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"For Many Years, Americans Have Been Dying at Younger Ages than People in Almost All Other High-Income Countries"

—This astounding statement is from the National Academies recent report.

An Editorial by Bob McEvoy, Managing Editor

The above National Academies statement, prepared by a panel of experts from the National Research Council and the Institute of Medicine, went on to say: "This disadvantage has been getting worse for three decades, especially among women. Not only are their lives shorter, but Americans also have a longstanding pattern of poorer health that is strikingly consistent and pervasive over the life course—at birth, during childhood and adolescence, for young and middle-aged adults, and for older adults."

Another distinguished researcher, Dr. Atul Gawande, Harvard Medical School scholar, practicing surgeon, and award-winning *New Yorker* magazine author has said that "We are in the deepest crisis of medicine's existence." He has also indicated that "Our medical systems are broken."

The recent report of the Trust for America's Health, "A Healthier America 2013: Strategies to Move from Sick Care to Health Care in the Next Four Years," verifies the poor outcomes identified by the National Academies report and Atul Gawande's call to action. The telling description below, from the Trust, is similarly astounding:

- Chronic diseases, such as type 2 diabetes and heart disease, are responsible for seven out of 10 deaths, 75% of the 2.5 trillion spent on U.S. medical care costs and billions of dollars in lost productivity each year.
- Infectious diseases, from the antibiotic-resistant Superbugs to Salmonella to the seasonal flu, disrupt lives and communities and result in more than $120 billion in direct costs and enormous indirect costs.

There are scholars and researchers working on the critical problems identified above. We have the great fortune to introduce to you an example of outstanding scholarship, which well characterizes American resilience rising to engage the profound difficulties of an evolving health care sector. International scholar and health services expert, Dr. Paul Sorum, has enlightened us in this Journal when we began our health care series, and now we bring you the work of three leading innovators who are enhancing our opportunities and abilities to move strongly forward. Their wisdom is presented for you as follows. ■

County Officials Embark on New, Collective Endeavors to ReThink Their Local Health Systems

by Bobby Milstein, Director, ReThink Health; Gary Hirsch, Modeler, ReThink Health Dynamics; and Karen Minyard, Director, Georgia Health Policy Center

A County Focus for Health System Reform

Good health and high-value health care are essential to the well-being and prosperity in every county. However, the U.S. health system is notorious for its costly, inequitable, and disappointing performance. As a result, health system reform is becoming a top priority for county officials as well as for scores of other regional stakeholders. Local action is so vital, in part, because the stakes are so high.

- Most counties deliver public health and health care services through their health departments, clinics, and hospitals, often amounting to a large portion of county spending. In addition, other county services such as public safety, transportation, housing, parks and recreation, arts, elder care, social services, and education have significant effects on people's health, their demand for care, and ultimately the cost of care.

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PRESIDENT'S CORNER

by Peter Crichton, County Administrator, Cumberland County, Maine

As we move through this year of challenges and opportunities, I have been thinking a great deal about the challenges that managers face. If there is one thing that we as managers are certain about, it is that there will be difficulties in the work we do that will supremely challenge all of our skills to the very core of our abilities. Fortunately, we seem to either have the innate ability or have learned through the school of hard knocks that the best way to be good managers and leaders is to see opportunities where others may just see problems or challenges!

I am a frequent reader of ICMA's *PM* magazine, and an article that appeared several months ago captured my attention and imagination. It focused on the future of local government management and what skills are likely to be most important. I remember thinking what an impressive group of managers ICMA has assembled! The theme that echoed throughout was that future managers, more than ever, will need to be master facilitators who can work in highly effective ways both inside and outside their organizations.

I have thought about this article many times since then. What an interesting profession we have all chosen! Just stop to think about the broad array of skills, knowledge, and abilities that we need to bring to our jobs. For me this is a huge motivation for why I want to see NACA be as successful as it can possibly be, together with ICMA and NACo.

The leadership of NACA, including your officers, directors, committee chairs, and past presidents, understands very well the challenges that we face today as managers, administrators, assistant managers, and assistant administrators. The leaders of NACA are working with ICMA and NACo to strengthen our association, find more ways to encourage professional excellence, and to improve the management of county governments.

At our recent meetings in Washington, D.C., during NACo's Legislative Conference, NACA board members met with the leadership of both ICMA and NACo at their respective headquarters. We approved a new and substantive affiliation agreement with ICMA to be complemented by an annual work plan. The support relationship ICMA has offered since 1999 will continue. In our dialogue with NACo, we agreed to develop NACA-sponsored educational sessions at NACo's 2013 annual conference in Tarrant County/Fort Worth, Texas. More details will be shared soon.

If you are not actively participating in NACA at this time, I encourage you to become involved. You don't have to get involved up to your neck as the expression goes, but it would be great if more people would step up and get involved. We have committees to engage your time and talent to help us become more effective promoters of our profession. For more information on NACA, take a few moments to visit the NACA website at: http://countyadministrators.org/.

There are many ways that you can make a difference. We have nearly 500 managers and administrators who belong to the association. Just imagine what we could accomplish together if we decided to take on an initiative! It's a tremendous way to give something back to the profession and to get to know your peers from every part of the nation. Feel free to share your thoughts about the work we are doing. Write me at crichton@cumberlandcounty.org or call 207–871–8380. I would also like to take this opportunity to express our sincere thanks to our dear friend and colleague Bob McEvoy for producing the *Journal.*

Thank you for all that you are doing to enhance our profession and improve county governments nationwide! ■

Best regards,

Peter

Peter J. Crichton, NACA President

NACA

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Inside

with Dr. Costis Toregas, The George Washington University

Interop !!

Every day, the machines we love to hate are performing miracles of interoperability, and we never even know! Our smart phones download and open photographs taken by digital cameras, text documents accept and show financial spreadsheets as if they were simple words, and music files are sent by e-mail and perform on distant machines without missing a note. All these events require programs and gadgets made by different companies to accept each other's products and somehow make them work—in other words, to interoperate.

However, when we turn around and have the same expectation of county information systems, we get frustrated because nothing seems to "interop"! A system that gives us access to a call center log to analyze citizen-serviced calls balks at presenting the data through a web browser that the same IT department installed and maintains. A voice file representing a critical 911 conversation cannot be played on the county web portal because the system that recorded it is "proprietary." And a resident who tries to make a traffic fine payment finds that their smart phone cannot present the entry screen because of software "incompatibility." And we ask ourselves, as well we should, why not? Why can't government systems behave more kindly towards the networked and collaborative environment that we expect to find as consumers?

The answer, dear readers, is the lack of Interoperability. And it is not only interoperability for the machines or the software that is the culprit. Alas, things are more complicated … and for some guidance, let us turn to two wise professors from the Berkman Center at Harvard, John Palfrey and Urs Gasser. In their recent book, *Interop–the Promise and Perils of Highly Interconnected Systems,* they argue that there are four separate and distinct levels of interoperability, and if you expect to have interoperable systems, you better be aware and be active in all four. They are:

- Technology Layer
- Data Layer
- Human Layer
- Institutional Layer.

It is clear that technology itself must be able to work together; if your machine works in 110 volts and you take it to Europe and connect it to a system that runs on 220 volts, you should expect fireworks! Similarly at the data layer, a file that describes a picture to a computer is a confusing array of zeros and ones, and unless the system you connect to understands its special code, you will see a string of gibberish and not a picture if you try to connect. So, as public administrators, we hire IT experts and CIOs and software designers who can help ensure the universal acceptance of what we do.

However, the human and institutional layers (orgware, some would say!) are far more complex, and could be a puzzle to our technical experts, who we ask for help. How one person understands and welcomes interoperability of another system is not easy to fathom, and how an entire institution can accept information or actions of another is predicated on laws, practices and cultural traditions that are difficult to fathom, let alone eliminate. As a consequence, systems from two different organizations that are linked together may fail, not because of technical reasons but because of human and institutional ones.

So what can you do as a public administrator? How can you increase the potential of success for systems that must interoperate in this increasing interconnected world of ours? Well, to start with, you have to understand that interoperability is not a technical challenge ONLY. You must provide help to the technical people you so much depend on in the human and institutional domain. This help could come as additional training of top IT managers in human relations and the softer skills of management. Or, alternatively, you might want to introduce a higher level of organizational management on top of the technical management that can anticipate and resolve the human issues that are sure to arise in any complex system implementation. In addition, many governments that are involved in complex system development where interoperability with other systems is essential, they are setting aside 10, 15 or 20% of their project funding to "Change Management" efforts that focus on the human reaction to IT deployments, where life style and job security could be threatened by the arrival of hi-tech solutions.

No matter how you proceed, you should be convinced of one thing: the world around us is increasingly networked, and isolated systems are rapidly being replaced with robust, networked and interoperable ones. And the way in which interoperability can be assured will require skills and talents way beyond technical ones. ■

FROM YOUR NACO REPRESENTATIVE

by Eugene Smith, NACA Past President, County Manager, Dunn County, Wisconsin

During the first week in December, the NACo Board of Directors convened in Memphis, Tennessee, for its final meeting of 2012.

In addition to the standard business items, committee reports, budget adoption, guest speakers, new Director Matt Chase delivered an overview of the new strategic blueprint and a review of what steps need to be taken to move ahead. The board participated in a lengthy SWOT analysis and planning discussion. A summary of that analysis has been distributed and is being used to refocus NACo. I think you will be pleased with the new mission that the organization is suggesting.

As part of a two-year, phase-in process, NACo made some immediate changes to the annual legislative conference. They continued the subcommittee and committee meetings on Saturday and Sunday this year and traditional workshops on Monday. However, they moved the conference-wide luncheon from Tuesday to Monday to free up more time for congressional and administration visits on Tuesday. They also condensed and streamlined the conference workshops on Tuesday, limiting them primarily to Tuesday morning. The goal is to use most of Tuesday and all of Wednesday for outreach meetings. As part of the congressional and administration outreach, NACo developed and provided each participant with a new Counties 101 presentation and message (yet allowing each county to customize and tailor to its state and county); legislative fact sheets and talking points on priority issues; and training on conducting effective Capitol Hill visits in today's environment. NACo released a "Frequently Asked Questions" form that outlined the immediate changes, along with the updated conference schedule. For 2014, NACo anticipates additional changes to streamline the legislative event, reduce participant costs, and improve our presence with Congress and the administration.

It was a pleasure to see many of you at the NACA Idea Exchange in March. We are working closely with NACo leadership for a larger NACA presence at the upcoming NACo Annual Conference, July 19–22, in Tarrant County/Fort Worth, Texas. We hope to see a strong representation of NACA members there. ■

NACo's New Vision

The National Association of Counties (NACo) has been undergoing a makeover of sorts led by the association's new Executive Director, Matt Chase. Since he took over the reins last September, Chase has spent considerable time engaging NACo's leadership, members and key partners, including state associations and affiliates. While a new strategic blueprint is still being developed this year, it is clear that NACo is focusing on four basic goals:

- Ensuring NACo and counties are relevant, present and influential in federal policy creation, implementation and innovation.
- Providing counties with timely, user-friendly and informative content.
- Building the NACo brand as the nation's premier thought leader on county governance, operations and practices.
- Expanding member services for counties, their residents and businesses.

To improve communications with the membership and public, NACo has made some preliminary upgrades to NACo.org and expanded its use of social media via Twitter and Facebook. A new weekly federal policy newsletter, *Washington Watch*, is now distributed to the full membership, rather than a biweekly report just for the board and committee members. In addition, the association's legislative team has prepared outstanding turn-key presentations about the federal sequestration process, potential impact of proposed changes to tax-exempt municipal bonds and the 2012 federal elections.

The new strategies aren't just about NACo pushing out information. This was evident at the recent Legislative Conference, where NACo focused on educating Congress and the administration through personal visits, media ads and a new awareness campaign, *Why Counties Matter!* The campaign features new key statistics about counties, legislative issue briefs and fact sheets, and a newly released video titled, "*Why Counties Matter!*"

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- Counties are also major employers that spend millions of dollars each year on health care for their own employees.
- Economic development in a region hinges on the local health system. Health care is often the single largest sector in the economy and health services are critical for maintaining productivity of the entire workforce. Also, the availability of high-quality health care, the presence of a healthy workforce, and the assurance of safe, thriving neighborhoods are themselves important attractors for recruiting new residents and new employers. On the other hand, rising health care costs and unhealthy living conditions tend to discourage families and employers from locating or remaining in a county.

Given the gravity of these issues, the question is not whether county officials ought to be involved in reforming their local health systems, but how. Here, we share stories from two counties where new, collective endeavors are under way to transform local health systems.

Our first example comes from Pueblo County, Colorado, a rural area about two hours south of Denver (population 140,000). The second comes from Fulton and Dekalb counties in Georgia, at the core of the Atlanta metropolitan area (combined population of 1.3 million). While being different in many respects, both sites are pioneers in the ReThink Health alliance, an organization committed to reimagining and reshaping health system performance across the United States—one region at a time. ReThink Health is sponsored by the Fannie E. Rippel Foundation of Morristown, NJ. (www.rippelfoundation.org)

ReThinking Health Systems

More and more, people are rethinking what it takes to achieve profoundly better results in health systems across the country. Such ambitious ventures, however, are hard to plan, unwieldy to manage, and slow to spread. ReThink Health and its allies are learning what it takes to spark and sustain system-wide improvements in different settings. These efforts usually involve three connected spheres of innovation:

- Stewardship sets the conditions for diverse stakeholders to work effectively across boundaries as they steer their common health system to fulfill shared aspirations over time.
- Organizing engages people around shared values to build power for concerted action.
- Dynamics equips leaders to see the system in which they work, play out plausible scenarios, weigh trade-offs, and learn where the leverage lies to alter future trajectories.

In practice, diverse groups of ReThinkers in a region work together to address practical, pressing questions about their health system, such as:

- How is our local health system structured?
- How and when does it change (or resist change)?
- Where is the greatest leverage to enhance performance?
- What trade-offs may be involved?
- How can diverse, often competing actors weigh those trade-offs and set priorities?
- What are we really trying to accomplish?
- Why do we care?
- Who are "we" and who ought to be involved?

Thinking through these and other issues is fraught with difficulties. As a result, most health reform initiatives tend to be short-sighted, fragmented, and unable to alter long-term trends. By contrast, those involved with ReThink Health use carefully-crafted tools, like simulation modeling, to bring greater foresight, evidence, and creativity to the process of multi-stakeholder planning and action.

Exploring Simulated Scenarios

The ReThink Health Dynamics model is a realistic, yet simplified, representation of a local health system. With a distinctive place-based and wide-angle view, it tracks changes in population health, health care delivery, health equity, workforce productivity, and

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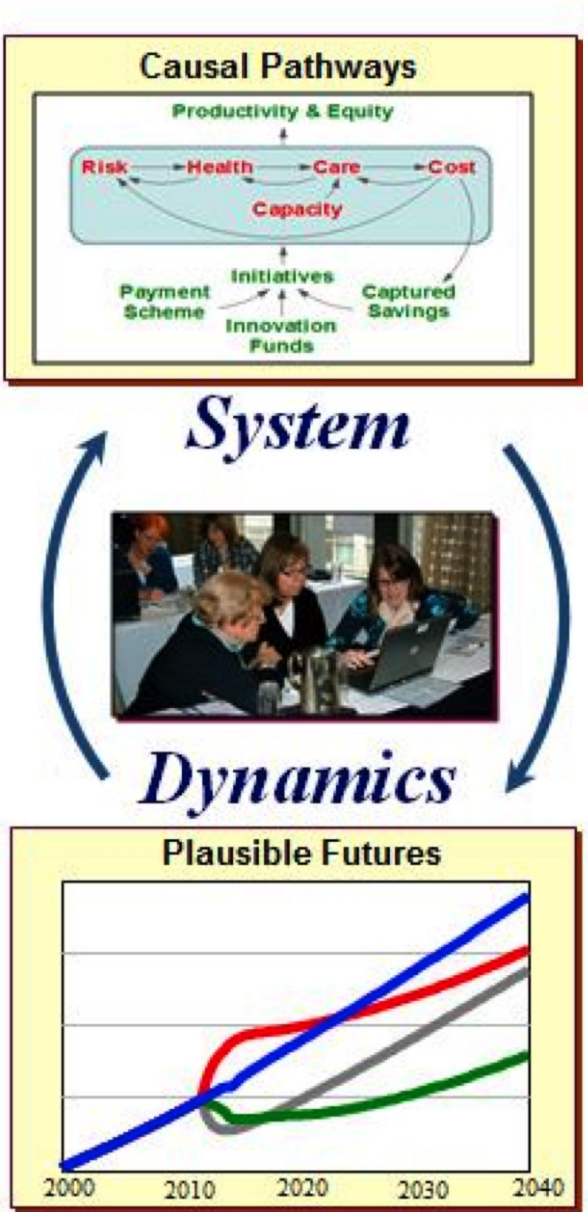

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health care costs under a variety of conditions—all within a single, testable framework tied to many sources of empirical data and open to sensitivity analysis. Information about the model and an interactive interface are available online at www.rethinkhealth.org/dynamics.

The primary purpose of this tool is to support conversations about strategy design, not to forecast specific outcomes. Planners may use the model to examine uncertainties and explore opportunities for change—as well as the stakes of inaction. Simulating scenarios also encourages greater alignment and action as innovators see and feel what their efforts could accomplish in the short-term and as they play out over decades. One potential benefit is the ability to anticipate how current investments (such as those from government, philanthropy, business, and nonprofit groups) could be leveraged for greatest impact.

Diverse teams are now using the ReThink Health model across the country, and several—like those in Pueblo and Atlanta—have incorporated local data to tailor it for their own region (other local configurations are listed online). This diagram shows the general boundary and major sectors represented in the model.

Within this general framework, planners can explore a variety of "What If … ?" questions. The model represents several dozen distinct initiative options (summarized in the table to the right). This menu includes a rich set of options, including upstream investments to reduce the risk of disease or injury, clinical initiatives to enhance the quality and capacity for care, strategies to cut costs, specific financing features, and more. Each action may be simulated individually or in combinations to study the likely consequences over time on many metrics of health, care, cost, productivity, equity, spending, savings, and return-on-investment. Additional design options let planners sequence initiatives and/or direct certain efforts only to sub-groups, as a way of concentrating limited resources among those with the most to gain.

Users may then explore the results of their scenarios by navigating through an extensive set of performance metrics. Scores of graphs like the one on page 7 show plausible paths under alternative scenarios. These graphs let users drill down beneath high-level summary statistics, yielding a deeper understanding about how the health system could change as different initiatives are enacted.

Despite its inevitable uncertainties and limitations, users have discovered many valuable insights when using the ReThink Health model. For example, local leaders have been consistently able to anticipate common pitfalls or "failure modes" that threaten to disappoint or derail regional change ventures. Some of the main failure modes stem from:

- Unsustainable program financing (i.e., attempting too much without adequate funding)
- Exacerbating bottlenecks (i.e., especially those affecting primary care)

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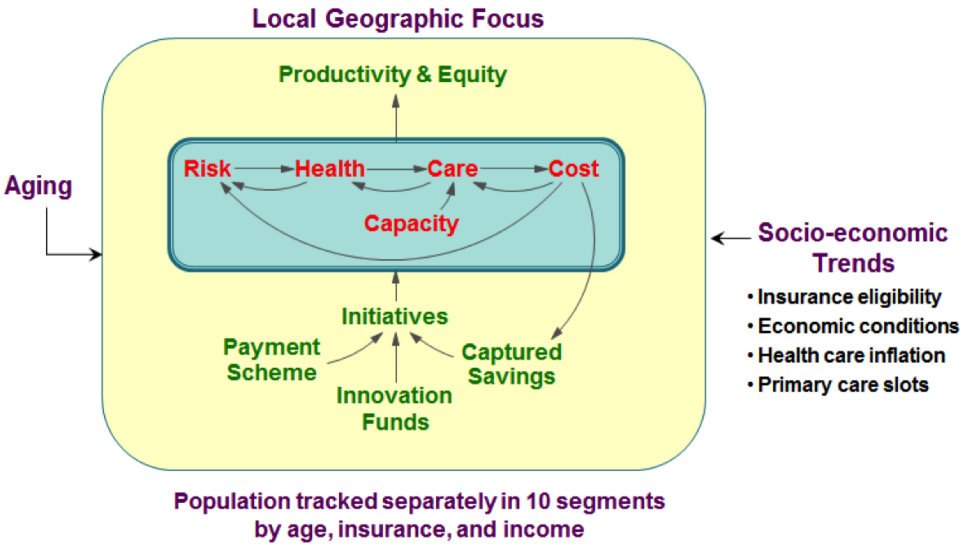
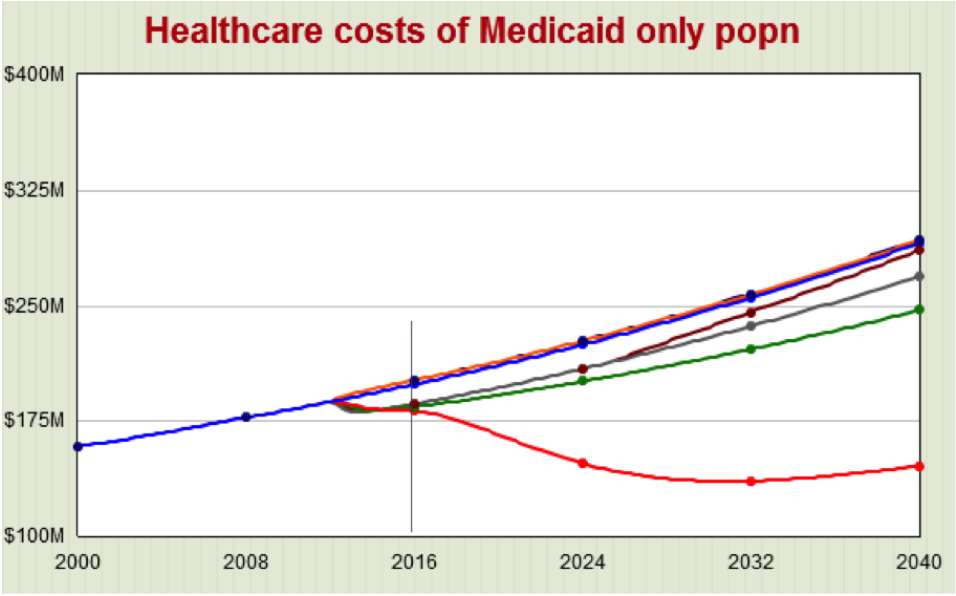


RISK	Behaviors Environ hazards	Crime	Pathways to advantage (family; student)
CARE	Prev/chronic Mental illness	Self-care	Hospital infections
CAPACITY	PCP efficiency	Recruit PCPs (general; FQHC)	Hospital efficiency
COST	Pre-visit consult Medical homes	Coordinate care Shared decisions Generic drugs	Post-discharge care Malpractice Hospice
TRENDS	Uninsurance Local economy	Primary care slots for Disadvantaged	Inflation rate
FUNDING	Innovation fund	Capture & Reinvest Share w/ Providers	Contingent Global Payment



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- Supply push responses from providers that undercut health care cost savings (i.e., increasing the intensity of care to compensate for drops in utilization and income)
- Comparing alternative strategies using only a short time horizon (ignoring longer-term benefits of different interventions)
- Improving health, care, or cost while perpetuating or exacerbating inequities (i.e., failing to alter the structural conditions that drive health inequity).

In addition, when equipped with model-based scenarios, planners are better able to address other shortcomings that may plague multi-stakeholder endeavors, such as lack of a common vocabulary, inability to interpret performance metrics, the absence of a strategic perspective, disorganization, and dysfunctional teamwork.

Pueblo Triple Aim Coalition

The health system in Pueblo County, Colorado, like many others, shows signs of stress. About 40% of the population falls under the poverty line; health care premiums are rising three times faster than wages; and health outcomes are among the worst in the state. In 2010, a small group of local leaders decided to pursue bold, comprehensive reform by declaring their commitment to the Triple Aim, an initiative led by the Institute for Healthcare Improvement that seeks to achieve the three-part goal of better health, better care, and lower cost. The initial team in Pueblo represented several of the principal health agencies: the city/county health department, the community health center, regional medical centers and hospitals, the mental health center, and Kaiser Permanente. They began by reviewing current investments in health and health care. But there were many questions about priorities and outcomes: *Are we investing our resources appropriately? Are we making enough of a difference? Is there something better we ought to be doing?*

The team sought to develop a Triple Aim strategy that would use their resources for greatest impact. They also wanted to devise a clear vision for the region and pursue a course of collective action to get there. But they recognized that their efforts were not well-coordinated; and even worse, many potential allies and stakeholders were not yet in the room. In a brief statement written to engage fellow leaders, Pueblo's Triple Aim Coalition explained that "*ever-rising healthcare spending weakens our local economy, threatens jobs, and has failed to deliver improved health.*"

Working with ReThink Health's team of modelers, they began to map the main features of their health system. *Which elements are most important? How are they connected? Where might interventions be tested? What do we know about the likely impacts and costs?* Eventually, they developed a diagram of the health system in Pueblo that helped each stakeholder find their place in the system and to see who they affect and are affected by.

They also engaged in facilitated, interactive scenario planning using the ReThink Health Dynamics model. Teams of users asked "what if" questions—and got answers instantly. They ran several hundred scenarios looking at likely results over a 28-year time horizon. Those simulated scenarios gave Pueblo's leaders an opportunity to explore what they could do through new or modified programs and policies, and just as importantly, how to pay for it, while factoring in the realities of their own region.

Over time, Pueblo's Triple Aim Coalition expanded to include more than 45 senior leaders in the region, including many who work outside the formal health sector (such as education or economic development). After wide-ranging experimentation, they converged on a set of high-leverage policies, with a durable financing strategy and critical sequencing. Their current strategy features a suite of cost-saving initiatives, like better coordinated care and post-discharge planning, combined with efforts to support self-care and new recruitment for over-burdened safety net clinics, along with focused investments to enable healthier behaviors and expand pathways to advantage.

A central element in every discussion was about the money: *How much is needed? How much could be saved? Whose was it? Where would the savings go?* Those discussions led to a remarkable stewardship strategy guided by insights from the ReThink Health model, grounded in the principles of collective impact, and governed by a new backbone organization with a commitment

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to capture and reinvest savings, share information, monitor progress over time, maintain constant communications, and assure mutual accountability.

The ability to experiment freely and to test novel strategies using a model, before attempting to enact them in the real world, stimulated their thinking and supported what might otherwise have been impossible conversations. The team determined that they could sustain a robust set of initiatives over time by reinvesting a portion of the savings back into the system. Dashboards, such as the one below, provided an overview of the results that could be achieved under their favorite scenario.

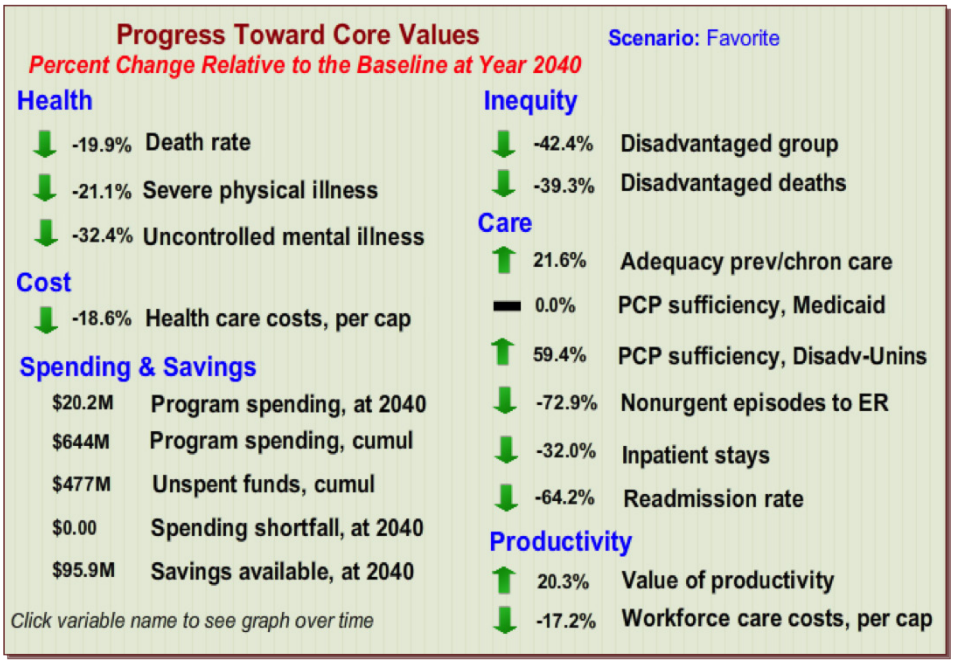
By investing just 1% of total health care spending over 5 years—or $10 million per year for a total of $50 million, this aspirational scenario suggests that by 2040 Pueblo could anticipate the following types of results: deaths decrease by about 20%, health care costs decrease by almost 19%, ER use for non-urgent events goes down by over 70%, workforce productivity increases by more than 20%, inequity is reduced, and there is money in the bank—several hundred million dollars that can be used to improve education, infrastructure, the environment, and the economy.

Leaders in Pueblo County are now creating the relationships and organizational structures that are required to implement their plan and to redesign the economic incentives that usually drive investments in health. Before moving to implementation, they are first working to create an enabling culture for this work to succeed. They are establishing a new governance structure, measurement systems, and a sustainable funding model to assure that effort will be sustained over time.

Two county officials closely associated Pueblo's Triple Aim Coalition described their insights from the ReThink Health modeling process this way.

"Gathering data and then using the model helped us to build trust and to be dedicated and committed ... The model helped us understand the importance of intervention timing, doing things in the right sequence, and identifying early wins... We can get satisfaction out of moving the dial today and knowing how it will contribute to results down the road. It gave us the impetus to stay the course because we could see the possibilities and know how successful we could be."

—Dr. Christine Nevin-Woods, Director of the Pueblo City-County Health Department



"Working with the model built consensus around common issues that will enable us to have collective impact. The work allowed us to develop a common language that made it easier to communicate. It also enabled us to see how the pieces fit together."

—Eileen Dennis, member of the Pueblo County Board of Health

They also pointed to negotiations with interested funders, promising conversations with state leaders about the prospects to reinvest savings, and the incorporation of a local backbone organization as further benefits of their disciplined, collective process.

Finally, they noted that all three of Pueblo's county commissioners were newly elected in 2012. But rather than beginning from scratch, those officials may now contribute to a transparent regional health reform process. Explicit planning tools, like the ReThink Health model, let all stakeholders see for themselves why the group's strategy is sound; and the process for collective stewardship that has been developing over the past two years remains open to contributions from everyone who is willing to work toward a healthier, more prosperous future for Pueblo County.

Atlanta Regional Collaborative for Health Improvement

The Atlanta Regional Collaborative for Health Improvement (ARCHI) is an interdisciplinary coalition working to improve health system performance through collaborative assessment and collective investment. ARCHI was created with the recognition that leaders in the Atlanta area have an opportunity to change the culture of health and health care throughout the region, and that in practice, many forces are drawing local stakeholders into a collaborative approach for health assessment and intervention. For example,

- Public health departments that seek accreditation must perform community assessments

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- Local governments are thinking seriously about their investments in health, assessing needs and setting priorities
- Foundations are increasingly choosing to invest in collaboratives rather than single agencies
- Federally Qualified Health Centers must assess the need for expansion
- Not-for-profit hospitals are pressed to assess, plan, and invest to meet new IRS regulations.

While it may be tempting to approach these challenges independently, the prospect of collaborating with others compels many leaders in the region to explore what they could accomplish together. With the potential for greater long-term efficiency and effectiveness, collaborative assessment can lay the groundwork for shared priorities and collective investments to achieve maximum impact.

Following a process similar to the one described above, a series of open meetings beginning in July 2012 prepared ARCHI members to think broadly and strategically about how their health system could change over time. Working rapidly over just four months, they compiled a rich set of both quantitative and qualitative data to develop a useful portrait of their current health system. But those data could not address some of the most critical questions: *Where is the Atlanta health system headed? How can we better direct the course of change? Where is greatest leverage? What costs and trade-offs are involved? Who decides?*

Recognizing how ReThink Health Dynamics model could support precisely these sorts of conversations, the ARCHI steering committee worked with members of the ReThink Health team to configure a model representing particular features of the health system in Fulton and Dekalb counties at the core of the Atlanta region. By November 2012, approximately 70 participants gathered for a five-hour workshop to explore simulated scenarios and consider provisional priorities. Among the participants at that event were two commissioners from Fulton and Dekalb counties and the principal health policy advisor for the chair of the Fulton County Commission.

The ARCHI modeling workshop began with a review of the baseline scenario so all participants could see what might happen if they did nothing differently. Then, working in teams of seven, they were challenged to craft their vision for Atlanta's future. Each team selected up to five initiatives plus any financing options they wanted. Nearly every group chose to capture and reinvest savings, and one group also embraced the idea of a shift from fee-for-service to per capita contingent global payments. The presence of these innovative financing schemes let the scenarios go well beyond limitations of collapsing budgets and unsustainable actions that erode over time. Despite that ability, budget constraints were still an important part of the discussion.

Eight teams submitted scenarios; however, there was only time to examine four of those in depth before voting on "*which one offers the strongest foundation for the ARCHI collaborative?*" Thanks to instant polling technology, anonymous opinions were gathered on the spot: 89% voted for the "Atlanta Transformation" scenario, which featured investments in the following policy domains: Healthier Behaviors, Family Pathways, Coordinated Care, Global Payment, Capture and Reinvest Savings, and Expand Insurance. Another half hour was spent systematically removing each major piece of that scenario to see its contribution.

Participants reported many powerful insights from the workshop, including

- The need to first assure a revenue stream before embarking on complicated policy ventures
- An appreciation for discipline to do fewer things more fully rather than many with a budget shortfall
- Observations about the relatively weaker impact of changes in insurance versus other facets of system performance
- The discovery that very different stakeholders had largely similar priorities (for example, virtually every group had Behavior, Pathways, and Coordination in their chosen set, with no prompting).

Local government leaders explained how important health is to people as individuals, to the community at large, and to the Atlanta economy. They also identified the importance of wisely investing scarce resources for health. Emil Runge, health policy advisor to Fulton County Commissioner John Eaves, indicated that formal modeling would *"help us let the people know that we are going to give them return on their tax investment. "* Dekalb County Commissioner Larry Johnson observed that, *"the county spends about $70 million a year on health and we want to achieve efficiencies and put money back into the people."*

Some additional insights from the ReThink Health modeling process were:

"The health care system can be overwhelming with its many providers and services. Working with the model enabled us to better understand what is going on. It will make it possible to have a coordinated continuum of care that functions well."

–Joan Garner, Fulton County Commissioner

"The model helped show how we could work toward the goal of a healthier community including for those who can't afford health care and healthier lifestyles.... Also, having all the people in the room who can make decisions made me want to be involved, made it worth my time."

–Larry Johnson, Dekalb County Commissioner

"The model helped us see if we will be getting the results we want. We saw how savings could yield a revenue stream down the road that would sustain the work. It showed that we can achieve the change we want by transition, we don't need to tear down everything and start over."

–Emil Runge, Health Policy Advisor to John Eaves, Chair of Fulton County Commission

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("ReThink" from page 9)

"It helped me think about the capacity to do this work as the county government and how we need to partner to fill in the gaps. The experience made it clear that you can't only have health care people in the room. You need a broad set of perspectives."

–Joan Garner, Fulton County Commissioner

As for the future, the commissioners said:

"With the information from the model, people will begin to see the pieces that they can add into what they are doing and we can gradually move toward system change."

–Larry Johnson, Dekalb County Commissioner

"The foundation has been laid. Now we need to make sure the resources are there."

–Joan Garner, Fulton County Commissioner

Conclusions

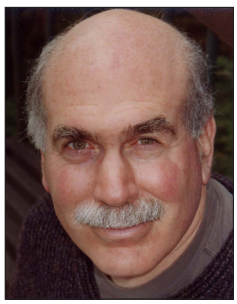
Health reform may be a national priority in the U.S., but it requires local action. Moreover, because of the sheer complexity of the health system, innovators typically require new teams, new tools, and new approaches to work effectively at this scale. For example, local leaders in Pueblo, Atlanta, and other regions are now beginning to use tools like the ReThink Health Dynamics model to support multi-stakeholder strategy design. Flexible, yet rigorous processes like ReThink Health provide an efficient way for diverse stakeholders, including county administrators, to develop their skills for true system stewardship. In particular, we have seen how innovators in Pueblo and Atlanta have used these processes to help diverse stakeholders

- See how they fit within the larger health system
- Play out alternative strategies and compare their short- and long-term effects
- Devise a sustainable funding scheme so that selected initiatives achieve their full promise over time.

Readers interested in learning more about ReThink Health can go to http://www.ReThinkHealth.org, where there are links to online simulation models, as well as many other tools and approaches designed to catalyze innovation in local health systems.

Author Biographies

Bobby Milstein, PhD, MPH, is the Director of ReThink Health's work in dynamic modeling and game-based learning. Dr. Milstein has led the creation of the ReThink Health regional model that is helping leaders across the country to develop interactive simulations that explore the likely impact of policy interventions on health outcomes and costs. He also heads the Hygeia Dynamics Policy Studio, which provides a forum for diverse actors to acquire the foresight and motivation needed to craft powerful responses to pressing priorities. Dr. Milstein is also a visiting scientist at the MIT Sloan School of Management. From 1991 to 2011, Dr. Milstein worked at the CDC where he founded the Syndemics Prevention Network, chaired the agency's Behavioral and Social Science Working Group, and was coordinator for a wide range of new initiatives.



Gary Hirsch, SM, is a system modeler for the ReThink Health data-based model and game. Mr. Hirsch specializes in applying System Dynamics and Systems Thinking. In health care, he has focused on population health and treatment of chronic illness, improving the performance of health care delivery systems, creating the capacity to respond to health emergencies, and improving oral health and delivering dental care. Mr. Hirsch is the co-developer of several simulation-based learning environments including *HealthBound,* created for the CDC to enable users to try their hand at health reform. Mr. Hirsch is the author of three books and numerous journal articles and conference presentations.

Karen Minyard, PhD, leads the evaluation team for ReThink Health. She has directed the Georgia Health Policy Center (GHPC) at Georgia State University's Andrew Young School of Policy Studies since 2001. She is also an Associate Research Professor in Public Management and Policy at GSU. Minyard connects the research, policy, and programmatic work of the center across issue areas, including community and public health, end of life care, child health, health philanthropy, public and private health coverage, and the uninsured. Prior to assuming her current role, she directed the networks for the rural health program at the GHPC. She has experience with the state Medicaid program, both with the design of a reformed Medicaid program and the external evaluation of the primary care case management program. She also has 13 years of experience in nursing and hospital administration. ■

Enhanced Access to In-Plan Roth Conversions; 2013 Legislative and Regulatory Outlook

by Joan McCallen, President and CEO, ICMA-RC
and John Saeli, Vice President, Market Development and Government Affairs, ICMA-RC

In-Plan Roth Conversions. The American Taxpayer Relief Act of 2012 ("ATRA"), enacted on January 2, 2013, includes a provision that expands the availability of in-plan Roth conversions in 457(b), 401(k), and 403(b) plans. The provision, which was effective immediately, allows a participant to convert pre-tax amounts to Roth amounts at any time, regardless of whether the participant is otherwise eligible to withdraw funds from the plan. Previously, only amounts that were eligible to be withdrawn from the plan could be converted to Roth. While income taxes are due on converted amounts, the participant generally can later withdraw Roth assets tax free. The in-plan Roth conversion provision is available to plans that allow Roth elective deferrals. Eligible plans may require a plan amendment in order to take advantage of the added flexibility introduced by ATRA.

2013 Legislative Outlook. In the coming year, the continuing national discussion over federal finances may include consideration of significant tax reform. This long-running debate previously led to an increase in the national debt ceiling in August 2011, a federal tax increase in January, and the sequester of $85 billion in federal spending for fiscal year 2013 starting this March.

Although pre-tax retirement plan contributions defer tax payments—often after several decades—Congress measures the budgetary impact of tax and spending policy within a ten-year window. This convention could make changes to the existing retirement system of interest to Congress as it seeks revenue to reduce tax rates and/or the deficit.

Tax reform could impact retirement plan contributions in a number of ways. Policymakers have been considering across-the-board limitations on a taxpayer's ability to claim tax expenditures, which collectively reduce federal revenues by more than $1 trillion annually. In his budget proposal to Congress for fiscal year 2013, for example, President Obama proposed to cap the value of a taxpayer's tax expenditures at 28 percent—including the exclusion for employee contributions to defined contribution plans. For those in a tax bracket above 28 percent, this could potentially tax contributions between the 28 percent cap and the taxpayer's marginal tax rate twice—both in the year contributions were made and in the year in which they were withdrawn. This proposal appears not to apply to Roth contributions, which would make Roth contributions more attractive.

There has been recent discussion of limiting all itemized deductions and possibly other deductions and exclusions taken by a taxpayer to a fixed dollar figure, or establishing a limit as a percentage of income. The incentive to save for retirement could be reduced if a low cap were established and retirement plan and IRA contributions were aggregated with itemized deductions, such as mortgage interest, charitable contributions, and state and local income taxes.

Several commissions and groups also have advanced proposals to simplify the tax system by directly eliminating or reducing most tax incentives, including those for retirement savings. Two leading bipartisan deficit reduction commissions included in their reports a proposal to limit the amount of contributions to defined contribution plans (possibly including IRAs) on behalf of an employee to the lesser of $20,000 or 20 percent of compensation. Others have recommended replacing the tax exclusion (in the case of defined contribution plans) or deduction (in the case of IRAs) with a tax credit.

2013 Regulatory Outlook. While the release of significant new regulations on retirement plans slowed at the end of 2012 in advance of the election, it is likely that the federal government will provide guidance in a number of areas this year. The Department of Labor (DOL), for example, in March released "tips" for plan fiduciaries regarding the selection and monitoring of target-date funds, which have become the default investment option for most defined contribution plans and therefore often are receiving an increasing portion of plan assets. The DOL and the Securities and Exchange Commission (SEC) also are anticipated to issue final regulations with respect to required disclosures to participants regarding target-date funds.

Both Congress and DOL have expressed interest in requiring defined contribution plans to provide an annuity equivalent on participant statements—the monthly annuity payment that would be made if the participant's total account were used to buy a life annuity commencing payments at the plan's normal retirement age. The DOL is likely to propose regulations this year, defining acceptable methods of including monthly income illustrations

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on participant statements in addition to the lump-sum balance that is now provided. It is unclear whether provision of an annuity-equivalent projection will be mandatory or voluntary (and protected by a "safe harbor") under the regulation. While this would apply to private sector Employee Retirement Income Security Act (ERISA) plans, public sector plans may choose to provide comparable projections for their participants.

A number of regulatory initiatives may continue to progress in 2013. These include release of a proposed regulation by the Internal Revenue Service (IRS) and the Department of Treasury to more clearly define which entities may sponsor public retirement plans. The proposed regulation would follow hearings that the agencies conducted in 2012 and would likely provide for additional public comment prior to the establishment of final regulations. The SEC and Commodities Futures Trading Commission also may release their long-awaited study on whether stable value contracts are swaps, and, if so, whether they should be subject to the regulation of swaps being developed in response to the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010. Continued debate regarding the development of additional regulations on money market funds, which could require that funds meet capital requirements or move away from a "stable" and fixed $1 per share, is expected. This change was proposed last year but did not gain sufficient support from the SEC Commissioners. ■

Pension Funding Policy

New guide provides key facts about public pensions for elected officials.

The "Big 7" state and local government associations and the Government Finance Officers Association (GFOA) have released *Pension Funding: A Guide for Local Officials* to provide key facts about public pension plans and a brief overview of the issues that state and local officials should address. The guide explores why developing a pension funding policy is essential and offers guidelines to follow when developing that policy.

Last year, the Governmental Accounting Standards Board (GASB) issued new standards that focused on how state and local governments should account for pension benefit costs but did not address how employers should calculate the annual required contribution (ARC) necessary to fund those pensions. To assist state and local government employers, the Big 7 and GFOA established a Pension Funding Task Force to develop policy objectives and guidelines. The policy objectives were released in October 2012.

"These new GASB accounting standards will change the way public pensions and their sponsoring governments report their pension liabilities. In fact, the new GASB standards end the relationship between pension accounting and the funding of the ARC, which is how many governments budget their pension plans each year," said Robert O'Neill, ICMA executive director and the current chair of the Big 7. "Because some ratings agencies could use another set of criteria to assess creditworthiness that could dramatically affect the issuance of municipal bonds, it is critical for both the financial community and the public to have an objective set of guidelines on which to present their financial reports. Thus, the most important step here is for state and local governments to base their policy on actuarially determined contributions that use these guidelines."

The task force recommends that pension funding policies be based on the following five general policy objectives:

1. Have a pension funding policy that is based on actuarially determined contributions
2. Build funding discipline into the policy to ensure promised benefits can be paid
3. Maintain intergenerational equity so the cost of employee benefits is paid by the generation of taxpayers who receives services
4. Make employer costs a consistent percentage of payroll
5. Require clear reporting to show how and when pension plans will be fully funded.

The Big 7 is a coalition of seven national associations in Washington, D.C., whose members represent state and local governments: National Governors Association, National Conference of State Legislatures, Council of State Governments, National Association of Counties, National League of Cities, U.S. Conference of Mayors and ICMA.

In addition, the National Association of State Auditors, Comptrollers and Treasurers; National Association of State Retirement Administrators; and National Council on Teacher Retirement serve on the task force. The Center for State and Local Government Excellence is the convening organization. ■

Many Opportunities for Conference Speakers!

ICMA 2013 Annual Conference

ICMA's 99th Annual Conference, September 22–25, 2013, in Boston, Massachusetts/New England is accepting applications from individuals who would like to be speakers at the conference.

ICMA is looking for the best combination of panelists to share their experiences for each session within these educational tracks:

- Civility, the Art of Positive Dialogue
- Comprehensive Sustainability: The Economic, Social, and Environmental Impacts
- Effective Community Collaboration: The Push and Pull of Citizen Engagement
- Evolutionizing Collaborative Service Delivery
- Leadership and Courage in Turbulent Times
- The Future of Local Government: Rhetoric vs. Reality
- The Next Generation: Inform, Inspire, and Ignite
- Turn ON Your Phone! Effective Use of Technology
- You Complete Me: Personal Skills to Make You a Better Professional

Please submit separate proposals for each session for which you would like to be considered. All applications must be received by **April 26, 2013**. Detailed information on how to submit your ideas is available at this link on the ICMA Conference website.

NACo 2013 Annual Conference

NACA has been invited to identify prospective presenters for sessions at the **NACo County Solutions and Marketplace** annual conference in Tarrant County/Fort Worth, Texas, July 19–22. The topics for the educational sessions NACA has committed to cosponsor are:

- Emergency Preparedness and Resiliency Planning for Environmental Change
- Effective Use of Social Media in Your Organization
- The Value of Professional County Management

If you have expertise and interest in any of these topics and are able to attend the NACo Conference in July, please contact NACA staff liaison Rita Ossolinski at NACA@icma.org by **April 26, 2013.** ■

("NACo's New Vision" from page 4)

The 2103 NACo Annual Conference, ***County Solutions and Idea Marketplace***, will have a new format with educational sessions focused on: Healthy Counties, Smart Justice, County Resiliency, Leadership & Management, Cyber for Counties, Green Government, Counties Work, and Jobs & the Economy. The sessions are being designed to appeal to staff as well as elected officials, and NACo and NACA are working on several cobranded sessions.

The cobranded sessions are just one step of many to come as NACo works with NACA to strengthen the partnership and to reengage county administrators and managers in sharing innovative ideas, building policy platforms and most importantly helping the public and federal policy makers understand Why Counties Matter! ■