02

CDC HEALTH POLICY SERIES

Towards Sustainable Improvements in Population Health

Overview of Community Integration Structures and Emerging Innovations in Financing

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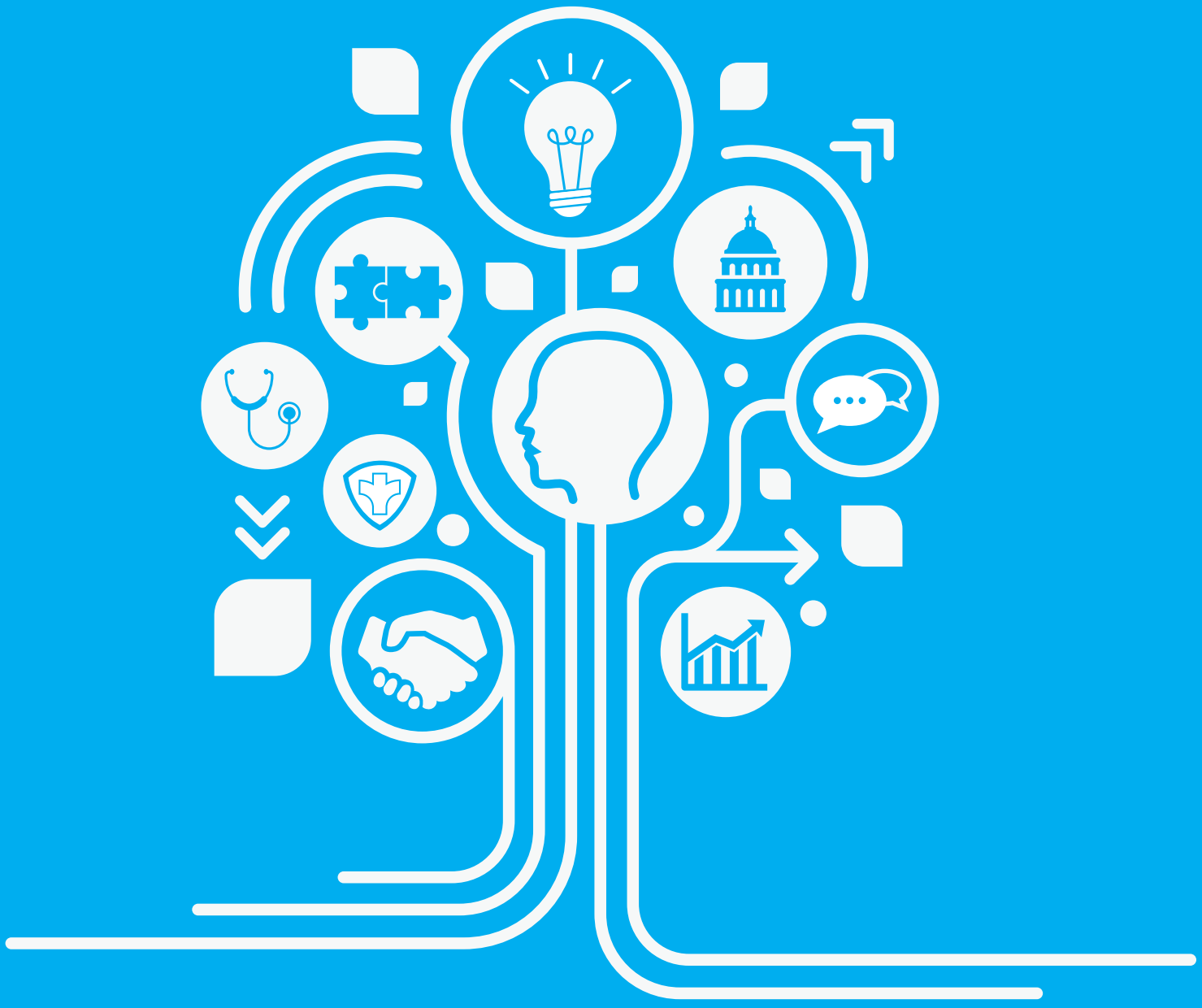

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The American healthcare system is in the midst of unprecedented change, and the Triple Aim®[1,2]—achieving better care for patients, better health for communities, and lower costs through healthcare system improvement—is becoming a widely accepted framework for the desired outcomes of the evolving system.[1,2] Key elements emerging in this transformation include new structures for integrating and coordinating services, a renewed focus on patient engagement and patient-centered care, and new payment models based on the value of population-based health outcomes rather than the volume of services delivered. Private and public payers are testing these payment models in large-scale settings involving thousands of providers and millions of patients. In selected markets, multiple payers are working to align their respective payment models with one another to speed the transformation. This period of change is creating important opportunities to establish effective, more sustainable, community-focused delivery and payment models to improve population health.

Those opportunities—and the accompanying challenges—are discussed in this report. We review evolving community-level population health delivery models; define the key functions, opportunities, and challenges of a community integrator; and introduce the concept of a balanced portfolio as a crucial component in developing a sustainable financial model. We also review emerging financing vehicles that could be used for specific population health interventions.

WHY EMPHASIZE POPULATION HEALTH?

Before going further, it is helpful to define population health and establish why the broader focus on population health is important. The term population health has a range of meanings and uses within the healthcare and public health fields. For this report, we will use Kindig and Stoddart's definition adopted by the Institute of Medicine Roundtable on Population Health Improvement: "the health outcomes of a group of individuals, including the distribution of such outcomes within the group…population health outcomes are the product of many determinants of health, including healthcare, public health, genetics, behavior, social factors, and environmental factors."[3,4]

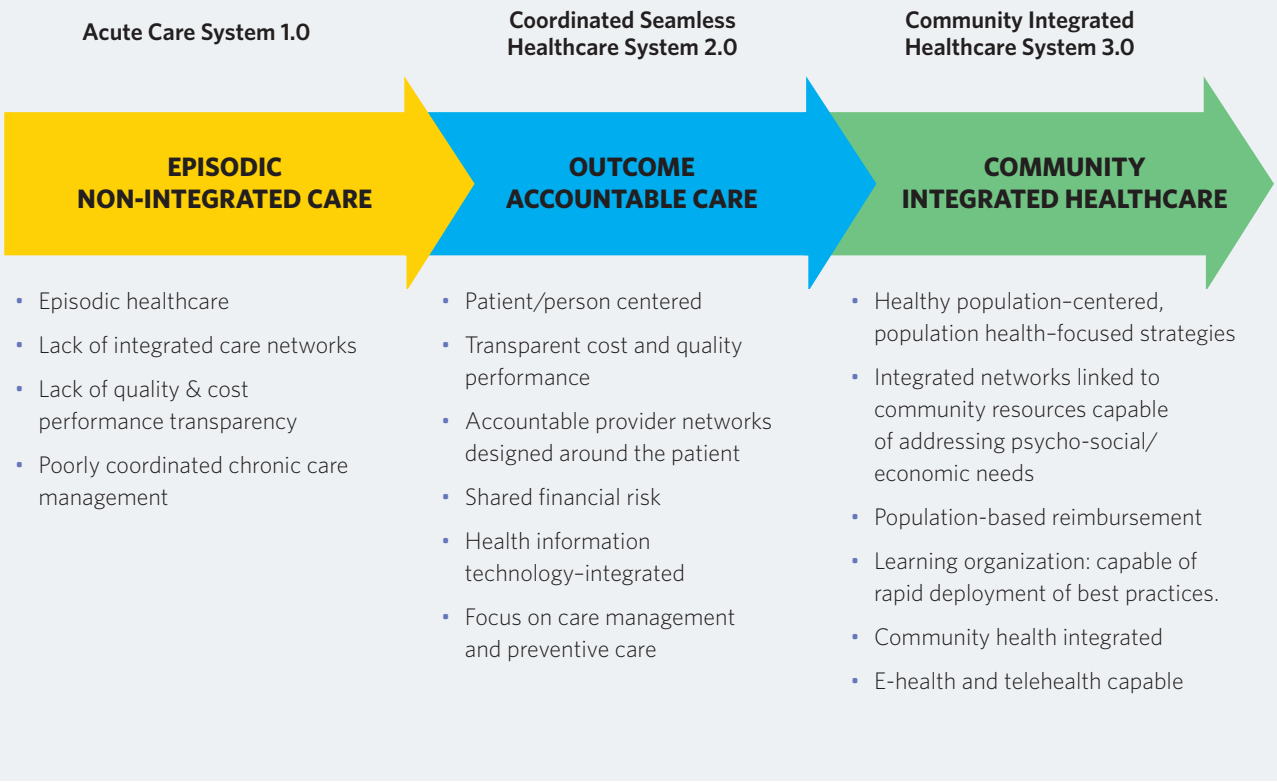
Determinants of health models attribute only a small percentage of a population's health to care received in a clinical setting[5]; however, most healthcare systems and payers continue to focus on improving care delivered to individual patients in a clinical setting with far less attention to the non-medical determinants of health that impact longer-term improvements in the health of individuals and the community. The implication for the current healthcare system seems clear: If the goals of the Triple Aim® are to be realized, this period of innovation must shift the focus beyond the clinical setting to also address other determinants of health for the overall population.

Halfon has created a helpful framework that defines transitions along three stages in the evolution of the healthcare system that must occur to achieve the Triple Aim® (Figure 1).[6] The first transition moves from the traditional, episodic, acute care–focused stage (Healthcare 1.0) to a more patient-centered stage that coordinates care for a variety of chronic illnesses across a broad range of caregivers and over the lifetime of the patient. This is Healthcare 2.0. Many local and regional healthcare systems throughout the United States are engaged in this transition, implementing new care models such as patient-centered medical homes[2,7] and accountable care organizations (ACOs).[2,8,9] The second transition moves from the 2.0 patient-centered care to a community-based system that addresses the full spectrum of health, including healthcare and the determinants of health, to reduce the prevalence of chronic disease and improve the quality of life. This is Healthcare 3.0, a community integrated healthcare framework.

One likely indicator of a mature 3.0 stage is a shift in accountability from a panel of patients who use a provider or healthcare system to the total population within a geographic area, only a subset of which Healthcare stages 1.0 or 2.0 traditionally serve. Recognizing the significance of the determinants of health within the 3.0 stage requires that the health system 1) expand the scope of interventions beyond clinical services to include a wide range of community-based interventions targeting non-medical determinants of health; and 2) access data that can measure clinical and non-clinical delivery and outcomes for a total geographically defined population.

Although the Triple Aim® is being embraced more widely and incorporated into mission statements and objectives of local, state, and national initiatives, many healthcare systems are reluctant to move away from the familiar fee-for-service payment model. In practice, very few are actually testing a path to Halfon's Healthcare 3.0.[6]

FIGURE 1: U.S. Healthcare Delivery System Evolution: Health Delivery System Transformation Critical Path



Halfon N, Long P, Chang DI, Hester J, Inkelas M, Rodgers A. Applying a 3.0 transformation framework to guide large-scale health system reform. *Health Affairs* 2014;31(11). doi: 10.1377/hlthaff.2014.0485.

EMERGING COMMUNITY-LEVEL INTEGRATION STRUCTURES

Improving population health requires integration of multiple levels within a health system.[8] The first is the primary care practice level—the foundation of integrated care to meet each patient's needs. Such integration requires managing care across multiple settings and supporting patients in making long-term changes in health risk behaviors.

The second is the community or regional health system level, which starts with a local network composed of the community hospital, its primary care practices and specialist physicians, and other key providers in the local area, including those addressing behavioral health.[8] This level must expand to include a spectrum of other public health services, social and behavioral health services, and community-based resources that are vital to facilitate effective disease management for the health of a population.

The third level—the state—provides the enabling infrastructure for the primary care and community health system. That infrastructure includes health information technology support, design and implementation of all-payer payment reforms, and

technical support and training to share best practices and build process improvement.[10] An important current state-based initiative is the State Innovation Model program of the Centers for Medicare and Medicaid Services (CMS).[11] This program will integrate and align state policies in a state transformation plan designed to accelerate delivery system reform.

Finally, an alignment of resources is important for an integrated health system. At the federal level, the transformative policy and payment reforms already occurring in Medicare[12] provide important opportunities for community provider networks to consider. All four levels need to be engaged, but we focus here on the community level.

Community Integrator and a Balanced Portfolio

At the community health system level, one promising approach is the establishment of a community health integrator, accountable for the health of a total population within a geographic area, including reducing health disparities within that population. A number of conceptual models identify the need for an integrator as a central component of a community health system to bring together clinical care, public health, and community services in a coherent strategy to meet the community's needs. This integrator is at the core of models such as the Community Chief Health Strategist,[13,14] Accountable Health Communities,[15] community integrators,[16] community quarterbacks for community development,[17] and the "backbone organization" described in the collective impact movement.[18] For the purposes of this report, we will refer to these models collectively as community integrators. As multiple community integrator models are emerging, the specific term used to describe the integrator is less important than an emphasis on its key structure and functions.

The community integrator is structured as a geographically based organization that identifies appropriate delivery partners for each intervention and selects a financing vehicle to match the time frame and risk profile of each intervention. The community integrator must be a legal, operational entity capable of establishing contractual relationships with delivery partners and have a broad-based and transparent governance. To successfully impact population health, the integrator's geographic boundaries of governance must align with the geographic boundaries of the community it serves. Its credibility and authority will stem from the inclusion of key community stakeholders and its ability to improve the health of the community over time.

The functions of a fully developed community integrator span the planning, implementation, and evaluation cycle. The integrator-led process begins with convening stakeholders and managing their diverse perspectives to establish a shared vision and goals. The integrator facilitates a common assessment of needs for its geographically defined community, defines health priorities, and identifies specific interventions, building on starting points such as the requirement for nonprofit hospitals to conduct community health needs assessments (CHNA).[19] The integrator facilitates development of a coordinated network of medical, behavioral health, and community and social services for its residents. For each intervention prioritized for implementation, the integrator makes the business case for the intervention and identifies a delivery partner and an appropriate financing vehicle.[20]

The resulting network of diverse providers implements a portfolio of interventions that is balanced along a spectrum of three perspectives: 1) time frames, reflecting short- and longer-term intervention effects; 2) level of investment risk,[i] reflecting both the strength of scientific evidence and investment in innovation to help develop the evidence; and 3) scale of return, based on measures for health, financial, and social impact. The balanced portfolio is strategically designed to realize **short-term** opportunities for savings in medical

[i] Investment risk is the likelihood that an investor will recover the principal invested and earn the projected return. It is a measure of the strength of the evidence supporting the use of a given intervention and the experitise of the organization responsible for achieving those results. It is quite different from actuarial risk for the medical expense of a given population, which is used in shared savings or global capitation payment models.

costs, such as providing housing-based services for high-risk Medicaid-eligible individuals[21,22]; to implement **medium-term** interventions to change health risk behaviors, such as the National Diabetes Prevention Program[23]; and to address **longer-term** determinants of health, such as investments in early childhood development. It reflects the assessment and prioritization of community needs aligned to best meet the goals established by the community. An example of a balanced portfolio is given in Table 1.

Balancing the portfolio to optimize returns requires alignment of multiple funding streams, both public and private. Given the need to create more global population-based payment models that align financial incentives with health outcomes, the community integrator might also manage a population health budget, serving as a neutral entity to allocate resources. The integrator additionally facilitates the process of monitoring progress and outcomes and implementing rapid-cycle changes. Early successes offer best practices that can be applied and expanded as new approaches are tested.

Existing integrator models[15-18] could serve as starting points for a fully developed community integrator that includes enhanced financial functions.

TABLE 1: Sample Balanced Portfolio for Community Health Systems

Intervention	Target Population	Implementation Partners	Financing Vehicle	Time Frame*	Investment Risk	Savings-Sharing Vehicle
Intensive care coordination	Dual eligible high utilizers	Accountable care organizations	Shared savings	Short	Low risk	Community benefit
Integrated housing- based services	Medicaid eligible, multiple chronic illnesses	Medicaid managed care plan, housing corporation	Capitation	Short	Low risk	Performance contract
Innovative use of remote monitoring	Medicare eligible, multiple chronic illnesses	Medicare Advantage Plan, private foundation	Grant	Short	High risk	None
YMCA Diabetes Prevention Program	Commercial insured and self-insured	Commercial health plan, self-insured employers	Shared savings	Medium	Medium risk	Performance contract
Asthma medical management	School-aged children	Commercial and Medicaid health plan	Shared savings	Medium	Medium risk	Performance contract
Asthma environmental hot spots	Children with asthma	Public health agency	Social impact bonds	Medium	Medium risk	Investing in social impact bond
Expanded early childhood education	Children at risk for adverse childhood events	Preschool educators	Pay for success, social impact bonds	Long	Medium risk	Investing in social impact bond
Community walking trails	Community	Nonprofit hospital	Community benefit	Long	Medium risk	None
New grocery store	Residents of U.S. Department of Agriculture food deserts	Community development financial institution	Community reinvestment	Long	Medium risk	None

* Time needed to generate financial savings.

Hester JA, Stange PV. A Sustainable Financial Model for Community Health Systems. Discussion Paper, Institute of Medicine, Washington, DC; 2014. Available at http://www.iom.edu/Global/Perspectives/2014/SustainableFinancialModel.

However, few, if any, of the existing models are currently working across the trajectory from planning to implementation and financing.[10]

A SUSTAINABLE PAYMENT MODEL FOR COMMUNITY INTEGRATORS

The elusive "holy grail" for the population health movement has been a payment model that breaks the cycle of dependence on limited-term grants and provides sustainable support for both infrastructure and interventions. Two critical requirements that support sustainable population health improvement are reinvestment of a portion of the savings from interventions back into the community and better alignment of diverse funding sources with interventions in the balanced portfolio.

Capturing a portion of savings for reinvestment is essential for long-term sustainability, and can be achieved in a variety of ways (Table 1). Savings accrued from improved efficiencies gained by restructuring uncoordinated medical and social services may be used to support interventions outside of the acute care setting that improve health and reduce costs. For example, in a short-term initiative using shared-savings payment models for an ACO built around nonprofit hospitals, the integrator could negotiate to receive a percentage of savings for reinvestment into the community. The hospital could classify the money returned to the community for interventions outside the healthcare setting as a community benefit.[19] Even while shared savings are an important potential source of initial funding for the integrator's portfolio, at some point the opportunities to realize savings from reduced medical costs will diminish and financing will need to transition to other, longer-term vehicles. In the early childhood education example in Table 1, for example, the integrator could participate as an investor in the pay-for-success financing, capturing a portion of savings for reinvestment in the community to support future programs.[20]

Viewing community health as a long-term, capital-investment venture will be essential to realize population health improvement. The capital requirements—not unlike those in well-established, rigorously planned regional transportation initiatives throughout the nation[24]—are well beyond the capacity of the health sector alone. Combining and leveraging investment capital from multiple public and private entities will be an important step. Further, as with regional infrastructure development, the necessary planning and investment must be considered on a longer horizon—decades, rather than 3–5 years commonly used in governmental and philanthropic grant-making—as very few interventions yield short-term returns on health or cost outcomes.[24,25]

The mix of financing vehicles in the portfolio will shift with the maturity of the community integrator. At the development and testing phase, integrators require greater grant support, which is more risk tolerant and allows for the time required to develop evidence of new interventions' effectiveness or expand existing initiatives to scale. As a community model matures and begins to achieve early successes, a broader range of financing vehicles may support dissemination of proven interventions and the infrastructure needed for larger-scale implementation. In the mature operation phase, the community integrator has established its balanced portfolio and, ideally, has developed sustainable financing.

EMERGING FINANCING VEHICLES

Currently, governments, insurers, healthcare systems, and other payers and providers are exploring a wide range of financing vehicles that support improved patient and population

TABLE 2: Emerging Financing Vehicles and Payment Mechanisms

Financing Vehicle	Payment Mechanism: How Does It Work?	Time Frame*	Investment Risk Profile	Status
Payment Models for Care Delivery				
Global budget/ capitation	Payment budget set for provider group for expected services (or subset thereof) for a given population. When spending is under budget, providers share the surplus; when spending is over budget, providers are responsible for extra costs. Similar to "capitation" model but more sophisticated means of risk adjustment, and financial results are linked with performance.[25]	Short	Moderate (with experience) two-sided risk.	Population measures are clinical.
Shared savings	Group of providers receive incentive to reduce healthcare spending for expected services (or subset thereof) for a defined patient population. Providers receive a percentage of the net savings. Access to savings often contingent on meeting performance measures for care access, quality, or efficiency.[25]	Short	Low to moderate risk (with experience); range of one- and two-sided risk options.	Implemented widely, but population health measures are clinical.
Care coordination fee	Providers receive payment specifically for care coordination,[26] typically in the form of a per-member-per-month fee for HMO enrollees or the attributed population in a multi-payer advanced primary care practice (aka "medical home").[27]	Short	Low risk.	Implemented with clinical health measures.
Fee for service with pay for performance (P4P)	Combines traditional fee-for-service physician payment system with a financial incentive based on meeting a set of performance or reporting standards over a specified period of time.[25]	Short	Low risk.	Gaining traction, but incentives are small.
Multisector Funds				
Blended: co-mingled	Funds from multiple funding streams are combined into one "pot." Programs and services are financed out of that pot without distinction of where original funding came from.[28]	Varies with funded intervention	Challenge to meet reporting requirements of various funders.	Implemented in early care and education and social services.[29-32]
Braided: coordinated targeting	Funds from multiple funding streams are combined, with careful accounting for how dollars from each funding source are spent.[30]	Varies with funded intervention	Must follow restrictions, reporting requirements for each funding stream.	
Medicaid waiver	States apply for waivers to test new ways to deliver or pay for healthcare services through Medicaid or the Children's Health Insurance Program.[33]	Medium	Loss of waiver or financial penalties for not meeting goals.	>450 waivers across all 50 states and DC.[33]
Innovative Financing Vehicles				
Charitable hospital community benefit	For tax exemption, nonprofit hospitals must file report to IRS of their community benefit.[19] Activities that meet this requirement must improve community health or safety, meet at least one community benefit objective, and respond to a demonstrated community need (determined through health needs assessment conducted every 3 years).	Varies with funded intervention	Low to moderate risk.	As ACA coverage for uninsured rises, charity care should decrease, freeing resources for non-clinical investment.
Pay for success or social impact bond	Government agrees to pay an organization for an intervention if it meets specific, measurable goals in a set time.[34] Organization secures funding from investor(s) to cover program costs and providers. Third-party evaluator assesses outcomes. If intervention achieved goals, government pays the implementing organization, which repays its investors. If not, government does not pay; investors are not repaid with public funds.[35]	Medium	Moderate risk (with experience). To attract capital, organizations must mitigate risks and offer high financial returns.	Several states use social impact bonds; 12 others considering them.[36] Early involvement in health sector.
Community development financial institutions (CDFIs)	CDFIs attract public and private funds—including from the Treasury Department's CDFI Fund—to create economic opportunity for individuals and small businesses, quality affordable housing, and essential community services.[37] All are private sector, market driven, and locally controlled. Closely tied to the Community Reinvestment Act.[38]	Long	CDFIs reduce financial risks for projects.	About 1,000 nationwide, with most focusing in urban areas.
Program-related investments	Foundations invest in charitable activities that involve potential return on capital within a set time.[38] They provide flexible loans, loan guarantees, and equity investments in charitable organizations and in commercial ventures that have a charitable purpose. Capital resulting from the investment is recycled for further charitable investment.	Varies with funded intervention	Foundations use endowments to absorb risks that hinder private investors.	Few hundred U.S. foundations make program-related investments.
Prevention and wellness trusts	State or community raises a pool of money that is set aside for prevention and community health. Funds for trust often come from taxing insurers and hospitals, but can come from pooling foundation resources or redirecting existing government funds.[39]	Varies with funded intervention	Medium risk; mix of innovation and evidence-based interventions.	Model is the philosophy behind Prevention and Public Health Fund.

*Time needed to generate financial savings.

health and have the potential to slow rising healthcare costs.

These vehicles, summarized in Table 2, fall into three broad categories:

1. Payment models for care delivery that reward value-based outcomes instead of volume[26,27];

2. Multisector funds that blend resources into a common pool, such as through some Medicaid Section waivers[28-33]; and

3. Innovative financing vehicles that access new and existing pools of public and private capital.[34-39]

The first category uses incentive-based payment systems for clinical services as a means of achieving better coordinated, accountable healthcare—Healthcare 2.0[6]—and redirecting funds from acute care to upstream determinants. Although Triple Aim® goals have been set in a number of new models, such as ACOs and patient-centered medical homes, the associated population health outcome measures have often been more clinical[40] rather than reflective of the broader measures of health and its determinants. The second category includes a number of evolving examples, some funded through the creative use of Medicaid and Medicare waivers, such as those recently granted to Maryland,[41] New York,[42] and Texas.[43]

Examples in the third category—innovative financing vehicles—include:

- Affordable Care Act (ACA) requirements for nonprofit hospitals to conduct CHNAs and adopt implementation strategies with specific resources to address priority needs[19];

- Recognition of the connection between healthy populations and strong, economically vibrant communities opening the door to access Community Reinvestment Act vehicles, such as Community Development Financial Institutions and Community Development Banks[37];

- The growing social capital movement, implementation of the first pay-for-success agreements (social impact bonds), and creation of new social mission corporate vehicles such as low-profit limited liability companies[34,35];

- Use of program-related investments by philanthropic institutions as a complement to traditional grants[39]; and

- Establishment of health and wellness trusts at the state and local levels, such as the Massachusetts Wellness Trust.[38,44]

While a diversity of financial interests, structures, and objectives is valuable because it increases the likelihood that a given intervention will be financed by an appropriate vehicle, it raises the unintended possibility of fragmentation and conflicting efforts. Simply implementing an uncoordinated series of intervention transactions will likely be neither effective nor sustainable. An important role of the community integrator is to avoid this fragmentation. To do this, it will need to implement a combination of complementary interventions that are tailored to each community's needs, generating a multiplier effect that results in positive community outcomes and achieves the goals of reduced disparities and better quality of life.

CHALLENGES AND CONCLUSIONS

Transitioning from an episode-focused, volume-driven healthcare system to an integrated system that supports population health by attending to both clinical care and the non-medical determinants of health will be challenging. To support change and sustain significant improvements in health at the community level, coordination of programs and policies at the federal level related to healthcare delivery and payment, public health, quality measurement, and financing will be of paramount importance.

The National Prevention Council[45]—created through the Affordable Care Act and composed of 20 federal departments, agencies, and offices, including housing, transportation, education, environment, and defense—is a unifying federal body that can provide leadership, coordination, and support for the kind of long-term integrated planning, prioritization, and financing that will support and sustain change at the community level. Through the *National Prevention Strategy: America's Plan for Better Health and Wellness*,[46] released in 2011, and the 2012 *National Prevention Council Action Plan: Implementing the National Prevention Strategy*,[47] the National Prevention Council continues to prioritize prevention across multiple settings to improve health and save lives. Stronger connections between federal financing and regulatory agencies, including the Department of Treasury and The Federal Reserve, could accelerate important links between health and innovative financing described in this paper. Existing federal initiatives—such as the "Partnership for Sustainable Communities," an interagency partnership between Housing and Urban Development, Department of Transportation, and the Environmental Protection Agency[48]; the Department of Health and Human Services' "Birth to 5: Watch Me Thrive" initiative[49]; and the Department of Defense's "Healthy Base" initiative[50]—could be examined as starting points for building collaboration, with an emphasis on those that already highlight cross-sector partnerships.

A key building block for emerging delivery and financing models is the ability to measure meaningful and timely health, quality, and cost outcomes at a population level across a spectrum of time horizons. Existing measures and datasets are not well developed and are not typically available at a local, census-tract level, limiting the ability to describe community-level health. They also focus more on short-term clinical and cost outcomes and less on non-medical processes and outcomes. Additional measures and analytic models are needed for use at the community level to address intermediate outcomes related to disease burden, patient-reported quality of life, long-term outcomes of quality-adjusted life expectancy, and the non-medical social determinants of health. Such analytic tools would also help to project long-term impacts and provide evidence to make a business case for population health, which is fundamentally different than demonstrating an impact on risk factors or specific conditions.

The business case for population health is complex and requires investments from multiple sectors that accrue over long periods of time. This requires a shift in focus, as population health programs have traditionally been evaluated on the basis of risk factor reduction—that is, whether an intervention changed behavior—rather than on their combined health and financial impact. Current shared savings models, with a focus on medical expenditures on an annual cycle, do not fully capture the longer term benefits of effective population health interventions. Emerging financial mechanisms, including shared savings models and social impact bonds, will likely be more sustainable in the intermediate to long term when both the health and non-health sectors at the community level move closer to an outcome-oriented, population-based global budget. Without these elements, the risk is that new payment models will be established with a limited population health component.[51,52]

Substantial developmental work and conceptual realignment is still needed to understand, prioritize, and finance efforts to improve population health. Broad-based, multi-stakeholder engagement of government entities, the healthcare delivery system, private investors, and communities can accelerate the development and testing of new and emerging models for improving population health. It will be important also to continue to test a broad set of interventions and sustainable financing vehicles for improving health, with successful models scaled up to the national level and lessons learned translated to private healthcare payer systems.

Examples of community-level innovation focusing on improving health and addressing and financing determinants of health are rapidly emerging. The private sector has initiated a number of community-centered programs to identify promising local initiatives, create learning networks, and disseminate best practices. Some examples include "The Way to Wellville," an investor-sponsored contest by HICCup (Health Initiative Coordinating Council)[53]; the "Moving Healthcare Upstream" collaborative funded by the Kresge Foundation[54]; and "Escape Velocity to a Culture of Health,"[55] organized by the Institute on Health Improvement.

Given the focus of public health on geographically defined populations and on community and social service supports, the public health enterprise—including governmental public health departments, non-governmental public health organizations, and academic public health—should play an important role to help accelerate evolution toward a mature and integrated healthcare system. As the infrastructure, delivery, and financing of community and population health evolve, so will the role of the public health enterprise and public health departments.[13,14] Public health and health departments should accelerate

strategic, collaborative partnerships with the changing community health system and with healthcare purchasers, payers, and providers and emerging shared-savings delivery models, building on early successes.[36] Public health has an important opportunity to exercise and strengthen its traditional roles of surveillance and epidemiology, measurement, evaluation, and the convening of key stakeholders, and adapt into critical new roles including policy design and a re-orientation of the health system towards prevention, health promotion, and wellness.[13,56] Alignment of the changing health system and evolving public health role with accreditation of public health departments may also be an important step. One important near-term role for public health is to promote the use of tools to help communities and nonprofit hospitals conduct their 2015 community health needs assessments and implementation plans in a coordinated, collective impact–driven fashion. Such tools are being developed by CDC and will be publicly available in 2015.[57]

While the number of private and public initiatives supporting system-level, integrated population health improvement is encouraging, a number of challenges will need continued attention, including:

As the infrastructure, delivery, and financing of community and population health evolve, so will the role of the public health enterprise and public health departments.

- Wider acceptance of the concept and implementation of a balanced portfolio, particularly support for interventions within the portfolio requiring a longer time horizon to achieve sustained outcomes;
- Better understanding of how to create and sustain a fully realized, credible community integrator that works from planning to implementation to evaluation and manages the financing of a balanced portfolio;
- Improved use of varied data sources, measures, and tools to facilitate the monitoring of complex and evolving community models and their intended short-, medium-, and long-term outcomes; and
- An improved ability for all key stakeholders, including public health, to articulate their individual added value towards true collective impact.

Sustaining attention to the evolving community-based delivery and financing models during this critical window of opportunity will be a challenge for the healthcare and public health fields, particularly in learning to collaborate with the private financial world on the financing innovations they are exploring.[52,58] Ultimately, it will be imperative to align a broad range of financial resources with the needs of each community if we are to fully address the upstream social determinants of health and succeed in substantially improving population health.

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About this Series

With the passing of the Affordable Care Act (ACA) came changes to the U.S. health care and public health systems. With both now positioned to place greater emphasis on better care, better health, and lower cost, there is tremendous opportunity to improve population health as more of the population is covered by health insurance. To support this change, the Centers for Disease Control and Prevention, Office of the Associate Director for Policy, in partnership with NORC at the University of Chicago, experts at the Milken Institute School of Public Health at The George Washington University, and Population Health Systems, have produced a series of issue briefs highlighting opportunities for public health to support health system transformation.

Each issue brief is designed to provide practical guidance to state and local public health departments and to health systems, highlighting specific opportunities for public health and health care to engage to improve population health. Additionally, the briefs include success stories to demonstrate how state and local public health practitioners can collaborate with the health system to catalyze health system transformation.

Disclaimer

The findings and conclusions in this report do not necessarily represent the views of the Centers for Disease Control and Prevention.

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