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Perceived Impacts of Health Care Reform on Large Urban Health Departments

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Context: The Patient Protection and Affordable Care Act (ACA) is changing the landscape of health systems across the United States, as well as the functioning of governmental public health departments. As a result, local health departments are reevaluating their roles, objectives, and the services they provide. **Objective:** We gathered perspectives on the current and future impact of the ACA on governmental public health departments from leaders of local health departments in the Big Cities Health Coalition, which represents some of the largest local health departments in the country. **Design:** We conducted interviews with 45 public health officials in 16 participating Big Cities Health Coalition departments. We analyzed data reflecting participants' perspectives on potential changes in programs and services, as well as on challenges and opportunities created by the ACA. **Results:** Respondents uniformly indicated that they expected ACA to have a positive impact on population health. Most participants expected to conduct more population-oriented activities because of the ACA, but there was no consensus about how the ACA would impact the clinical services that their departments could offer. Local health department leaders suggested that the ACA might create a broad range of opportunities that would support public health as a whole, including expanded insurance coverage for the community, greater opportunity to collaborate with Accountable Care Organizations, increased focus on core public health issues, and increased integration with health care and social services. **Conclusions:** Leaders of some of the largest health departments in the United States uniformly acknowledged that realignments in funding prompted by the ACA are changing the roles that their offices can play in controlling infectious diseases, providing robust maternal and child health services, and more generally providing a social safety net for health care services in their communities. Health departments will continue to need strong leaders to strengthen and maintain their critical role in protecting and promoting the health of the public they serve.

KEY WORDS: **Big City Health Coalition, health care reform, Affordable Care Act, public health practice, urban health**

Background

The Patient Protection and Affordable Care Act (ACA) reduced the number of Americans without health insurance by 9.3 million between 2013 and 2014.[1] However, expanding coverage has had unanticipated impacts for the nation's public health system, particularly in terms of the clinical care services they offer, including infectious disease control, family planning,

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The de Beaumont Foundation and the Robert Wood Johnson Foundation funded the Big Cities Health Coalition.

Because data collection for this manuscript focused on key informant interviews from professionals representing their LHDs, because the questions pertained to their professional experiences and professional opinions, and because all information is reported in aggregate or anonymously to preserve confidentiality, IRB submission was not deemed necessary.

The authors thank Elizabeth Rhoades and Philippa Benson for their assistance in the preparation of this manuscript.

The authors declare no conflicts of interest.

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DOI: 10.1097/PHH.0000000000000145

maternal and child health, and other specific services.[2,3] Of the nation's 2800 local health departments (LHDs),

- 90% provide immunizations to children and adults
- 75% treat tuberculosis
- 60% provide STD treatment
- 50% provide family planning services
- 25% treat HIV/AIDS
- 10% provide comprehensive primary care.[4]

Local health departments are reexamining their roles in the community, particularly for individual clinical care services.[5-10] Although the ACA does mandate additional coverage for preventive services, there may be a continuing need for safety net clinical services.[3,6,11-13] Local health departments may choose to discontinue clinical services in favor of activities that have a population-oriented focus, in keeping with changes that have been recommended by an Institute of Medicine committee more than 25 years ago.[14-17] Alternatively, LHDs may continue to provide clinical care that addresses unmet needs in their communities and/or generates revenue.

Little is known about the attitudes of local public health leaders toward the ACA or their decision-making processes in reaction to the health systems and community changes prompted by its enactment. Addressing this gap in knowledge is important, given the role of LHDs as a safety net provider in their respective communities. We conducted a mixed-methods study among leaders in 16 large, urban LHDs. Our goal was to assess leaders' perspectives, attitudes, and concerns regarding the impact of the ACA on health systems, on the communities they serve, and on their departments. This study was prompted by the recognition that the ACA could potentially greatly impact how LHDs function in providing these and other public health services.

Methods

We conducted the study as part of a larger assessment of the capacities, needs, and priorities of members of the Big Cities Health Coalition (BCHC); detailed methods used in the larger assessment have been described elsewhere.[18] The BCHC is a group within the National Association of County & City Health Officials with 20 members*, representing some of the largest LHDs in the country, including those in Atlanta, Baltimore, Boston, Chicago, Cleveland, Dallas, Denver, Detroit, Houston, Los Angeles, Miami, New York, Philadelphia, Phoenix, San Antonio, San Diego, San Francisco, San Jose, Seattle, and Washington, DC.

The study focused on leadership perceptions and attitudes about the potential impacts of ACA. We used a mixed-methods design, beginning with interviews and followed by a Web-based survey. Participants included 45 leaders from 16 participating BCHC LHDs. Each participant held 1 of 3 specific positions: local health official (LHO), chief of policy, or chief science/medical officer. Since LHDs are often structured differently, participants came from departments that did not necessarily have a staff member in each of these positions (eg, 3 LHDs did not have a chief of policy position). All respondents participated in a semistructured interview portion of the study and were asked the same questions. The Web-based survey questions were separated into different modules, with questions regarding the impacts of ACA on specific programs directed only to the 16 LHOs. The questions were closed-ended and focused mainly on organizational characteristics and anticipated programmatic changes. Questions regarding expected changes in provision of services due to the ACA were accompanied by response options on a 7-point ordinal Likert scale. Response options included "My LHD doesn't currently perform this activity and I expect it would not start performing it"; "I expect the LHD will not provide this activity"; "I expect the LHD to perform much less of this activity"; "I expect the LHD to perform somewhat less of this activity"; "I expect the LHD to perform somewhat more of this activity"; and "I expect the LHD to perform much more of this activity."

We collected interview and survey data between August and October 2013. Interviews lasted 1 hour, on average. Qualitative data were independently coded thematically by 2 researchers and were managed and analyzed in NViVo 10 (QSR International, Cambridge, Massachusetts). Data were analyzed in aggregate, as well as by position type and by location. Quantitative data were cleaned, managed, and analyzed in Stata 13 (StataCorp LP, College Station, Texas). Integration of data occurred during analysis, per the embedded mixed-methods design.[19] Both instruments were pretested with 5 people who had backgrounds in state and/or local public health.

Results

Forty-five respondents participated in the interviews. Six respondents from 2 LHDs did not respond to requests for interviews. Study participants were leaders of 16 of the 18 LHDs in the BCHC at the time of the study. Twenty-five respondents had a legal or medical degree (JD or MD), 6 had a PhD or DrPH,

*At the time of this study, 18 LHDs constituted the BCHC; 2 have since joined the coalition.

12 had a master's degree, and 2 had a bachelor's degree as the highest level of education. At the time of interviews (Fall 2013), participants had served in their current positions for an average of 3.4 years (median, 3.0).

Answers to the closed-ended survey questions by the 16 LHOs also reflected a wide range of expectations about possible changes ACA might bring to specific programs and services (Figure). Generally, participants agreed that population-oriented services would increase in scope and scale, and that the information-related services provided by public health offices would grow in importance. Specifically, 13 of the 16 LHOs said they expected to do more epidemiology and surveillance, 13 expected to do more population-oriented primary prevention, and 12 expected to conduct more outreach/enrollment for health care exchanges and/or Medicaid expansion. There was no consensus about expected changes in clinical care provision. Eight LHOs expected their offices to provide more screening or treatment of chronic disease, 3 LHOs expected to provide somewhat less or much less screening and treatment, and 2 expected that their departments would provide no chronic disease screening or treatment. There was also no consensus about how ACA might impact immunization services. Seven LHOs expected their offices to provide more immunization services, while 6 expected to provide fewer. Several LHOs did not provide certain direct clinical services (most notably behavioral health care) at the time of the study and did not anticipate that they would be doing so in the future. Respondents, respectively, noted that the uncertainty about the continued provision of clinical care services was due both to the complex local political environment and to the fact that ACA was directed at health care reform, rather than public health, per se.

Examples of Potential Service Changes

Participants said that they believed that 3 particular categories of services might be affected by the ACA: epidemiology/surveillance, safety net clinical services, and immunizations. Thirteen LHOs expected that the ACA might change surveillance activities, perhaps substantially. Eleven respondents noted that a significant amount of new health data might become available through health information exchanges, and that health departments might be best positioned to collect, analyze, and report these data to community partners. The leaders said that they expected that the ACA would prompt more epidemiology and surveillance work, although some expressed concern about funding for these and other core services.

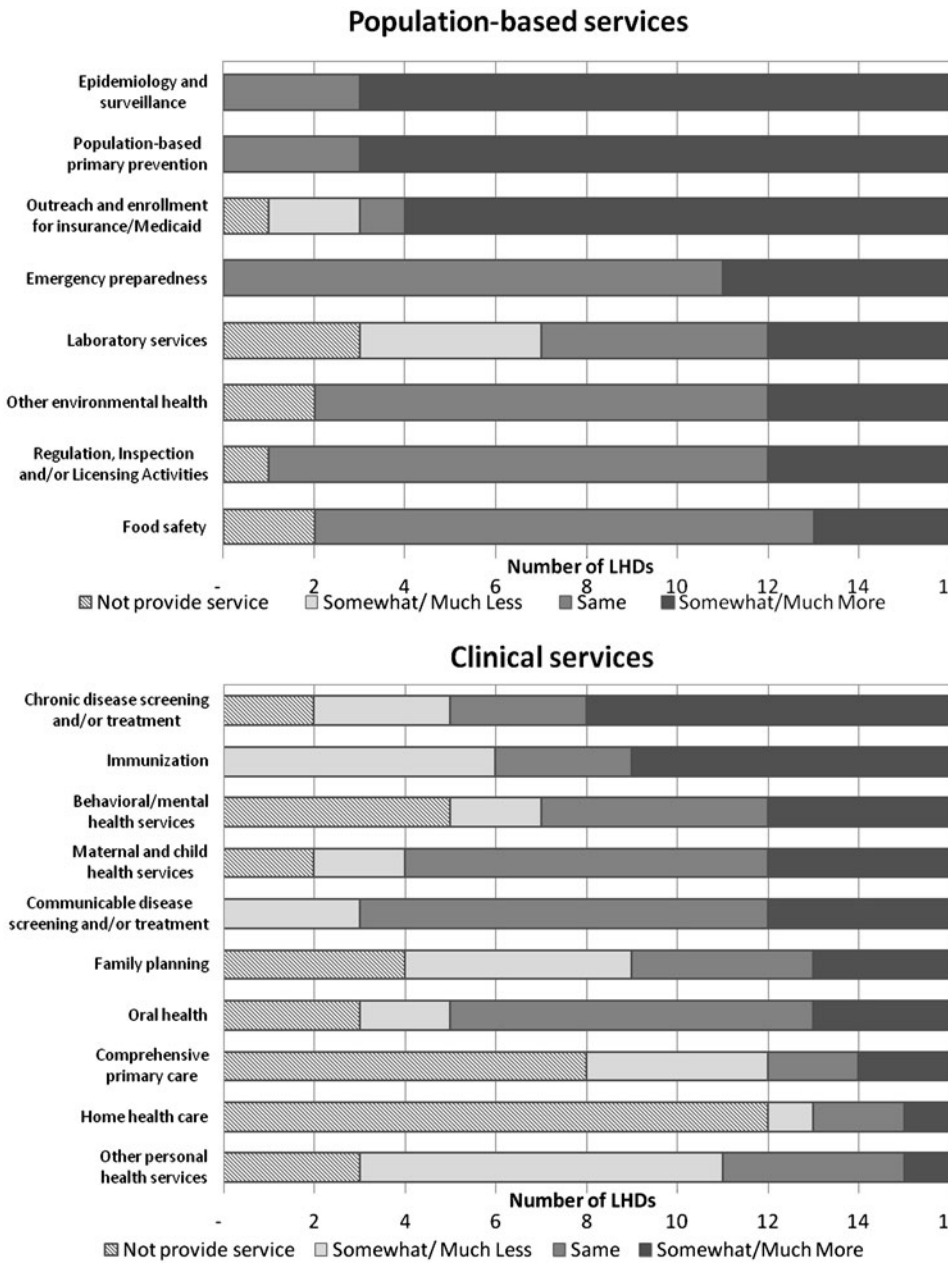
A majority of participants said that they felt that ACA would likely precipitate changes to safety net clinical services. Respondents from 13 cities said they were specifically concerned that the ACA might cause their departments to lose funding, especially for clinical services. In their view, safety net clinical services could be cut if policymakers perceived that expanded health insurance coverage would eliminate the need for safety net services. However, several leaders expressed concern that, regardless of insurance status, demand for services such as treatment of sexually transmitted diseases or family planning would continue. From their perspective, needs of the uninsured will persist, and some insured patients will continue to want to avoid engaging their normal care providers or billing processes for certain treatments.

Several respondents were concerned that there could be decreased immunization rates in their jurisdictions. These respondents noted that expanded health insurance coverage under ACA might change the availability of immunization services, and that despite continued funding for programs such as Vaccines for Children, a confluence of additional financial and policy pressures may lead to a decrease in funding for vaccines that were previously provided by health departments. In addition, participants noted that private providers also might be discouraged from administering vaccines because of both relatively low reimbursement rates and new Centers for Disease Control and Prevention regulations regarding vaccine storage. Several respondents also said that a relatively large proportion of their population was covered by the "grandfather clause" provision of the ACA (>50% of the residents younger than 65 years in one jurisdiction), which does not require insurers to cover preventive treatments, such as vaccines, at no cost to patients. Leaders from 2 cities thought that these factors, taken together, might mean that a substantial number of people may lose both a provider and a payer for immunization services that they had had prior to ACA.

Potential Opportunities Afforded to LHDs by the ACA

Participants uniformly expressed a belief that ACA would be a boon to population health and would also benefit government efforts to improve public health. Respondents also identified specific potential positive impacts for public health and possible opportunities for their health departments as a result of ACA implementation (Table 1). Respondents from 12 LHDs felt that ACA provided more opportunities for prevention in public health, and respondents from a different set of 12 LHDs said that they felt that greater insurance

FIGURE ● Expected Change in Provision of Services at Big Cities Health Coalition LHDs Due to the Patient Protection and Affordable Care Act (n = 16)[a]



Abbreviation: LHDs, local health departments.

[a]For purposes of this chart, "I expect the LHD will not provide this activity" and "My LHD doesn't currently perform this activity and I expect it would not start performing it" were combined into "Not provide," "I expect the LHD to perform much less of this activity" and "I expect the LHD to perform somewhat less of this activity" were combined into "Somewhat/Much less," and "I expect the LHD to perform somewhat more of this activity" and "I expect the LHD to perform much more of this activity" were combined into "Somewhat/Much More."

coverage would benefit population health. Respondents from 10 LHDs thought that collaboration with Accountable Care Organizations held potential to improve population health, and respondents from 9 LHDs said that they thought that additional billing/reimbursement opportunities could be a revenue generator for their LHDs. Five respondents thought that it was too early to tell, because of uncertainty about how ACA would be implemented in their jurisdiction, and 2 said that they did not think that the ACA would help their LHD at all. Nine respondents spontaneously mentioned that the Public Health Prevention Fund created by the ACA could significantly enhance public health by supporting

TABLE 1 ● Illustrative Quotes From Leaders of BCHC LHDs on the Potential Opportunities to Their LHD Due to the ACA

Item	Illustrative Quotes From Key Informant Interviews
More prevention opportunities (20 respondents)	"Having presumably more preventive care delivered, you will have a healthier population in the long run and the ACA, if nothing else, is promising more preventive care. Both by people getting enrolled and by services being covered in a way that encourages preventive care. That's good, for all of us, we're all going to benefit from that."
Helps with getting greater insurance coverage (18 respondents)	"There's loads of ways that it will help our health department, right. I mean I think in our assurance role that trying to assure that our [jurisdiction's] residents have access to health services and quality services. I think it's a huge catalyst, obviously on the insurance side."
Collaborative work with ACOs (16 respondents)	"We are working with developing ACOs to try and figure out how we can integrate what do we do that can benefit them. How can we convince them that some of what we do will benefit their bottom line as well as the health of their clients? What is it they want us to do that we haven't thought of? Because we're working it from both directions."
Revenue-generator for LHD through billing (12 respondents)	"We're working hard on making our direct service areas be increasingly self-sufficient from revenue—from billing revenue. And without a doubt ACA will have a huge impact. So, for example in our sexual health clinic we'll go from—I don't remember the exact figures—but something like 15% being covered by Medicaid to ideally—and I don't know how quickly that will happen—but ideally 65% or 70% of persons coming to that clinic being covered by either Medicaid or the exchange. And surely we won't get to quite that, still, it should make a real difference in our ability to derive increasing proportions of the funds needed to run those programs from billing and the revenue from them."
Prevention fund (9 respondents)	"A lot of our policy systems and environmental change efforts that we've done here in [city], most of these efforts are paid for by the Affordable Care Act. So when I look at our smoking rate going down because of all the, you know, the changes, our policies in creating more smoke-free environments and more smoke-free campuses and all of that, we couldn't have done any of that without the Affordable Care Act, honestly."
Increased integration of health care and social services (7 respondents)	"With the bulk of places here, people who are currently uninsured are about to become insured and now hopefully being seen in a medical home by the medical care system, a real opportunity to engage our community and the health care system more in making available the wrap-around human and social services that are affecting the true social determinants of health, particularly in this population that's about to become insured."
Frees LHDs to focus more on core public health (6 respondents)	"We are a department that's very lopsided. We have a huge health care delivery side and a tiny population health side . . . So the ACA is a huge driver for our budget and as a result it ends up being a huge driver for the population health division's budget. And while there are great opportunities under health reform to get reimbursement for people that we're caring for now that we don't get reimbursement for today it also is taking away those sources of funding that support uncompensated care, federal funding that supports uncompensated care. And so I think on the one hand that puts the population health side of our budget into a little bit of jeopardy because a kind of gets dragged along with whatever happens to the health care side but on the other half of it because we are such a comprehensive department I think that the expertise that the population health folks have on health promotion and disease prevention are going to be critical for us as we try to manage the care of our patient population."
Increased public awareness of LHD (6 respondents)	"While we're not getting direct funding from the state or the federal government to enroll people, we're playing more of a leadership role and a convening role for all of the agencies that have received funding from the state and the feds to enroll people in [the city]. We have around, over 500,000 residents in [the city] who are currently uninsured and who will qualify for some type of insurance, whether it's expanded Medicaid or the marketplace. And our work with all these agencies providing the leadership, developing reports, issuing reports, being involved in the training documents and the training material, I think has been critical for our department."

Abbreviations: ACA, Patient Protection and Affordable Care Act; ACOs, Accountable Care Organizations; LHD, local health department.

population-oriented programs and services, despite it being a political target.

● Potential Challenges Due to ACA

Respondents identified 6 categories of potential challenges for LHDs created by the ACA (Table 2), the most common being decreased funding. At least 1 respondent from 12 of the LHDs thought that funding for clinical services might be reduced by policy makers who believe that the expanded health insurance coverage created by the ACA would eliminate the need for clinical services. All respondents from 3 LHDs agreed on this point. In addition, leaders

TABLE 2 ● Illustrative Quotes From Leaders of Big Cities Health Coalition Local Health Departments on the Potential Downsides to the Patient Protection and Affordable Care Act for Their Agency

Item	Illustrative Quotes From Key Informant Interviews
Less funding for clinical services (eg, screening, immunization) (19 respondents)	"There are also concerns with respect to funding for tertiary care specialty clinics that generally fall within the purview of public health—so, for example, categorical STD clinics. I think there's a perception that once everyone has a medical home that we're not going to need things like STD clinics and tuberculosis clinics because everyone will receive those services at their primary care provider. And I don't think that's actually the case because we know that at least at our clinic, a good number of patients have insurance and choose not to go to their primary care doctors. So I think that's going to be a challenge from the public health perspective to ensure that safety net services are maintained for the folks who either don't choose to use their insurance or don't have access to that insurance. And again, I'm not sure how that's all going to play out."
Will lose funding overall (13 respondents)	"The main thing that we've talked about is that the ACA does medicalize some public health issues and at the same time pull some discrete funding away from public health agencies. So immunizations might be a very good example. So there are cuts to the vaccines for children program because more dollars are being invested on the clinical side of things in terms of getting kids vaccinated. Similarly, now we have new restrictions on using federal funds for vaccinating adults for influenza in ways that weren't the case before. Also because those funds are being moved to the health care side of the ledger, I think particularly around immunization, we in [this city] and a lot of other cities have developed really good processes for getting vaccine to providers and then getting vaccine from providers to kids. So figuring out how to adapt and adjust based on these funding changes is going to be challenging, for sure."
Perceived that public health no longer needed (10 respondents)	"When you hear the word prevention, a lot of the lay public and a lot of decision makers, when they hear the word prevention think of preventive health care. And if the ACA is not—Even though the National Task Force has developed a National Prevention Strategy that includes an awful lot of population health-related stuff that public health has always done, there's this perception out there that, maybe even more than ever, that prevention equals screenings and early treatment as opposed to population-based interventions. And one of the ways ACA as it is misunderstood in some sectors is not helping us is that it's a little harder than ever, it seems like, to get across the message that public health is different than that. It is not health care."
Confusion about roles (8 respondents)	"And then I think the whole idea about a transformed health care system— what are the roles of a public health department? I don't know if this is good or bad. Maybe it's somewhere sitting on the sidelines. Do we know whether the role of the public health department, how it changes as the funding for health care changes and what—So I don't [know]—First of all we use the word public health broadly and I don't know which public health we're talking about."
Additional barriers to those seeking care (7 respondents)	"With the decision by many states not to do Medicaid expansion, and at least in some of those states, an even more visceral reaction that is leading to reducing the safety net, I think that we are inadvertently creating huge disparities even larger than have existed across the country with respect to health and access to health care."
Timing—Possibility of traditional funding being cut too fast (5 respondents)	"The cut-backs in funding from Congress make me a little despairing of how the ACA will actually help the health department. In a state where Medicaid is not likely to be expanded right away, the potential cutbacks and disproportionate share funding for hospitals without commensurate Medicaid expansion is very worrisome. We don't know yet, since we're also a state that is not doing a local exchange, what the costs are going to look like for individuals and families at various income levels. We know in general, sort of in theory. We don't have the specifics yet."

said that they thought categorical grants from the federal government may be at risk for reduction before their departments were able to find alternative sources of revenue, such as reimbursement through Medicaid. Finally, participants from 10 cities noted that they expected the budgets of health departments to be cut broadly, especially to help pay for Medicaid expansions in cash-strapped states.

Respondents from 10 LHDs were concerned that both the policy makers and the public would think that public health services were no longer necessary because of the expanded insurance coverage for all citizens provided by ACA. Respondents felt that a change in demand for public health services might be more likely if policy makers assumed that patients would prefer to see their primary care physicians or visit their medical home, rather than to turn to services traditionally provided by public health departments. Three respondents believed that their undocumented immigrant communities would still have substantial problems accessing needed health care (Table 2).

Participants also noted significant confusion about roles and responsibilities among partners in the health care community since the passage of the ACA. Several said that although the ACA might allow their departments to focus on population-oriented work, they expected that their department would be providing more clinical services, and perhaps new services such as behavioral health treatment. These respondents pointed to continuing needs for these kinds of services in their communities as ones that might not be addressed by the ACA. They also noted that reimbursement for clinical services could be a revenue driver for health departments.

Collaborations Between Public Health and Primary Care Under ACA

Participants also noted that implementation of the ACA might significantly increase opportunities for collaboration between public health departments and health care providers, especially primary care providers. Although the majority of leaders in this study said that their offices were already connected with the primary care community in their area to some degree, the degree of communication often varied. Participants discussed both challenges and opportunities (summarized in Table 3) associated with more collaboration between the 2 fields, including greater integration of preventive care into primary care (14 respondents), increased data sharing between primary care and public health (11 respondents), and decreased morbidity and mortality due to an increasing focus on prevention (8 respondents).

Several respondents also noted that more collaboration could lead to business models that could support ongoing partnerships between public health and primary care professionals. As one respondent stated:

> If we each do our jobs well, our jobs will both be easier. So if our primary care provider partners are truly promoting healthy eating, smoking cessation, exercise, all of those good qualities of living well, I think we'll see the health of the public improve dramatically. And I think if we as a public health force are really doing our jobs well, we will be here to support our primary care providers more, not only through clinical guidelines but also by implementing systematic changes [and] environmental changes that will promote health and make it easier for our primary care providers to care for their patients.

Respondents also discussed community health needs assessments (CHNAs), and most said that they felt that CHNAs present an opportunity for increased collaboration between public health departments and health care providers. According to new IRS regulations, nonprofit hospitals and health care systems must connect with public health experts during their CHNA as part of community benefit requirements. Leaders from 15 of the 16 BCHC LHDs in the study said that they were already developing CHNAs with local nonprofit hospitals/systems. In these collaborations, BCHC LHDs were providing hospitals with analyses of health data from a variety of sources: 12 were providing hospitals with analysis of local data, 6 were providing analysis of state data, 4 were providing analysis of hospital-generated data, and 3 were providing analysis of national data. Eight of the 16 also said that they were working with hospitals or health care systems in the health improvement planning associated with CHNAs. Although the exact roles of the health department and hospitals in the CHNA vary from community to community, participants in our study indicated that their LHDs are playing a central role in data analysis and policy design and are working with otherwise-competing health systems to engage their community overall, beyond their catchment areas. As one respondent said,

> [Hospitals] are all required to do these needs assessments that public health agencies have been doing since the beginning of time. And none of them want to be told what to do, but I think as they rethink their charity care, there's a tremendous opportunity for prevention. And one of the things I'm working on now is trying to frame the findings of their individual needs assessments so we can present it to them and show them the significant consensus that they have—the overlap in their service areas—and then also give them guidance on what's known to work as interventions.

TABLE 3 A Summary of Participant Perspectives on the Opportunities and Challenges Relating to Closer Connections Between Public Health and Primary Care as Identified by Big Cities Health Coalition Members

Opportunities	Challenges
Integration of prevention care into primary care	Different priorities (eg, perception of money-driven versus population health-driven)
Data sharing	Different cultures and/or different language
Decreasing morbidity/mortality as a result of prevention	Lack of money for integration efforts
Creating joint community programs	Financial competition with potential partners
Increasing efficiency, reducing duplication of services	Lack of awareness of public health role
Increasing awareness of public health agencies	Different visions of what has to be achieved

Participants identified differences in communications and priorities as significant challenges to this type of collaboration. They felt, for example, that primary care and public health professionals "spoke" different languages, that the 2 groups had different priorities, and that there was a lack of awareness and knowledge about each other's professions and values. In addition, a perceived lack of interest on the part of primary care was troubling to several of the leaders participating in the interview, as illustrated below.

> You know, we've tried a lot. We've met with all the pioneer ACOs. We've got a bunch of proposals on the table. We've submitted some joint grants with some of the community health centers. But I would say nothing's really happening yet. So we're trying to identify where there might be opportunities for a common agenda and common work, but it's not like everybody is beating down our doors saying, 'Oh, we want to partner with you guys!'

Discussion

The participants in our study, all leaders of large, urban LHDs, said that they were optimistic that the ACA would result in a net benefit both for governmental public health and population health. They believed that expanded health insurance coverage would somewhat alleviate stress on the existing safety net services by providing access to care by other health care providers. They also felt that ACA would help public health departments strengthen their roles as analysts of health information, better regulate factors that impact public health, and more effectively serve as conveners of collaborations that can promote healthy behaviors in communities.

The ACA has profound implications for how governmental public health entities are able to provide services to improve population health. Leaders of public health departments now must make critical choices about what roles they plan to play in the ACA environment. In our study, most respondents said that they plan to provide more population-oriented services. However, most were not clear about the clinical care services they would provide, although they were planning to decrease or discontinue some types of clinical care services, acknowledging that this action may result in reduced revenue used to support other core public health programs. Participants suggested that the variation in the number and kind of clinical services that LHDs may provide is driven both by the services now offered and by local political contexts.

The ACA is largely clinically oriented, and public health was not a primary focus of the legislation. It is, therefore, not surprising that leaders of large, urban health departments are unclear about what clinical services they can and should continue to provide. On the one hand, decreasing clinical care services may lead to a greater focus on population health by their departments; on the other hand, decreasing clinical services may also jeopardize the health of populations that will not be covered by health care insurance, even with the ACA in place. In addition, some participants also acknowledged that if they expand clinical services or seek reimbursements from insurance providers, they may be seen as competitors to local private or other public providers, particularly for patients who were previously uninsured. This shift from a public service to a competitive provider of care may have political implications in some jurisdictions. Beyond the business incentive to provide more clinical services, LHDs planning to increase some of their current direct service offerings or to offer new services (such as behavioral health care) say that they are doing so primarily in response to a priority need in their communities. Addressing persistent need is further complicated for large, urban health departments that often provide services to undocumented immigrants, who will not be covered under the ACA or Medicaid expansion.

Providing clinical care has been a challenge for public health, especially in LHDs, for more than 20 years,[14,20-24] and our study supports the fact that these challenges are ongoing. Large LHDs, such as those in the BCHC, tend to provide more clinical services than do those in midsized jurisdictions; the majority of LHDs are discontinuing or planning to discontinue certain types of clinical care—but not uniformly.[25,26] In addition, leaders in this study have noted significant opportunity for public health to define its role as a convener, information broker, and analyst in their communities, a sentiment supported by with other research in this area.[3,12,13,27]

The results of our study also underscore the concern among leaders of large, urban health departments that the ACA could have negative consequences for their jurisdictions. Budget cuts to the federal agencies that provide categorical grant awards may occur as a result of a perception that covered programs and services are no longer needed because of the ACA. If LHDs cannot depend on revenue from clinical services or on funds from local, state, or other federal sources, their ability to fulfill their mission may be compromised. For instance, concern around vaccine shortages or lack of providers in the wake of ACA and new regulation has started to play out in some jurisdictions.[28]

Limitations

This project had several limitations. First, this was a cross-sectional assessment of a subset of the nation's

largest LHDs. Generalizability of the results to all LHDs is, therefore, limited, as the experience and capacity of larger health departments is often quite different from those of medium-sized, small, or rural health departments.[4,29] As such, these results should be interpreted only in the context of large, urban health departments. In addition, our results are based on subjective self-reports of participants.

Conclusion

The ACA has helped many public health departments to establish themselves as expert analysts of community data, influencers of policy change, facilitators of community collaboratives, and providers of evidence-based strategies for improving health in communities. Local health departments across the country continue to assess the clinical and population-level needs in their communities and to make important strategic decisions about their evolving role. Leaders see the possibility that the ACA could lead to decreases in or elimination of historically stable grant funding.[30] Despite these challenges, however, leaders recognized that the ACA is creating new opportunities to expand their focus on population health and increasing collaborations between public health and health care.

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