The Affordable Care Act & Racial and Ethnic Health Equity Series

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Public Health and Prevention Programs for Advancing Health Equity

Executive Summary

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Executive Summary

I. Introduction

The United States spends more on health care than any other industrialized nation, yet this greater spending does not translate to better health or life expectancy. In 2009, the U.S. spent more than twice the average of industrialized countries on health care, yet the U.S. ranked 27th among 34 industrialized nations in terms of life expectancy. Health care spending in the U.S. is also steadily growing as a percentage of the economy and estimates affirm that this growth is "largely attributable to preventable conditions…More than 85 cents of every dollar spent on health in the U.S. are spent on the treatment and management of chronic diseases, such as those caused by preventable conditions related to obesity and tobacco use." Only 3% of the nation's health care dollars is spent on disease prevention.

Compounding these trends are health disparities—which also contribute to unnecessary and preventable medical expenditures. According to the Agency for Healthcare Research and Quality's most recent report on disparities, while quality is improving, access and disparities are not. Healthy People 2010, a comprehensive framework developed by the U.S. Department of Health and Human Services, included two overarching goals, one of which was to eliminate health disparities. However, in an assessment of its progress toward achieving this goal published in 2010, it was found that there is much work still to be done. In fact, a significantly larger number of health indicators showed an increase in disparity rather than a decrease in disparity.

The enactment of the Affordable Care Act (ACA) in 2010 offered a unique opportunity to create a more equitable, high quality health care system focused on prevention, with its commitment to establishing the Prevention and Public Health Fund and numerous other programs on community health and prevention. The purpose of this report is to provide a point-in-time status on the implementation of the ACA's 11 key provisions for advancing racial and ethnic health equity in public health and prevention. In particular, the report describes opportunities presented by the new law for bridging longstanding disparities in health and health care through prevention and public health, offering details on emerging programs, best practices, and resources. Challenges, barriers, and important priorities moving forward are also discussed to assure that equity remains core and central to any prevention and public health strategy.

II. Methodology

We utilized a multi-pronged, qualitative design to monitor and assess the implementation progress, opportunities, and challenges of the ACA's 11 public health and prevention provisions with explicit mention of or major implications for racially and ethnically diverse communities. These provisions were categorized into three priority areas and organized as follows:

1. **Public Health Initiatives for Children and Adolescents**
   - Maternal, infant, and early childhood home visiting programs (§2951)
   - Personal Responsibility Education (§2953)
   - Funding for Childhood Obesity Demonstration Project (§4306)

2. **Community Health and Prevention**
    - National Prevention, Health Promotion and Public Health Council (§4001)
    - Prevention and Public Health Fund (§4002)
    - Clinical and Community Preventive Services (§4003)
    - Community Transformation Grants (§4201)

3. **Chronic Disease Programs Targeting Diverse Populations**
    - Oral healthcare prevention activities (§4102)
    - Indian health care improvement (§10221)
    - Young women's breast health awareness and support of young women diagnosed with breast cancer (§10413)
    - National Diabetes Prevention Program (§10501)

For each topic area, we reviewed: peer-reviewed literature and national reports; emerging federal rules, regulations, and funding opportunities; state models and innovations; and community and local programs and policies. Findings on progress, opportunities, and challenges identified through our review were synthesized with information and perspectives obtained through a series of key informant interviews with numerous thought leaders, experts, and community advocates in the field.

III. Implementation Progress

This section describes the implementation progress, opportunities, challenges, and road ahead for 11 provisions in the ACA critical to advancing racial and ethnic health equity in public health and prevention. These provisions are discussed in context of the aforementioned three topic areas.

A. Public Health Initiatives for Children and Adolescents

Children from diverse racial and ethnic heritage experience persistent and pervasive disparities across multiple health and health care measures when compared to their White counterparts. Comprehensive policy reforms proposed to ameliorate the excess burden of poor health among diverse children have gone beyond ensuring health insurance coverage to advocating for services such as: health and nutrition counseling for pregnant women and infants; home visiting for at-risk families; and multi-sector strategies that promote behavior change at the individual, institutional, and community levels. At least three key provisions in the ACA intend to improve health outcomes for racially and ethnically diverse children and adolescents. This section provides a review and update on implementation progress of these provisions:

Maternal, infant, and early childhood home visiting programs. Section 2951 of the ACA intends to strengthen maternal, infant, and early childhood home visiting programs, support service coordination for at-risk populations, and improve outcomes for families through the provision of comprehensive services. Grants are authorized for states to deliver maternal, infant, and early childhood home visiting programs with the goals of reducing child abuse, neglect and injuries, and improving health outcomes such as infant health, child development as well as improving parenting skills and school readiness. The Health Resources and Services Administration (HRSA) awarded funding in FY 2010 to FY 2013 for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. All programs are targeted to vulnerable and at-risk

families and in addition several programs plan to explicitly tailor services to improve outcomes among diverse racial and ethnic groups or individuals with cultural or linguistic differences.

Political challenges have confronted states as they seek to implement MIECHV programs under the ACA. For example, Florida stood to receive $31.3 million over five years in total grant funding for MIECHV. However, action was thwarted by the state's legislature, which eventually rejected the funding due to general opposition to the ACA. Next steps for advancing minority health status in MIECHV programs are to ensure that approved evidence-based home visiting programs include cultural competency components. It is also important to ensure that race/ethnicity data are collected whenever possible to assure reporting explicitly integrated measures assessing impact for diverse populations.

Personal Responsibility Education. Section 2953 of the ACA authorizes an adolescent Personal Responsibility Education Program (PREP) offering support for abstinence and contraception learning initiatives to prevent pregnancy and sexually-transmitted diseases. The program is required to incorporate culturally-appropriate information into program activities, with $75 million allocated for each of the years FY 2010 to FY 2013 to 46 states. Based on a review of brief program descriptions, all grantees describe goals around reducing rates of teen pregnancy, HIV, and STIs among at-risk groups. Several program descriptions (29) mention their intent to target racially and ethnically diverse teens. However, the abstinence-only programs, as described in the law, do not require specific tailoring for diverse youth which may limit their focus and effectiveness among youth from diverse racial, ethnic, and socioeconomic backgrounds.

Childhood Obesity Demonstration Projects. Section 4306 of the ACA amends the Social Security Act by appropriating $25 million for grants to conduct childhood obesity demonstration projects in FY 2010 to FY 2014. On September 29, 2011, CDC announced the three grantees that received funding to establish a Childhood Obesity Demonstration Project. A fourth grantee received funds to evaluate the interventions and share best practices and successes. All three of the funded entities with demonstration projects to reduce childhood obesity target racially and ethnically diverse and/or low-income children. Results of the demonstration projects, to be released in 2015, will inform federal, state, and local policy, and are expected to provide important next steps for curbing the childhood obesity epidemic among underserved children. However, future legislation will be required to continue and expand on this initiative, leaving uncertain broader intervention reach.

B. Community Health and Prevention Initiatives

Racially and ethnically diverse populations have much to gain from the newly established priorities put forth by the ACA to address the underlying social and physical determinants of health within communities. Social determinants of health such as education level, socioeconomic status, and neighborhood often differ by race and ethnicity. In fact, there is an established link between low socioeconomic status and racial and ethnic disparities in health, with diverse individuals from low-income backgrounds suffering from higher rates of chronic diseases such as obesity and diabetes as well as other conditions. Addressing the current disparities in such determinants through novel national policies and community-level interventions is an important step to achieving true health equity, and the ACA has woven this concept into several of its provisions.

National Prevention, Health Promotion, and Public Health Council. Section 4001 authorizes the establishment of the National Prevention, Health Promotion and Public Health Council, a federal interagency group established by the President. The Council is charged with: coordinating federal efforts in health promotion, prevention, and wellness; developing a national prevention strategy; and making recommendations to the President and Congress regarding federal health priorities. In June 2011, the National Prevention Council, comprised of 17 federal agencies and headed by the U.S. Surgeon General, released the *National Prevention Strategy*. The Strategy emphasizes that optimal health should come not only from the medical care received in hospitals and clinics, but should also be addressed through improvements in clean air and water, nutritious foods, and safe recreation areas, homes, and work places.

The *National Prevention Strategy* outlines five recommendations to achieve the strategic direction of eliminating health disparities: ensure a strategic focus on communities at greatest risk; reduce disparities in access; increase capacity to identify and address health disparities; support research to identify effective strategies to eliminate health disparities; and standardize and collect data to better identify health disparities. In June 2012, The National Prevention Council released its Action Plan enumerating goals around the outlined strategy. However, sustainability remains a major concern due to continued financial constraints, as do efforts to encourage collaboration between multiple federal agencies.

Prevention and Public Health Fund. Section 4002 of the ACA authorizes the HHS Secretary to transfer funds, beginning in FY 2010, to HHS programs for prevention, wellness, and public health activities intended to both improve health and control health care costs. The first year of funding was primarily spent on infrastructure and workforce (69%), mainly for primary care workforce development. In FY 2011 and FY 2012 most financial assistance was dedicated to community prevention (40%), which includes Community Transformation Grants, Racial and Ethnic Approaches to Community Health (REACH), and tobacco prevention. In FY 2013 funding was reduced across all categories, representing "significant reductions to critical programs and services aimed at community prevention, immunization, substance abuse and mental health and health equity." However, the Fund's support was reduced by $6.25 billion from the original amount over nine years beginning in FY 2013—a decline that the 2013 sequestration increased by $51 million. And in April 2013, $453.8 million was used to supplement insurance enrollment activities for the ACA's Health Insurance Marketplaces. These financial reductions and diversions call into question whether the Public Health and Prevention Fund will be able to achieve its goal of significantly reducing rates of chronic disease and controlling health care costs.

Community Transformation Grants. Section 4201 of the ACA authorizes the HHS Secretary to award grants to state and local government agencies as well as community-based organizations to reduce rates of chronic disease and address health disparities through community-level prevention programs. Activities under the grants are intended to focus primarily on several community improvement strategies including: ensuring healthier school environments; building infrastructure to promote active living and improve safe food access; encouraging healthy food options at restaurants; and implementing strategies to improve determinants of health underlying racial and ethnic disparities. In 2011, CDC awarded $103 million for 35 implementation grants and 26 capacity-building grants. In addition, $4 million were awarded to six networks of community-based organizations. During FY 2012 $70 million was awarded to 40 communities with fewer than 500,000 people. Approximately two-thirds of current grantees address populations experiencing health disparities. However, as with a number of other ACA provisions budget constraints have

led to reductions that may thwart fuller realization of intended goals: the FY 2013 budget allocated $80 million less than the President requested in 2012.

Clinical and Community Preventive Services Task Force. Section 4003 of the ACA amends the Public Health Service Act to clarify the role of two previously established prevention task forces. AHRQ's Preventive Services Task Force is authorized to review research and evidence for clinical preventive services, including effectiveness, appropriateness, and cost-efficiency. The Task Force is charged with developing new recommendations based on this review as well as updating previous preventive recommendations for the health care community, with findings to be published and disseminated through the Guide to Clinical Preventive Services. The Task Force also evaluates programs for how well they apply to racially, ethnically, and socioeconomically diverse populations. The Task Force's first and second reports to Congress highlight ways in which communities are implementing its recommendations, provide updated recommendations and findings, and reveal current research gaps and future priorities including those related to advancing health equity. The Community Preventive Services Task Force now includes addressing health disparities through evidence-based research among its priorities. However, its 2011 progress report did not include any systematic reviews related to health equity and since the publication of that report the group has only performed one systematic health equity-related review.

C. Chronic Disease Programs for Diverse Populations

Preventable chronic conditions and, rates of chronic disease are among the major health challenges facing the nation—a concern and priority reflected throughout many ACA provisions. As such, the ACA has established a number of national campaigns targeting costly and preventable health conditions. And, as this focus is of critical importance for racially and ethnically diverse populations who suffer disproportionately from these diseases, the ACA has included explicit language to tailor programs and initiatives in diabetes, cancer, and oral health disease for these populations.

National Diabetes Prevention Program. Section 10501 of the ACA establishes a national diabetes prevention program for high-risk adults. The provision is designed to disburse grants to model sites for community-based diabetes prevention and includes support for training and outreach for intervention instructors as well as monitoring and evaluation conducted. On October 9, 2012, the CDC awarded $6.75 million to six organizations to expand the National Diabetes Prevention Program. Grantees are expected to work with both employers and public and private health insurance companies to coordinate performance-based reimbursement to organizations implementing these programs. Of the six grantees at least five have incorporated strategies to target racially and ethnically diverse individuals at higher risk for diabetes through recruitment initiatives, culturally competent program goals, or as part of the organization's vision. However, while authorized in FY 2010 and FY 2011, appropriations were not forthcoming until FY 2012, with future funding uncertain.

Breast Cancer Education Campaign. The Education and Awareness Requires Learning Young (EARLY) Act was passed as part of the ACA as section 10413. It provides funding through the CDC for a breast cancer education campaign for young women, under age 40, to improve knowledge of: breast health among women of all racial, ethnic, and cultural backgrounds; risk factors for breast cancer such as familial, racial, ethnic, and cultural background; and evidence-based early detection strategies, among others. As part of this provision, the CDC established the Advisory

Committee on Breast Cancer in Young Women to guide the CDC in its development of policies and programs related to breast cancer awareness among young women. As part of this provision, the CDC has supported seven organizations targeting young women diagnosed with breast cancer, with two programs specifically addressing racially and ethnically diverse populations. Notwithstanding progress in implementation, concerns have arisen around the efficacy and appropriateness of such a campaign and best strategies around prevention of breast cancer among young women. Most notably, some leading cancer researchers have voiced concerns about the appropriateness of a widespread campaign, especially as breast cancer occurrence among women younger than 40 years is relatively rare.

Support for Prevention Programs for American Indians and Alaska Natives. Section 10221 of the ACA makes the reauthorization of the Indian Healthcare Improvement Act permanent as well as authorizes new programs within the Indian Health Service (IHS) to increase the types of services available for American Indians and Alaska Natives. These efforts are intended to reduce preventable illnesses, with an emphasis on diabetes, substance abuse, and suicide. The changes made by the ACA include improvements in the health care delivery system under IHS. For example, the law now authorizes hospice, long-term, and home-based care and authorizes the training of more American Indian and Alaska Native health care providers through the Community Health Representative program. However, progress has been slow especially with little to no appropriations for many programs.

National Oral Health Campaign. Section 4102 of ACA authorizes a five-year public education campaign targeting prevention and education in oral health through the CDC. The campaign stresses the importance of reaching certain vulnerable populations such as children, pregnant women, the elderly, and racial and ethnic minorities, and includes language specifying that services be provided in a culturally and linguistically appropriate manner. Grants to all 50 states for school-based dental sealant programs and improved data collection for oral health activities have been authorized by the ACA, but not funded. The CDC is using current funding to implement these activities among 19 states; however, without new appropriations CDC has been unable to fund additional states. Additionally, the five-year national oral health education campaign with a focus on health disparities authorized under the law, has not received any appropriations to date. While the CDC Division of Oral Health continues to support infrastructure for oral health activities with its current budget, without funding for expansion of activities authorized under the ACA or complementary public education campaigns and disease management initiatives, it will be difficult to achieve the broad results in reducing gaps in oral health care experienced by vulnerable communities.

IV. Public Health and Prevention: Emerging Opportunities and Challenges for Advancing Equity

Our review has found that public health and prevention provisions have stressed evidence-based models and outcomes, cross-sector collaboration, and assisting community-based organizations, with several provisions specifically including health equity among their priorities. Support for such initiatives occurs by authorizing dollars to extend programs already in existence, allowing them to expand in their efforts to reach diverse and vulnerable populations. At the same time, the ACA authorizes and funds several novel programs focusing on disease priorities and diverse

populations. However, effective implementation is contingent upon appropriations and sustainable funding.

The ACA opened new doors for advancing public health and prevention, particularly to address the underlying social, economic, and physical factors which affect how diverse individuals and families access health care, the quality of care they obtain, and health status and healthy living. However, the path to realizing these opportunities has been challenging. In this context, at least three key dynamics with implications for public health, prevention, and health equity have emerged following the advent of health care reform.

Continued challenges to funding public health and prevention. The provisions under review present with varying levels of funding concerns and challenges. Some programs, such as the National Diabetes Prevention Program and the Indian Healthcare Improvement Act, were extensions of existing efforts and will continue with or without the additional support provided by the ACA, although they may not live up to their full potential due to the limited or partial funding appropriated. Other provisions have received mandatory funding, have not been subjected to funding cuts, and are well on their way to achieving stated goals. These initiatives include the maternal and child home visiting program and grants for personal responsibility education. One provision, the oral health prevention campaign, however, has made no progress to date as no funds have been appropriated. The Prevention and Public Health Fund was intended to provide more continuous financial support to public health initiatives as, in the past, federal funding was provided by category, and this new fund was intended to move away from that approach. However, questions remain as to whether the fund will fulfill its purpose. While new funding streams are a promising start to improving population health and eliminating health disparities, it appears that budget deficits, cuts to the Prevention and Public Health Fund, and sequestration continue to challenge public health programs funded through the ACA. As local and state departments that have received ACA funding struggle to fulfill their general required duties and objectives, priorities in health disparities may remain on the sidelines.

Need for more evidence-based outcomes related to public health interventions. Data collection and evaluation have presented long-standing challenges in efforts to document effectiveness of population health programs, especially those related to health disparities. Frequently, public health departments and other organizations involved in public health interventions use different tools and measures to collect data and report progress. Many public health programs have had difficulty, for example, correlating investment with a decline in tobacco use. Instead, public health practitioners are more likely to track progress of process measures such as awareness of messaging and characteristics of persons reached. Furthermore, sharing and disseminating lessons learned and evidence-based practices resulting from state-based initiatives has historically been handicapped due to the lack of a centralized system or process to collate information, results and data. In addition, limited timeframes to demonstrate improvement for broad health outcomes for diabetes, obesity or other conditions often prove challenging. This theme of varying measures and outcomes also stood out in our analysis of the law's public health and prevention provisions. The evaluation and efficacy of such programs should be consistent across programs, including measuring improvement in health disparities. The ACA's enhancement of the Community Preventive Services Task Force presents as a potential avenue to moving toward an enhanced and more standardized assessment of community health interventions, including those that will benefit diverse populations.

Enhanced emphasis on partnership development and community-based prevention. The fusion of a "health in all policies" approach and an increased focus on prevention at the community level holds much promise for significant progress toward health disparities. However, many key informants have reported that public health practitioners frequently "work in silos" hindering the scope and breadth of their work. Previously, federal funding for public health has not typically emphasized collaboration and was often provided through rigid categories. Provisions within the ACA aim to increase the importance of establishing partnerships across public health, communities, and other sectors, as well as promoting flexibility in targeting goals for improved health. Challenges for new partnerships in public health include the difficulty in measuring and assessing the health impact of non-health policies. For non-health agencies, collecting baseline data and projecting impacts of a policy on health are both notably challenging tasks, especially in terms of training and supporting staff to conduct such activities. The successful implementation of a "health in all policies" approach will help to reduce the fragmentation of funding for different programs and break down the "silo effect" among different agencies to promote health and equity. When results are integrated across sectors and partnerships are formed to acknowledge the connection between health and other non-health policies, it will minimize the perceived effect of separate programs churning out stand-alone results. As new policies promoting eliminating health disparities are being implemented, the expected challenges such as bureaucratic barriers and battles for territory have emerged, but it is perhaps the more unforeseen challenges that have gained attention and presented the most severe threat to the ACA's successful implementation. A mixture of financial pressures, political opposition and rising rates of chronic disease stand as road blocks to ensuring these policies and programs move forward quickly and effectively.

V. Moving Forward: Strengthening Public Health & Prevention to Advance Health Equity

Investment in public health and prevention, particularly in the context of addressing the overarching determinants of health, are core to advancing and achieving health equity. As noted, despite the ACA's intent and support, the full realization of the law's public health and prevention objectives have generally been stalled by a combination of factors from political opposition to federal budget cuts including sequestration, and declining state and local budgets. The Prevention and Public Health Fund, in particular, has felt the brunt, serving more as a "safety-net" fund to support and sustain existing workforce and public health programs rather than being used to invest in new and novel public health and prevention initiatives. Still, the Fund did establish the Community Transformation Grant program, among others, which is intended to support community-level initiatives targeting the social, economic, and physical determinants of health. Our review of the ACA's related provisions has identified at least four priorities that may assist in elevating its prominence and assuring that equity is core and central to any public health and prevention strategy:

Leveraging ACA's Health Care Delivery Investments to Support Public Health & Prevention and Reduce Disparities. Public health and prevention are integral to many dimensions of equity embedded in the ACA. As such, the Act includes numerous other equity opportunities that can feature, integrate, and otherwise address public health and prevention related priorities. Outcomes of integrating these goals and strategies may add both value to the provision intent and help expand recognition of their importance in addressing patient and population health. There are at least three examples among ACA's many relevant provisions

where public health and prevention can both benefit from and enhance program objectives around equity: Community Health Needs Assessments (CHNAs); medical homes; and initiatives supported through the CMS Innovation Center. The ACA's requirement for all nonprofit hospitals to conduct a CHNA to maintain their tax-exempt status offers a unique opportunity to integrate assessment indicators related to prevention, community health, and equity as well as build and foster unique collaborations for system-wide interventions. Medical homes, or partnerships between the patient, family and primary care provider in collaboration with other specialty areas, are also supported in the ACA, and offer an avenue for advancing equity and prevention. Many of these programs integrate cultural and linguistic competence into care service, prevention, and health promotion. The CMS Innovation center offers additional opportunities for aligning prevention-focused activities with the objective of advancing equity.

Encourage the Explicit Recognition and Integration of Health Equity Where Absent in Public Health and Prevention Provisions of the ACA. Health equity, disparities reduction, and cultural and linguistic priorities are clearly cited as priorities among a number of the ACA's public health or prevention related programs. For example the personal responsibility education grants identify the need for providing culturally appropriate education. However, the majority of provisions do not explicitly mention or cite the need to address racially and ethnically diverse communities. For example, grants for the childhood obesity demonstration projects, diabetes prevention and the maternal and child home visiting programs describe the need to target "at risk" communities and individuals but do not state a focus on diversity or the need for culturally appropriate services. For these and other provisions, specifically recognizing the role and importance of addressing health equity will elevate its importance and likely encourage initiatives that address the needs of diverse patients and communities. Should opportunity be available at the policy level, equity language should be included in federal rules, regulations, and guidance, funding announcements, or charter for related taskforces and committees. At the programmatic level, explicitly integrating racial and ethnic health equity priorities into public health and prevention may involve one or more of many concerted actions, such as infusing equity into program goals and objectives, addressing workforce diversity, and assuring culturally and linguistically appropriate outreach and education, among others.

Develop Incentives to Encourage Cross-Sector Collaboration. Addressing the social and economic dynamics that influence and determine health should be considered a core aim in eliminating health inequalities. Multiple sectors, including public health, the community, social service organizations, and the health care delivery system should develop flexible roles and responsibilities and integrate services and goals for improved population health. Comprehensively assessing health effects of non-health policies such as zoning regulations, housing permits, transportation and business initiatives is likely to be a central task. Public health expertise and experience can assist by providing, tracking and analyzing data to demonstrate progress toward strategic goals. Related incentives, in the form of new payment models and structures and a shared financial target, will motivate different sectors "to engage in the difficult work of building effective partnerships based on shared goals, information systems, innovations in the use of human resources, and cross-sector leadership." And while the shared goal of improved population health alone is an important priority, successful cross-sector collaboration can also include opportunity for participating agencies to elevate their own status and influence.

Incorporate Enhanced CLAS Standards into Public Health and Prevention Initiatives. The release of the enhanced National Standards on Culturally and Linguistically Appropriate Services (CLAS) in 2013 comes at a pivotal point in efforts to redress longstanding disparities and advance health equity. Building on the original standards issued in 2000, its expanded scope spans a broad range of activities central to enhancing prevention efforts and promoting public health, including: improving quality and safety; engaging communities; meeting standards and accreditation requirements; and justifying the business case through a set of identified actions ranging from governance, leadership, and workforce to communication, language assistance, and engagement as well as continuous improvement and accountability. The CLAS standards are intended to serve as a set of guiding principles for health care organizations serving diverse populations. At the same time, specific standards may have special relevance for public health and prevention, including the six focused on: responsiveness to cultural and language needs; use of trained personnel in interpretation and employing a variety of strategies in communication; actively engaging communities; developing and using relevant, valid data; and conducting as well as acting on findings from health assessments.

VI. Conclusion

The Affordable Care Act holds considerable promise for elevating the importance and, in turn, the contribution of public health and prevention to improving the nation's health. Moreover, many of the provisions discussed in this report directly or implicitly reflect the law's intent to advance health equity as part of the public health and prevention agenda. At the same time, given the goal of reaching and insuring new populations and supporting innovative programs aimed at addressing the needs of vulnerable individuals, this era of health care reform offers the chance to broaden knowledge and understanding around the role and value of public health and prevention in improving the nation's health. In particular, the intended initiatives offer new if not unique opportunities to improve the health of diverse and other vulnerable children and adults, including those with chronic conditions, while opening doors for engaging communities and forming partnerships with other service sectors.

Notwithstanding the intent of the law and its public health and prevention provisions, much remains uncertain. Shortfalls in appropriations, state budget restrictions, the lack of a stronger efficacy evidence base and historically low priority given to these programs threaten significant progress. Other current uncertainties around the rollout of the ACA's marketplaces and ultimate acceptance of the law's vision and principles may have a spillover effect that may inhibit fuller realization of public health and prevention goals. Nonetheless, the ACA has created the occasion for breaking new ground in advancing public health priorities. Time and intent will determine whether the hoped for goals are achievable.