Between 2000 and 2011, prescription opiate overdose deaths increased more than 400 percent, while heroin overdose deaths increased 42 percent. Since 2009, the Multnomah County Health Department has led efforts to reduce overdose deaths through surveillance, harm reduction, and policy advocacy. Currently, we are providing funding and technical assistance to organizations like Outside In, the nonprofit where Wheelock works.

"Overdoses are terrifying," Wheelock



ABOVE: Haven Wheelock, Coordinator of Syringe Exchange at Outside In, demonstrates how to prepare a dose of naloxone.

says. "People don't want to die, and they don't want their friends to die. With naloxone, I know I'm doing everything I can to help."

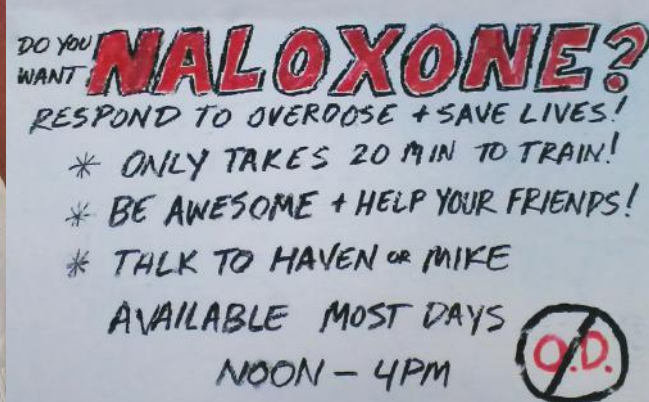
Naloxone is a safe, widely used medication that can reverse an opiate overdose. Historically, Oregon law allowed only physicians and emergency medical personnel to administer naloxone. The new legislation allows public health departments and community organizations to distribute naloxone to lay people and train them to use it in opiate overdose situations. Since July 2013, more than 600 people have been trained to administer naloxone. This training has resulted in the reversal of approximately 200 overdoses.

Compared to the year before the

naloxone legislation was passed, there has been a 44 percent decrease in heroin deaths.

Multnomah County plans to distribute more naloxone through our own needle exchange sites and increase capacity for naloxone distribution at homeless shelters, substance abuse treatment centers, and correctional facilities.

We will also be working with community partners to identify culturally specific ways to engage communities of color in overdose prevention and align this work with efforts to address substance abuse and addictions treatment in communities of color.



LEFT: The Healthy Birth Initiative team at a staff meeting. **CENTER:** Shantae Johnson, HBI participant and former Community Action Network Chair, with her son Sekou Shavers. **RIGHT:** Outside In offers training to administer naloxone.

More people are getting a second chance through these life-saving efforts. As health system transformation expands access to mental health and addictions services, we are hopeful that more pathways for opiate treatment will open up for those seeking help.

Community partner Wheelock said those conversations have already begun.

“Since we started the naloxone program, more clients are talking to me about their habits, treatment options, and HIV prevention,” Wheelock said. “It’s opened doors that I didn’t expect.”

PARTNERING TO PROMOTE HEALTHY BIRTH

African American women in Multnomah County are more than twice as likely to deliver a baby with low birth weight, and almost twice as likely to have their babies die in the first year of life, than non-Hispanic white women. The Healthy Birth Initiative Program is changing these alarming statistics.

The program works to improve birth outcomes and the health of mothers and fathers in the African American community. It is a partnership between our health department, program participants, health and social service providers, and the community. The program uses a family-centered approach that engages mothers, fathers, and other caretakers in supporting a child’s development. The Healthy Birth Initiative is directed by a client-governed Community Action Network of medical and social service providers and community members.

The program is seeing success. Participants have demonstrated lower rates of infant mortality and low birth weight and higher rates of early prenatal

“It is great to be around other African American women my age. The whole group helps me cope. When I get depressed, or stress out, I know all the girls’ numbers and can call them, or I can use things they taught me to do at home.”

– Shaqulia Roach, mother and Healthy Birth Initiative participant

care compared to those not enrolled in the program.

Shaqulia Roach attests that the program has made a big difference in her life. After her firstborn son died during an asthma attack at age 17 months, the Portland mother found support and education through the program. She attended Healthy Birth Initiative classes about asthma that prepared her to manage the health of her three surviving sons.

“I didn’t know anything about asthma, other than about inhalers. But now I know all the triggers,” she said. When she was pregnant, program staff helped her reach doctor’s appointments. She also attended classes on nutrition, domestic violence—“anything they offered.”

“It is great to be around other African American women my age. The whole group helps me cope,” Roach said. “When I get depressed or stressed out, I know all the girls’ numbers and can call them.”

This innovative care model brings a high degree of trust and community connection to the health system transformation table. “We are excited about linking the experiences of our clients to the design of new policies and practices in the larger health care system,” says Rachael Banks, Program Director for the Healthy Birth Initiative.

The Healthy Birth Initiative currently has an agreement with Health Share of Oregon—an Accountable Care Organization that includes all the major health care systems and three public health departments in the Portland area—to collaborate on improving services. The agreement includes cultural competence training and enrollment data-sharing to reach out to pregnant women earlier and get them into appropriate care.

AN ASSET IN HEALTH SYSTEM TRANSFORMATION

As we move more deeply into the uncharted terrain of health system transformation, local public health departments can be valuable assets. At Multnomah County Health Department, we have acted as leader, convener, and coordinator on a number of long-standing and emerging public health issues. We do this in partnership with the communities we serve. As one of the moms from the Healthy Birth Initiative Program said, “This program develops leadership skills and supports us to network. This is unique. When I started in this program I was afraid to talk in front of people. Now I’m running for Community Action Network Chair because I think it will help me continue to grow.”

Loreen Nichols is Director of Community Health Services at Multnomah County Health Department in Portland, Oregon. ■

Hospitals COME TOGETHER for Community Health

by Candace Tkachuck

Under the Affordable Care Act (ACA), nonprofit, tax-exempt hospitals are required to conduct a community health needs assessment (CHNA) at least once every three years. They must also show they are providing a community benefit. In King County, Washington, CHNAs have led to increased collaboration between hospitals and public health.

THE ACA STIMULATES HOSPITALS TO become involved with community health in new ways. A significant mechanism for this involvement is the community health needs assessment (CHNA) process outlined in section 9007 of the law. Hospitals must conduct these assessments every three years and then demonstrate a strategic response to the needs the assessments identify.

As organizations conduct these assessments, the ACA specifies that hospital staff must consult with individuals who can speak to the “broad interests of the community served by the hospital facility.” The law then goes on to identify those “with special knowledge of or expertise in public health” as suitable partners in the CHNA process.

In Washington State, this has spurred hospitals throughout the state to reach out to local health jurisdictions with collaborations in place in Pierce, Snohomish, and Spokane counties. In King County, hospitals and Public Health - Seattle & King County have formed a collaborative for the CHNA process: King County Hospitals for a Healthier Community. All nonprofit hospitals in King County are part of the collaborative. “Community health needs assessment regulations in the ACA are really clear about collaboration with public health. It’s a lot more robust than just having the health department provide data,” said Anna Markee, Health Reform Project Manager at Public Health - Seattle & King County.



ABOVE: The SCCA Mammogram Van. **RIGHT TOP:** SCCA Health Educator Beth Olenchek at a Latino Health Fair playing nutrition bingo with kids. **RIGHT BELOW:** A Virginia Mason resident with patient at the Eastgate public health clinic.



In fact, the collaborative has the potential to improve health on a population level—to make King County healthier. Over time, as the hospitals in the collaborative work on shared goals and track health outcomes, it will be possible to know what differences are being made and how. This result—for a county to know definitively if the health of its citizens is improving—is a compelling destination.

In many contexts, hospital systems are highly competitive with each other. The chance for these same hospitals to be partners is welcomed by those involved in the CHNA process.

“I remember the first meeting the Washington State Hospital Association organized in 2012 to begin to bring people together about CHNAs. There was real energy in the room,” said Ingrid Ougland Sellie, Community Benefit Manager at Virginia Mason. “The community health assessment is not a competitive space. For us at Virginia Mason, it is rewarding to work with others to focus on where our community needs our help.”

It’s not that hospitals are just now wading into activities that benefit the community. In the past, many hospitals provided non-clinical services designed to help communities. Some hospitals may have even assessed these efforts to see what effect they were having. What is different now is that the CHNA process provides an opportunity for a hospital to collaborate with others in public health and health care so that efforts can be systematic and strategic.

“CHNAs are a different way of approaching what hospitals have typically done. The process may result in new programs, but hospitals will also use the data they have from the CHNA

process to rethink the programs they already have,” said Markee.

All the hospitals in the collaborative have completed their first ACA-mandated CHNAs and implementation plans. Although it is possible that this process identified unknown needs in some locations, it is more likely that the assessment validated what hospital staff already knew about their community. “All of the health needs that were identified in our CHNA, we weren’t surprised with,” said Jamilia Sherls, Community Outreach Liaison, MultiCare Health System. “But our implementation plan prompts us to come up with new approaches for addressing these community health issues.” As a result of the CHNA process, Sherls and her colleagues at MultiCare Auburn Medical Center are in the midst of a three-year focus to reduce chronic disease, obesity, tobacco use, depression, and anxiety rates in the Auburn, Washington, area.

Some needs may be identified in the CHNA process that are impractical for hospitals to address, either due to resources or scope. In these cases, it is up to the hospital leadership to decide what they want to take on. “We looked at how we could respond to community needs and considered how these could be addressed based on our current resources and where we believed we could be most impactful,” said Linda Gainer of the Seattle Cancer Care Alliance. “We found that our four focus areas (tobacco cessation, outreach to Hispanic/Latino community, breast cancer screening, colon cancer screening) are also in alignment with our strategic goals.”

“Some of this has been a bit of a judgment call,” said Joe Larson,



Community Health Assessment Coordinator at Snoqualmie Valley Hospital in Snoqualmie, Washington. “When you start going upstream with a health issue, you very quickly get beyond the traditional scope of clinical work. My sense of the ACA is that we are asked to paint a picture of health in collaboration with the community and then demonstrate a coherent response.”

Ultimately, the CHNAs are meant for the public. (The law requires that these documents be made publically available.) As it has been a learning curve for the hospitals involved, so also for people in the community. “Right now the biggest response we are getting is, ‘What is this and why is it important?’ said Ougland Sellie. “It feels like our 2013 CHNA was a good launching pad to educate our patients about population health.”

The enhanced connections between hospitals and communities around population health are time intensive, but valuable. “Ninety percent of the work it takes to produce the health assessment and the implementation plan is civic engagement. This way we can genuinely strive together to come up with a collective impact,” said Larson. ■

PHOTO: Thomas Partman and Sam Byers enjoy a moment together in DESC housing.

Rx home

by Daniel Malone

Implementation of the Affordable Care Act (ACA) offers new opportunities to integrate health care, public health, and social services. Daniel Malone, Deputy Director of DESC (formerly Downtown Emergency Service Center), gives his prescription for an effective way to use these new opportunities: supportive housing.

PEOPLE CONCERNED WITH homelessness have eagerly anticipated implementation of the ACA for two reasons. One reason is that in states that are expanding Medicaid programs, nearly all uninsured homeless people will be eligible. But as important as increased coverage is, the part of the ACA that really gets ending-homelessness advocates excited is the opportunity to use health-reform processes and medical-system resources to fund what homeless people really need: a home. Not a “patient-centered medical home” or a “health home,” but a *home* home.

Using health care sector funds to pay for housing? That sounds like an overreach by human services advocates, doesn't it? But when housing is provided to high-needs people, housing becomes health care. Converting this knowledge into financial support for housing is not yet a reality, but policy makers and human services providers are engaged in exploration of creative ways to bring this about. Much of the conversation centers on how state Medicaid plans can be modified to make housing costs, or at least the costs of social services delivered to people in housing, eligible for Medicaid payments.

When people talk about reducing health costs, they talk about better access to care so people will use primary care services rather than crisis services. Or it's the use of community health workers to manage chronic conditions they have in mind. But what about people whose high use of expensive services may be caused or greatly exacerbated because they are homeless? In these cases, supportive housing can be a solution.

Supportive housing targets long-term homeless adults living with addictions, untreated mental illness, and other disabilities. In particular, a type of supportive housing known as Housing First is seeing good results. Rather than trying to manage the effects of illness and disability before housing is given, Housing First ensures the homeless person gets what matters most to him or her: a decent place to live. Of course, supportive housing programs offer behavioral health care and access to other medical services, but participation in these services is voluntary.

Housing First has been met with controversy. Critics would like to see housing used as a reward for better behavior and healthy choices. But what if stable housing is what enables a person to begin to improve his or her life?

The story of “Rhonda” shows how the model works. Rhonda lives in supportive housing operated by DESC in Seattle, Washington. Rhonda has a serious mental illness and co-occurring substance use disorder. After losing a clean and sober living environment a number of years ago, she began a life on the streets. She had a frequent pattern of presenting to hospital emergency departments several times a week, or even several times a day. Most times, she would arrive extremely intoxicated and complain of a variety of medical conditions, but when medical staff attempted to help, Rhonda would grow hostile and leave.

Rhonda was offered alternative living options but rejected all of them due to treatment participation requirements. She ultimately accepted a Housing First placement, thanks to its

“low demand” approach. Although her emergency room use continued for a time, with staff support she began to develop insight into what prompted her behaviors and agreed to see a psychiatrist. She uses strategies to seek informal help before calling 911, and this help is often enough to keep her from using emergency services.

Stories like Rhonda's are supported with a strong body of research on housing interventions:

Supportive housing can be used for people who may not engage in other interventions.

Supportive housing interventions are attractive to people with aversion to treatment. People will accept housing when they would have refused a place in a social service or treatment program. These people are able to retain housing at very high rates (more than 85 percent remain for at least a year), even if their symptoms remain active.

Supportive housing can dramatically reduce crisis services costs.

When homeless people are provided with housing, their use of crisis services drops steadily. In one DESC Housing First program, University of Washington researchers documented cost avoidance of approximately \$4 million in one year for a study population of 95 people.

Supportive housing improves health status.

Conventional wisdom holds that the way to get costs down among frequent emergency health care users is to shift services to primary care settings. But supportive housing can prevent injuries and health problems in the first place. Consider the story of “Clint” who often passed out on the street after consuming hand sanitizer, a product he could readily find at little or no cost. After passing out, Clint would be taken to the emergency department for treatment of cuts and bruises, as well as for the management of alcohol withdrawal symptoms. Once in housing, staff helped Clint develop a plan to avoid consuming non-beverage alcohol, and to have regular visits with social service and primary health providers. In a year's time, Clint visited the emergency room only once.

Supportive housing works for people with criminal backgrounds and reduces their continued involvement in the criminal justice system.

More than half of homeless people with behavioral health disabilities have criminal records (most commonly, but not always, for minor offenses such as trespass), and they are often excluded from community housing opportunities. Housing First programs remove these barriers. Studies show that post-housing involvement with the criminal justice system decreases substantially.

If a new medicine came on the market that achieved these results, there would be a clamor to make it available to people who are homeless. But we already have a way to treat homelessness and its effects on health: supportive housing. Let's use this treatment to lower costs and improve lives.

For more information on DESC or research on supportive housing, go to www.desc.org.

Daniel Malone is Deputy Director of DESC. ■



WRANGLING HEALTH DATA IN WYOMING

by Candace Tkachuck

A key goal of health care reform is to give health care providers incentives for delivering higher quality of care instead of higher volumes of care. Wyoming is exploring how integration of health care delivery data with public health data can help improve quality of care.

“ I WANT ALL DOCTORS IN Wyoming to internalize population health management,” says James Bush, Medical Officer for Wyoming Medicaid. “I see a future in which immunization rates go up, and chronic diseases are managed more proactively.”

To work toward this future, Bush works with Wendy Braund, State Health Officer at the Wyoming Department of Health. Together, Bush and Braund are pioneering new ways for the health care delivery system and public health to share data and improve population health in Wyoming.

Wyoming is the nation’s least populous state. Relatively few physicians serve its vast expanse. Many communities have only one or two physician groups, and specialists often work as primary care physicians. As a result, Wyoming physicians take a more community-based perspective than doctors in other more populated states. Because most Wyoming physicians are

Medicaid providers, Medicaid reforms designed to improve population health affect most physicians in the state.

National legislation paved the way for this collaboration. In 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act was passed. From this, Medicaid and Medicare providers are offered staged levels of financial incentives to “meaningfully use” electronic health records (EHRs) to record patient data and improve care. In Wyoming, Medicaid providers have access, at no cost, to an EHR system called the Total Health Record.

HITECH and provisions in the Affordable Care Act that encourage the collaboration of clinical care and public health have fostered development of health information exchanges (HIEs) that share electronic data among EHRs and other health data systems. Wyoming Medicaid’s HIE links Wyoming Department of Health data to Medicaid claims and immunization data in the Total Health Record.

The vision is for the Medicaid HIE to link with a future statewide HIE, as well as with a state-level registry of health care quality indicators. When this happens, every provider in Wyoming will be able to share patient care information and have access to a wealth of population health data.

THE PUBLIC HEALTH PERSPECTIVE

When Braund joined the Wyoming Department of Health in October 2011, the department’s public health functions had just been combined into a single division. Both the Public Health Division and Wyoming Medicaid are housed in the Wyoming Department of Health, so it was natural to look for synergies. Braund says, “Integrating clinical medicine and public health seemed like a great opportunity for the department.”

Bush says, “Historically, Medicaid had never been in the business of tracking or rewarding quality. We were never interested in population health, so

we've had to design our new focus from scratch and bring doctors along as well." He quickly adds, "I've been impressed with how receptive the physicians have been to including a population health focus to their clinical work."

Braund says, "It's important for everyone in the department to have an understanding of how public health relates to all of our programs and how we can be a resource to them. So we've been reaching out to explore opportunities for collaboration. We want the focus to be on health and not solely health care."

MATERNAL AND CHILD HEALTH

Maternal and child health is an area that lends itself well to integration. The state public health nursing office receives a monthly report from the Medicaid Management Information System that lists pregnant women enrolled in Medicaid. Information from this report is broken out by county and routed to local public health nursing offices. Public health nurses then can set up

health offices, the nurses can locate even those patients who have uncertain housing and are sleeping on someone's sofa."

Wyoming recently rolled out "Due Date Plus," a smartphone app for expecting mothers. The app (free to all Wyoming residents) includes links to public health nurses, obstetric and pediatric physician locators, and many other features.

OTHER POSSIBILITIES

Beyond maternal and child health, there are other ways that health care reform is connecting public health and clinical care.

The data available through the Wyoming Immunization Registry can be analyzed to show where in Wyoming immunization rates are low. This information can be given to Medicaid providers and public health nurses to focus vaccination efforts.

Wyoming's county health officers also are a critical link between public health and the clinical sector because most of them practice clinical medicine full-time.

The Public Health Division's Oral Health Unit employs Community Oral Health Coordinators (COHCs) who perform dental screening and provide oral health education in schools, senior centers, and other community settings. The COHCs also connect those in need of treatment to local providers.

LOOKING AHEAD

The vision that both Bush and Braund have is for a strong partnership between public health and clinical care in Wyoming. This partnership makes it possible for patients to get treated for the health issues they are concerned about and also to get good information from providers about prevention and community resources.

Bush says, "Where I see this going is that people will stop thinking 'my patients, my charts, and my records,' and instead say 'Let's mobilize all resources to provide the best care at the lowest cost.'" ■

#ACA Thoughts

We invited people across our region to share their thoughts, hopes, and observations about ACA implementation. Our commentators bring a diversity of perspectives, from frontline to leadership, from health care to policy.



DAVID FLEMING
Director and Health Officer, Public Health – Seattle & King County

What's so important about the Affordable Care Act is that it's providing coverage to people we need to reach—low-income adults who often face poorer health, fueled by the social conditions that influence it. From a public health perspective, it's exciting to have this momentum and opportunity to make significant headway in improving these conditions in affected communities, and in turn improving people's health. We can do this by linking health and human services in a customer-centered framework that emphasizes prevention and addresses the larger community forces at work, such as education, employment and the built environment, in creating good health.



VICKI DUNDAS
Nursing Supervisor, Missoula City-County Health Department

I've been a registered nurse for 29 years, and I've seen the toll our health care "system" has taken on families and children. An uninsured family whose child has been diagnosed with cancer can easily emerge from the ordeal with over a million dollars in debt. And that's not counting the emotional and physical toll on everyone in the family. Families shouldn't need to have bake sales to cover the cost of their child's illness in America in 2014, nor should they be ruined financially the rest of their lives! I'm glad the ACA provides insurance to people who previously could not afford it or were ineligible. This will be a cost savings for the country in the long run.

"I've been impressed with how receptive the physicians have been to including a population health focus to their clinical work."

– James Bush, Medical Officer for Wyoming Medicaid

home visits with the newly pregnant mothers.

The information flow works the other way too. When public health nurses conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT), they can relay information from this screening back to the appropriate physician. At times, the clinician may seek additional information from a public health nurse. For example, if a baby is having failure to thrive, the doctor can consult the public health nurses who also work with the mom about what might be going on at home.

Bush says, "Public health nurses have a high level of awareness of their clients. When I've visited some local public

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THE UW SCHOOL OF PUBLIC HEALTH: MAKING A DIFFERENCE



SHOTS FOR SERVERS

Last fall, researchers from the **Health Promotion Research Center** conducted a pilot study aimed at increasing flu immunization among restaurant workers. The intervention, which focused on lowering barriers to flu immunization through increased access and targeted messaging, resulted in a 74 percent increase in immunization rate among workers at 11 Seattle-area restaurants. The pilot was part of a series of studies known as the **Workplace Immunization Project**. "Our team feels terrific about these results," says HPRC research scientist **Kristen Hammerback**. "Our next step will be putting together an easy-to-use toolkit so that restaurants can do their own flu-shot program in the future." Led by center director **Jeff Harris**, the research team also included **Peggy Hannon, Meredith Cook, Amanda Parrish, and Claire Allen**.

PHOTO: BRIAN HOSKINS



FROM CANCER GENE TO SILVER SCREEN

Mary-Claire King, Adjunct Professor of Epidemiology, wowed the science world when she discovered BRCA1, the "breast cancer gene." Now actress Helen Hunt portrays King in *Decoding Annie Parker*, a movie chronicling King's 16-year quest that is slated to be released in the summer of 2014. In "A Seattle Geneticist Gets the Hollywood Treatment," *Seattle Magazine* calls King's findings "one of the most important discoveries of the 20th Century. Through King's work, genetic testing can now identify the 10 percent of women who are at an extremely high risk of inherited breast/ovarian cancer." King says she joined the UW's Department of Genomic Sciences in 1995 "to try to make discoveries and develop approaches based on those discoveries that can actually be used in the real world, right away, by all of us."

PHOTO: UW OFFICE OF NEWS AND INFORMATION

DID YOU KNOW?

Did you know that the School of Public Health has begun a visioning and planning process for a new building? As a global leader in research, teaching, and service, the School needs spaces and facilities that are innovative, flexible, and people-centered. This visioning and planning project is an exciting first step toward the creation of a building that will support new ways of teaching and facilitate synergy with other UW schools. More online at depts.washington.edu/sphbuild

PHOTO: UW ADMISSIONS FLICKR



LOWERING THE PRICE OF SAVING LIVES

Kathy Neuzil, Clinical Professor of Global Health and a program leader at Seattle-based PATH, partnered with a Chinese vaccine manufacturer to obtain World Health Organization (WHO) approval of a vaccine for Japanese encephalitis. It was the first time WHO has approved a vaccine from China for global use. Transmitted by infected mosquitoes, Japanese encephalitis is a deadly brain disease that claims the lives of about 15,000 children a year. Neuzil is director of the Vaccine Access and Delivery Program at PATH, which tested the vaccine and got it to 200 million children in Asia before its formal approval. "It really is a major milestone," Neuzil said in a KUOW interview. "The entry of China onto the global vaccine marketplace could fundamentally shift how vaccines are made, how they're delivered, and how they're priced for the developing world." **PHOTO: JULIE JACOBSON, PATH**

Stay up-to-date with the latest headlines and news from the UW School of Public Health at sph.washington.edu



ABOVE: Nicholas Salazar, illustrator of *The Return*.



LATINO OMICS

Biostatisticians at the UW School of Public Health are hoping to better understand the genetic risk factors for diseases such as diabetes and asthma in Hispanic/Latino populations in the United States. The School's new Omics in Latinos Genetic Analysis Center, recently established with a \$4.5 million grant from the National Heart, Lung, and Blood Institute, aims to develop new statistical methods to analyze genomic data from about 16,000 Latino participants. Using biostatistical methods, scientists can determine which genetic variants are associated with disease and how they affect the probability that someone would get the disease. "These kinds of studies have been going on for a long time, traditionally in European-ancestry people," said **Bruce Weir, Professor and Chair of the Department of Biostatistics**. "It's important to extend them to Latinos."

PHOTO: MAGGIE BARTLETT, NHGRI

SOMETIMES A STORY IS BEST

The **Center for Ecogenetics & Environmental Health** has worked with the Northwest Indian College to develop a 32-page comic book version of *The Return, a Native Environmental Health Story*. *The Return* is a dreamlike account of a Native woman and her baby. It's based on findings from the Native Tradition, Environment and Community Health project, which looked at differences in Native and Western understanding of environmental health. Three core themes emerged: community, wellness, and inter-relationship. *The Return* explores how these concepts are passed to the next generation.



HEALTH CARE ACCESS A CHALLENGE FOR CHILDREN WITH DISABILITIES IN ALASKA

Alaska Governor Sean Parnell's decision not to expand Medicaid in his FY 2015 budget proposal complicates health care access for families of children with disabilities. The Catalyst Center reports that more than a third of children and youth with special health care needs and their families experience underinsurance. The challenges of Alaska's climate, geography and workforce

shortages further complicate health care access. Says one parent with two adopted sons who experience disabilities along with anxiety and behavioral issues, "We had to seek care from private providers outside the Indian Health Services to access services. Related to the Affordable Care Act, it was hard to see how any of the plans would be considered affordable. If we didn't have TEFRA* our boys wouldn't receive the care they need, or we would go under financially."

** A Medicaid program designed to help the parents of children with disabilities.*

Contributor: Virginia Miller, Assistant Professor of Public Health at the University of Alaska Anchorage

STATE INNOVATION MODEL TESTING IN OREGON

In April 2013, Oregon was one of six states to receive a 42-month State Innovation Model testing award from the Center for Medicare and Medicaid Innovation. The total amount awarded to Oregon is \$45 million. The Public Health Division of the Oregon Health Authority (OHA) is using \$5 million of these funds to integrate population health with the state's health system transformation efforts.

This integration includes enhanced surveillance capacity through a Behavioral Risk Factor Surveillance System (BRFSS) survey of Medicaid members and a BRFSS race/ethnic oversample. OHA will also augment a public health database for community health assessments and administer a \$1.8 million grant program that supports four consortia that are implementing evidence-based population health programs. Each consortium is a joint effort of local public health authorities and Medicaid Coordinated Care Organizations.

Contributor: Cara Biddlecom, Health System Transformation Policy Lead, Public Health Division, Oregon Health Authority

TRIBES SUCCESSFULLY EXPAND INSURED POPULATION

A successful example of a tribal program using Medicaid expansion is in the Swinomish Tribal Community, in Skagit County, Washington. Within the first 90 days of implementing a Medicaid Eligibility Assistance program, the tribe reduced its uninsured population by 45 percent by enrolling newly Medicaid-eligible individuals. Similar results have been seen with the Quinault Tribe and Port Gamble S'Klallam Tribe, also in Washington State. These tribes have developed and implemented plans to use benefits coordinators to assist in enrolling and eligibility for Medicaid or the health insurance exchange.

Contributors: John Stephens, Programs Administrator for the Swinomish Indian Tribal Community; Amanda Gaston (Zuni Pueblo), Project Manager at the Northwest Portland Area Indian Health Board

ADVOCATES OF MEDICAID EXPANSION IN IDAHO CITE ECONOMIC BENEFITS

Idaho's legislature and governor elected not to expand Medicaid in their state. Now many Idaho public health and advocacy organizations are calling for a reversal of that decision. Idaho has the highest per capita rate of minimum wage jobs in the United States, and about 15 percent of Idaho's population lives below the federal poverty level. Under Medicaid expansion, the federal government would cover all

costs of the expansion until 2016, after which time the payments would be reduced gradually until 2022 when the State of Idaho would become responsible for a maximum of 10 percent of the costs. Advocates of Medicaid expansion argue that this cost shift to the Federal government would result in net savings for the Idaho taxpayers in the amount of \$400 million over the 10-year

period. Furthermore, they say the increased federal payments to local medical service providers could inject about \$8 billion into Idaho's economy.

Contributors: Padma Gadepally, graduate student in the Department of Community and Environmental Health at Boise State University; Uwe Reischl, Professor, Department of Community and Environmental Health at Boise State University; Stephen Weeg, Board Chair of the Idaho Health Insurance Exchange

WASHINGTON CREATES STATE HEALTH CARE INNOVATION PLAN

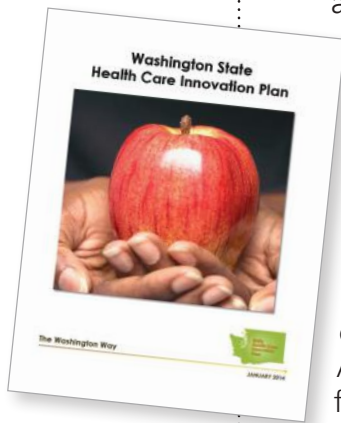
In 2012, Washington received a State Innovation Models Pre-Testing Award from the Center for Medicare and Medicaid Innovation. The grant funded extensive analysis and stakeholder engagement around the topics of universal access, improved quality, and greater efficiency in Washington's health care delivery and financing system.

The result? A State Health Care Innovation Plan, which calls for three main strategies:

1. With state government leading other purchasers, move away from fee-for-service to health outcomes payment and toward greater price and quality transparency.
2. Work at the state level and with communities to shape policies that bridge disparate systems (e.g., physical and mental health, public health, education, community development) and promote "upstream," health promoting actions; create "accountable communities of care" to focus regional capacity for this effort.
3. Integrate mental health, substance abuse, and primary care services to improve health outcomes for people with chronic, complex needs.

To be implemented, the Innovation Plan will require additional funding, but may bring estimated savings of \$730 million over a three-year period.

Contributor: Aaron Katz, Principal Lecturer, Department of Health Services, University of Washington School of Public Health



WYOMING SEEKS TO INSURE MORE CHILDREN

With ACA implementation, Wyoming Medicaid expected to see a large increase in children covered by health insurance. So far, that increase has not yet materialized. Projections had estimated that by 2016 the ACA would stimulate average enrollment to grow by 12 percent to 15 percent by adding 6,900 newly eligible children and approximately 1,800 children that were already eligible but not enrolled. But as of March 2014, there were 48,660 children enrolled in Medicaid or CHIP, slightly fewer than the 48,693 children enrolled at the same time last year. It is possible that Wyoming's improving economy may be diluting the impact of the ACA.

Contributor: James Bush, Medicaid Medical Health Officer, Wyoming Dept. of Health

MONTANA ACA DEBATE STIMULATES COMPETING INITIATIVES

Two ballot initiatives on the November 2014 ballot—I-170 and I-171—show divergence of thought about the ACA in Montana.

Initiative 170, the "Healthy Montana Initiative" favors Medicaid expansion. I-170 asserts that Medicaid expansion will create 12,000 jobs in Montana and will provide \$1.4 billion to the state

economy through federal funds. Expansion of Medicaid would provide health coverage to approximately 70,000 Montanans.

Initiative 171 is in opposition to Medicaid expansion and the ACA in general. It prohibits the state from "using funds, personnel, or other resources to administer or enforce the Affordable Care Act." This Initiative also includes language assuming that the federal government will halt all federal health funding based on noncompliance with the ACA and cites the total cost to the state at \$2.83 billion due to lost federal revenue.

Contributor: Kathryn Fox, adjunct faculty for the University of Montana's Master of Public Health program. Language of ballot initiatives: sos.mt.gov





workplace wellness

The Affordable Care Act's (ACA) Prevention and Public Health Fund has provided new opportunities for workplace wellness programs. By identifying workplace wellness programs as a national priority, the ACA promotes a cultural shift towards recognizing how social and structural interventions influence public health.

by Rebecca L. Levine

THE TACOMA-PIERCE COUNTY HEALTH Department has some tough challenges. Pierce County is the second-most populous in Washington State, but ranks an alarming 26th out of 39 counties in county health rankings. The county's rate of tobacco use and percentage of individuals classified as obese are higher than state and national averages.

Workplace wellness programs could be an important part of the solution, and in March 2014 the health department launched a new program for the health and well-being of its approximately 270 employees. Kirsten Frandsen, a project manager at the department, explains, "Prioritizing funding for internal uses is hard when we are losing services in the community, but worksite wellness, implemented correctly, saves costs in the long run."

Worksite wellness programs are designed to help employees reduce or prevent chronic disease. In the United States, full-time workers with chronic health conditions miss about 450 million more days of work each year than healthy workers, resulting in an estimated \$153 billion in lost productivity annually. Many companies, including Seattle-based Starbucks, have turned to workplace wellness programs. The coffee giant established its Thrive Wellness program in 2004, which includes weight loss and smoking cessation resources for its employees.

The Tacoma-Pierce County Health Department had its own wellness program in 2005, but it ended in 2008 due to a lack of funding. Linda Graves, a health promotion coordinator, remembers that when this program was active, participating employees enjoyed a strong sense of camaraderie

that motivated their ongoing engagement. So when the health department was able to begin a new wellness program in 2014, staff welcomed it.

The program's reincarnation was made possible by ACA funding allocated to the Centers for Disease Control and Prevention (CDC). In 2011, the CDC received \$9 million from the Prevention and Public Health Fund to create the National Healthy Worksite Program (NHWP). NHWP has three goals: (1) reduce chronic disease risk among employees and their families through science- and practice-based workplace prevention and wellness strategies; (2) promote sustainable and replicable workplace health activities such as developing a worksite health committee, senior leadership support, and community partnerships and health coalitions; and (3) promote peer-to-peer business mentoring.

The Tacoma-Pierce County Health Department is part of a select group that is participating in NHWP. Only 104 employers in eight counties across the country are part of this program, which targets organizations with 1,000 or fewer full-time employees that offer health insurance but lack a comprehensive wellness program. Counties selected for the program have high rates of chronic diseases and health risk behaviors. At the same time, all participating counties must have resources to support sustainable wellness programs. Fifteen Pierce County employers with a combined total of 1,386 employees are participating in NHWP.

Budgetary concerns limit the program's scope at Tacoma-Pierce County Health Department, but the program saves two percent in health insurance costs because it incorporates wellness program criteria from the department's insurer. The program also includes valuable "no cost" elements, such as



JESSICA ALVESTAD AND PAT DARDEN, employees at the Tacoma-Pierce County Health Department, use a walking meeting to incorporate physical activity into their workday.

promoting walking meetings, flexible hours to encourage participation in exercise programs, and use of an onsite fitness room. Additional services are available through the department's health insurer, such as nutrition counseling, biometric assessments, and behavioral health classes. "We welcome the chance to promote employee wellness within our organization and model healthy behaviors to the community," said Anthony L-T Chen, MD, MPH, Director of Health at Tacoma-Pierce County Health Department. "Over time, we have taken steps to implement a healthy food policy, an exercise room, and a tobacco-free policy; this worksite wellness grant is helping us to re-energize, reassess, and refocus our efforts," he said.

Over a period of 24 months, the department will work with a government contractor (Viridian Health Management) to develop a set of interventions that help employees reduce their risk of chronic disease. These interventions will include supports such as fitness classes, chronic disease self-management tools, or wellness newsletters. Leadership at the department will receive training, technical assistance, and mentoring so that it can effectively administer the program.

Evaluation is an important part of NHWP. For ten months after the two-year program ends, an employee survey will assess changes in knowledge, behavior, and health status. The survey will also ask about changes in productivity through decreased absenteeism. The

CDC intends to share information gathered through NHWP with participants and also with other employers and organizations across the country seeking to develop wellness programs.

Although continuing or expanding NHWP depends upon additional funding, positive results could encourage employers nationwide to develop interventions based upon emerging data. Partnerships formed through NHWP could create a nationwide network that supports employee health programs.

Though effective worksite wellness programs require investment up front, decreases in lost work days, workers' compensation premiums, and employee attrition may achieve net cost savings. Companies such as Johnson & Johnson, Citibank, Chevron, and Proctor & Gamble have reported positive returns on investment from workplace wellness programs.

Can a medium-size organization like Tacoma Pierce County Health Department realize similar benefits?

Graves is enthusiastic about the opportunities, stating, "Creating a culture of health is a win-win situation: employees are more satisfied when they have opportunities to be healthy, and employers gain a healthier workforce."

For additional information, go to www.cdc.gov and search "ACA workplace wellness."

Rebecca Levine is a Judicial Clerk at the Washington State Court of Appeals. ■



Doug Conrad is a professor in the Department of Health Services in the UW School of Public Health.

From November 2012 to January 2014, he served on the Board of the Washington Health Benefit Exchange.

close up with Doug Conrad

Remind us why the Affordable Care Act (ACA) is so important.

The root problem we're trying to address is that 15 percent of the US population does not have health insurance. In Washington State, that's roughly one million people. We do need to toss resources at health care reform. It's not something to be done by eliminating waste—or solely by tackling disintegrated or uncoordinated care. Those that say we can make these changes within existing resources are wrong about that.

What's the overall mission of the Washington Health Benefit Exchange?

Affordability of health insurance is absolutely a key goal. Equity is another key principle. When I was on the board, we looked at everything through the lens of whether the choices and recommendations made would reduce disparities in health insurance and disparities in health care.

What do you hope will ultimately be achieved with the ACA?

I'm hoping the ACA in Washington State will improve both the risk protection and the affordability in the individual and small group health insurance markets. And that's a challenge because we have to get the carriers to compete on price and on the quality of the benefits they offer and the services they provide. I think it will work, particularly over three or four years.

What is your assessment of how well the Washington Exchange did when stacked up against other state exchanges?

I think they've done quite well with respect to enrollment. Michael

Marchand, the Director of Marketing and Communications for the Exchange, used every technology possible to reach the "Young Invincibles" and those in the general population who are underinsured or uninsured.

The numbers after the March 31 deadline are good. In the early days of enrollment, there were issues with the call center and with bugs on the web portal. Those were disappointing, but the Exchange handled them honestly.

We need to remember that this is a massive undertaking that hasn't been done before. By 2019, we are aiming to have 34 million new people signed up for insurance in the United States.

In the years ahead, what do you think some of the primary challenges will be for the Exchange in Washington State?

In year one, the first year of implementation, the key emphasis was getting health insurance carriers to participate in large numbers along with plans that were reasonably protective against consumer financial risk and affordable. For year two, I think the challenge will be to see the plans being efficient and competitive. We need to get to a place where the total of the premium and out-of-pocket costs are not such a large share of family income.

When we set the exchange up, we were anticipating lower deductibles. It will be interesting to see if relatively high deductibles will keep people from signing up for health insurance and from getting necessary health care.

What the Exchange and the ACA are trying to do will require patience and compromise. If we can keep our eye on the ball and say what this is really about is improving access to good health care and access to improved health through population health and health

investment, then I think compromises can be negotiated.

What are your hopes for ACA implementation in our region with regard to population health?

My hopes would be that the ACA as implemented in Washington State would give people improved access to primary care and prevention services.

The research shows that having insurance really does help the health of vulnerable populations. To the extent that the ACA improves access for vulnerable populations, it will improve population health.

You've worked a lot with Public Health - Seattle & King County to develop methods to evaluate the impact of the ACA. In what areas would you like to see public health and health care delivery coming together to improve population health?

To the extent that the ACA sends resources to health care delivery, health care has a responsibility to work with public health, particularly on population health. Explicit collaboration is needed to figure out new ways to move the needle to improve health with immunizations, prenatal care, and the integration of behavioral health and physical health.

It will take time to build relationships between different parts of the system. They are different types of work. We need consciously to commit to working together.

I don't believe that the ACA will be repealed in the future. Instead, it will be improved, and I predict that the ACA will end up being a huge benefit for Americans. ■

Asesor de Seguro Médico

Connecting People to Health Care

as told by Jose Carmona

Health departments throughout the Northwest play an important role in implementing the Affordable Care Act. For example, since August 2013, Public Health - Seattle & King County has trained more than 600 "in-person assisters," people who guide individuals through the complex process of finding and enrolling in health insurance. Jose Carmona of Global to Local (www.globaltolocal.org) shares his experiences working as an in-person assister in south King County.

WORK FOR GLOBAL TO LOCAL.

Global to Local is an organization that uses community-driven and global health strategies to improve health and economic disparities for the local underserved community. Global to Local focuses on the SeaTac/Tukwila region. This is an area that is highly diverse, and we are using evidence-based practices to improve health outcomes in this area. A basic strategy that Global to Local uses is to hire people who share the language and cultural background of groups with lower rates of health care access. We currently run the Affordable Care Act Enrollment program for the SeaTac, Tukwila, and Des Moines communities.

This is where I come in. I am an in-person assister for the Washington Health Benefit Exchange, our state's new

insurance marketplace for health care reform. My job is to help Spanish-speaking individuals and families in south King County apply for health insurance on the Washington Healthplanfinder website, www.wahealthplanfinder.org. Most of my clients don't speak English. Many of them don't feel comfortable with computers. Some don't have an e-mail address of their own. Whatever the case, it's my job to help clients find out if they are eligible for health care coverage. If they are eligible, I help them sign up for it. I was trained to do this work by Public Health - Seattle & King County.

I work out of our SeaTac office at the Angel Lake Center. I also attend other open enrollment events that Global to Local holds with other organizations such as HealthPoint, Matt Griffin

YMCA, and Lutheran Community Services. Global to Local organizes events at various locations in the SeaTac/Tukwila region and community members are invited to come if they want

help signing up for health insurance under the new provisions of the ACA. Although my colleagues and I work in large, open spaces in these community centers, we try to be confidential as possible with the information that is given to us. We walk clients through a series of questions, some of which may be sensitive. For example, I am required to ask female applicants of childbearing age if they are pregnant. I also ask about immigration status. To me, the fact that clients stay and respond to these questions shows how much they want health coverage.

Sometimes, when we finish an application and send it in, it doesn't go through. It's better now, but in the fall of 2013, I would send people home without getting them signed up. During these early days, to maximize the help we were able to get from Healthplanfinder representatives, my fellow in-person assisters and I would pass the phone around once we got someone on the line. We knew that if we hung up, it would be a long time before we were able to connect with a representative again. As the enrollment events have gone by, the number of application errors has gone down.

It takes from 30 minutes to 2 hours to complete an application. Sometimes, clients have to come in two or three times to finish application because of their schedules or because they need to track down information. The applications that go the fastest are for clients who are United States citizens who are also unemployed and applying as individuals. The process becomes more challenging when there is more than one person applying for health insurance in a family or if clients are naturalized citizens or residents and have an income of some sort.

“It doesn't happen very often, but sometimes, I'll have clients who are forced to decide between signing up for coverage or paying rent. These are often immigrants who do not qualify for Medicaid because they haven't lived in the United States for five years or more.

— Jose Carmona

Language can be a huge barrier to getting the most from Healthplanfinder, so clients want me to explain as much as possible during their visit. Health insurance terms can seem strange to people who haven't had health insurance before. Although the Healthplanfinder website has all necessary forms in Spanish, the language used is quite technical. The clients who seek us out are often recent immigrants, with no prior experience with signing up for health insurance. So even when I talk to them in Spanish, I still find myself having to use jargon that they can find challenging. One of my approaches is to use real life scenarios on how premiums, deductibles, co-payments, etc., would affect their budget.

It doesn't happen very often, but sometimes, I'll have clients who are forced to decide between signing up for coverage or paying rent. These are often immigrants who do not qualify for Medicaid because they haven't lived in the United States for five years or more. These clients are sometimes eligible for tax subsidies. It is my understanding that policy changes are underway to allow recent immigrants to qualify for more subsidies.

I find my work satisfying, especially when clients leave an enrollment event knowing that they will be covered soon. For many of the people I see, this will be the first time in many years that they can start making plans to go see a health provider. I often hear my clients say something like, “This will be the first time I see a doctor in 10 years. I haven't been going because I haven't been able to afford it. But now I can.”

Jose Carmona is an undergraduate student in the UW School of Public Health ■

#ACA Thoughts



JIM ROBERTS
(Hopi), Health Policy Analyst, Northwest Portland Area Indian Health Board

The most important thing that tribal communities should understand about the ACA is that it provides an opportunity to get health coverage that will complement the services they receive from Indian Health Service (IHS). It will allow their health programs to generate resources by billing insurance carriers for such services and the revenue can be reinvested back into their health programs. This will provide more resources to provide health care to tribal members in their communities. If they don't participate, it will simply draw down IHS funds to provide health care, with no reimbursements, and there will be fewer health services available in their community.



WILL PITTZ
Executive Director
Washington CAN!

I am most concerned about affordability. Will low-income working people be able to afford premiums, cost sharing, and deductibles? How will this impact access and coverage for people who need health care? Despite the ACA, advocacy for health care reform remains as important as ever. Health care is still treated as a privilege and a commodity; until we recognize health care as a human right and minimize the profit motive in the system, we will always need to work for health care reform.

We welcome you to share your thoughts, hopes, and observations about ACA implementation on our website: www.nwpublichealth.org.

the invin



“Young Invincibles”—young adults who think they don’t need health insurance coverage—are often described as a barrier to ACA implementation. But students in the University of Washington (UW) School of Public Health are proof that their generation is also key to the success of the ACA in Washington.

by Carly Miller

“WE WERE OVERWHELMED THE FIRST day,” says Eric Ofori, recounting his volunteering with the south King County nonprofit Global to Local on October 1, 2013, the first day of ACA open enrollment.

“The enrollment website was down, and we were passing out paper applications.” Ofori, an undergraduate senior and public health major in the UW School of Public Health, worked with a dozen other UW students as in-person assisters (IPAs) to help people sign up for health insurance through the Washington Health Benefit Exchange. These students conducted outreach in the culturally diverse communities of South Seattle, SeaTac, and Tukwila. (For more on IPAs at Global to Local, read Jose Carmona’s story on page 20.)

While Ofori enrolls the uninsured, Jeremy Snider has a different focus. Snider, a Health Services PhD student in the UW School of Public Health, works with fellow students Megan Shepherd-Banigan and Ian Randall under the mentorship of Professor Doug Conrad on the Quality Assurance and Evaluation Framework. This group is developing methods to assess the impact of ACA implementation on the health of King County, Washington. “I have been working [in quality assurance research] on the global and national level with these issues for several years,” Snider says, “but this is a unique opportunity to learn about how local health authorities interact with the health system.” Working alongside colleagues from Public Health - Seattle & King County to improve



cibles



Further information online:

- ▶ blogs.uw.edu/acainfo
- ▶ globaltolocal.org/about
- ▶ younginvincibles.org/issues/health-care

local health care has taught Snider the value of collaborative work. “We’ve formed a unique research relationship between UW and Public Health - Seattle & King County where we’re focusing on both ‘real-time’ monitoring/quality assurance questions and longer-term research/evaluation questions.” (*Read more about Professor Conrad on page 18.*)

Inderpal Virk is a graduate student in the UW School of Public Health’s executive MPH program. As part of his studies, Virk is required to complete a practicum project that addresses a public health issue in the community. A native of Canada, Virk understands the importance and value of universal health care. For a practicum in the fall of 2013, he worked directly with Public Health - Seattle & King County, focusing on the enrollment of the Young Invincibles—18- to 34-year-olds—the demographic least likely to have health insurance. His project included many outreach events, including a highly publicized ACA forum at UW during the fall quarter. “We knew we had to have a presence on campus,” Virk says.

He also worked with advertising agencies to promote the Washington Health Benefit Exchange. These promotional activities included ads on public buses, a mobile enrollment site at UW’s Red Square, and a “Go

Health Yourself” concert at the Seattle nightclub, Chop Suey.

The second year of medical school is known for its academic rigor, leaving students little time for extracurricular activities or community service. But Alex Ajeto refused to let his class load keep him from actively promoting the ACA. Like Ofori, Ajeto has been involved as an IPA, but his main focus is on a different population: medical students. Ajeto worked tirelessly to educate his classmates and other students about the ACA and its importance.

With colleagues, he has worked with Health Equity Circle, a UW interdisciplinary organization aimed at advocating for health equity. When asked about his motivation for the effort, Ajeto responds quickly, “it is an income inequality issue.”

Ajeto plans to continue his involvement with health policy through medical school and beyond. He also understands the difficulty in reaching the Young Invincibles. “We must simplify the process and get them to the website,” he says.

Carly Miller is an occupational and preventive medicine resident at UW and a graduate student in the UW School of Public Health. ■

#ACA Thoughts

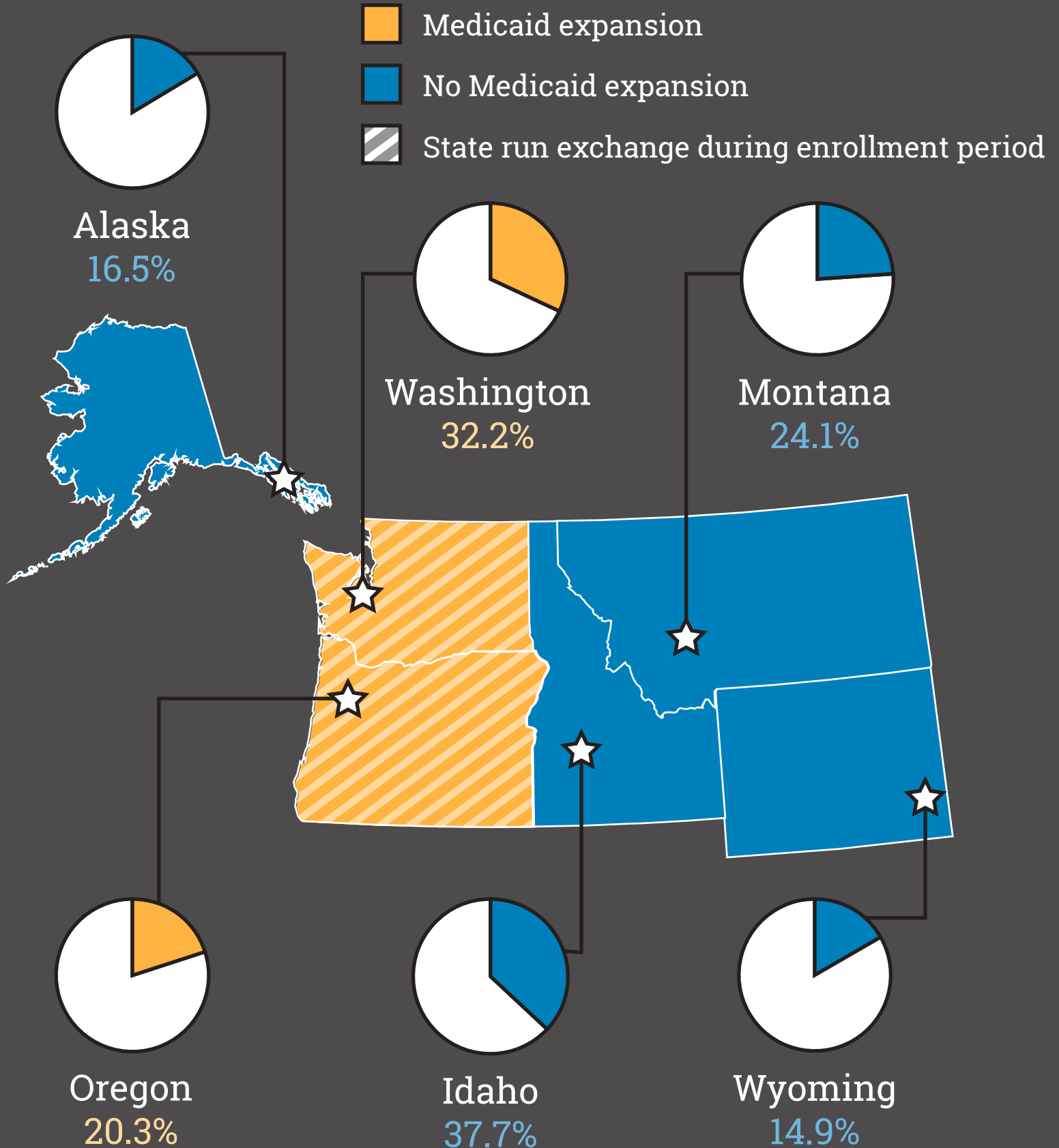


**REPRESENTATIVE
LAURIE JINKINS**
27th Legislative
District, Washington
State House of
Representatives

It’s our job as legislators to make the ACA work.

When I first ran for office, my then 10-year-old son told me that health care should be my number-one priority because too many people were worried about losing their health care. He was right. Now that people have access, we need to focus on cost control. The health care industry is one of the biggest on earth. And it gets to drive demand for its own products. We need to help bring down the cost of care. We need to incentivize quality care with good results, not incentivize expensive procedures.

Percent of Potential Marketplace Population Enrolled



Data source: Kaiser Family Foundation, based on Health Insurance Marketplace March Enrollment Report, October 1, 2013–April 19, 2014

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The combination of discipline-oriented academic programs, strong interdisciplinary research, and community-based public health activities provides a setting for faculty and students to apply in-depth expertise to important public health problems.

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The Northwest Center for Public Health Practice (NWCPHP) assumed responsibility for publishing *Northwest Public Health* in 2008. NWCPHP was established in 1990 to coordinate outreach activities for the UW School of Public Health. NWCPHP promotes excellence in public health by linking academia and the practice community.

NWCPHP provides training, research, and evaluation for state, local, and tribal public health in six Pacific Northwest states—Alaska, Idaho, Montana, Oregon, Washington, and Wyoming.

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#ACA Thoughts



RUSSELL DUKE
Director, Idaho Central
District Health
Department

Until our country has the political will to shift resources away from paying

for health care to investing in keeping people well in a meaningful way, costs have nowhere to go but up. I am hopeful that as a state our policy makers will identify a solution for our low-income, uninsured individuals and families so they can purchase affordable health insurance and gain access to a patient-centered medical home. As a country, I would like to see the health care system quickly evolve into one that is truly incentivized for keeping people healthy.



DACEY STORZBACH
Incoming medical
student

It seems almost certain that physicians will be asked to do more with less. This isn't necessarily

a bad thing if it means creating more efficient ways of practicing medicine, but the trick will be to create efficiencies that have minimal negative consequences for patients or providers. I expect to see greater utilization of electronic medical records and telemedicine, care teams composed of multiple types of health care providers, and compensation based more on results and less on individual procedures. I don't think that a physician's job will look anything like how it's been for the last 10-15 years or so.

We welcome you to share your thoughts, hopes, and observations about ACA implementation on our website: www.nwpublichealth.org.

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The mission of the *Northwest Public Health* is to provide a forum for practitioners, teachers, researchers, and policy makers in public health to exchange ideas, describe innovations, and discuss current issues.

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Health care has a responsibility to work with public health, particularly on population health. Explicit collaboration is needed to figure out new ways to move the needle to improve health with immunizations, prenatal care, and the integration of behavioral health and physical health.

It will take time to build relationships between different parts of the system. They are different types of work. We need consciously to commit to working together.