

September 2016

***The Department of
Health and Human
Services as the Nation's
Chief Health Strategist:***

Transforming Public
Health and Health
Care to Create Healthy
Communities

About this report

This report was prepared by a group of thought leaders (see roster on page 17) convened under the auspices of the Public Health Leadership Forum (<http://www.resolv.org/site-healthleadershipforum>), which is funded by the Robert Wood Johnson Foundation (www.rwjf.org). The group met 4 times between January and September of 2016.

Overview

Everyone in America deserves to live in a healthy nation—and in healthy states, regions, cities, and neighborhoods. And America needs a healthy population to be competitive and secure in the 21st century. As Chief Health Strategist for the nation, the Department of Health and Human Services should lead a national initiative that assures *America's communities are places that provide every person with the opportunity to achieve optimal health and are served by a strong public health infrastructure.*

In December 2015, the Centers for Disease Control and Prevention (CDC) reported no gains in life expectancy in the United States for the third year in a row.¹ Indeed, even though access to health care has improved as insurance rates have increased, the health of Americans is far from optimal. The opportunity to **prevent** the leading causes of disease most often exists outside the care setting and therefore we must embrace a new set of strategies, goals and competencies for health promotion in communities and the nation. In the next administration, the US Department of Health and Human Services (DHHS) should lead efforts to make progress on health by embracing the role of Chief Health Strategist² for the nation and by extending the effort to improve health beyond the clinical setting into the community.

The Department can:

1. Transform the health care and public health investments by the federal government into a Health Promoting System and adopt metrics that foster activities that support longer, higher quality life and reduce health inequities.
2. Assure communities have the data, evidence, analytic capacity and flexibility they need to build healthy and resilient communities including supporting cross-sector collaborations at the federal, state, and local levels.
3. Assure every community is served by a well-resourced public health department that is accredited and able to provide foundational capabilities and respond to unanticipated emergencies.

A growing body of evidence indicates that:

- A healthy nation is achieved by more than what happens in public health agencies and the health care system, but by what happens within and among diverse communities and is realized through partnerships across communities, sectors, and levels of government;
- A healthy nation is built through healthy, engaged communities with equitable access to opportunities and resources achieved across all communities and populations;

¹ Life expectancy at birth and at age 65 remained the same in 2012, 2013, and 2014. Mortality in the US, 2014 <http://www.cdc.gov/nchs/data/databriefs/db229.pdf>; Mortality in the US, 2013 <http://www.cdc.gov/nchs/data/databriefs/db178.pdf>

² One working paper defined this term as follows: "Health departments as chief health strategists will lead communities' health promotion efforts by catalyzing, conducting, supporting, and sustaining health protection and promotion activities, and in partnership with health care clinicians and leaders in widely diverse sectors, from social services to education to transportation to public safety and community development. As such, health departments will play a vital role in promoting the **reorientation of the health care system towards prevention and wellness.**" Public Health Leadership Forum, The High Achieving Health Department in 2020 as the Community Chief Health Strategist, 2015. <http://www.resolv.org/site-health-leadershipforum/hd2020>. See also: DeSalvo, K. B., O'Carroll, P. W., Koo, D., Auerbach, J. M., & Monroe, J. A. (2016). Public Health 3.0: Time for an Upgrade. *American Journal of Public Health, 106*(4), 621-622.
Public Health 3.0: A Call to Action to Create a 21st Century Public Health Infrastructure. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health. Available online at <https://www.healthypeople.gov/2020/tools-resources/public-health-3> on October 18, 2016.

- A healthy nation assures equitable access to and engagement in quality physical and behavioral health services and that all, regardless of race, ethnicity, gender or gender identity or sexual orientation are served by a robust public health system;
- A healthy nation is safe and secure from and able to respond to natural and human-made threats and disasters.³

The Secretary of Health and Human Services and his/her colleagues in DHHS are uniquely positioned to mobilize partners across the country to advance equity and the opportunity for each person, family and community to be healthy. Indeed, the Secretary should help change the narrative and engage the American people about what creates and improves health and contributes to health equity.

Federal leadership is essential for creating a future where the demographic and geographic inequities in health that exist across the country are reduced, including health outcomes that are related to economic opportunity, and Americans are resilient in the face of all health threats—from chronic disease to infectious disease epidemics to natural or man-made disasters.

This should be the legacy of the next Administration.

3 See National Prevention Council, *National Prevention Strategy*, 2011 and National Academy of Medicine Vital Directions series including *Advancing the Health of Communities and Populations: A Vital Direction for Health and Health Care*, 2016.

Why more progress is needed

1. U.S. health outcomes in perspective

Over the last few years, we have seen critical improvements in individual access to health coverage. This has improved the number of Americans who receive effective clinical preventive services and clinical care for illness and injury. However, US population health outcomes are often worse than in comparable developed nations and *US life expectancy improvements have stalled and some populations have experienced worsening disparities*. For example:

- US health outcomes are among the worst when compared to similar nations in the Organization for Economic Cooperation and Development (OECD). US life expectancy is near the bottom in rankings with US men ranked 25th of 31 and US women ranked 28th of 31 OECD countries.⁴ Similarly, US infant mortality rates are the highest among OECD countries, and are worse than some less developed countries at 5.87 deaths per 1,000 live births in 2013 (compared to 4.63 in Cuba).⁵
- The CDC reports that while racial/ethnic gaps in outcomes have been narrowing in many measurements, an evaluation of 10 key indicators shows a persistent gap in outcomes based on race/ethnicity. Although the CDC notes progress in many areas, it also notes that disparities of some kind remain in all 10 areas ranging from infant mortality to life expectancy and vaccination rates.⁶
- Income and wealth are strongly associated with differences in life expectancy. One recent study showed the gap in life expectancy at least doubling between those in the top ten percent of incomes levels as compared to those in the bottom 10 percent.⁷ Nonetheless even those who are not in poverty are facing new health challenges. Recent reports indicate that white, middle-class men and women have experienced an increase in all-cause mortality between 1999 and 2013, unlike any other demographic group in the US.⁸
- Zip code may be a more powerful predictor of health than genetic code, especially among the poor and disadvantaged. Researchers have documented significant differences in life expectancy between neighborhoods in relatively close proximity.⁹
- Quality of life remains a challenge. Chronic disability now accounts for nearly half of the health burden in the United States¹⁰ and people with psychiatric disabilities constitute the largest and most rapidly expanding group of Social Security disability beneficiaries.¹¹

4 US Centers for Disease Control and Prevention, *Health, United States, 2015*.

5 http://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63_05.pdf ADD FULL title of report ALSO reference AHRQ disparities report ADD CIA FACTBOOK AS SOURCE

6 US Centers for Disease Control and Prevention, *Health, United States, 2015*.

7 New York Times, "Disparity in Life Spans of the Rich and the Poor Is Growing," February 12, 2016.

8 Anne Case and Angus Deaton, Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century, *Proceedings of the National Academy of Sciences*, December 8, 2015, 112:49, 15078-15083.

9 See Center on Society and Health, *Mapping Life Expectancy*.

10 US Burden of Disease Collaborators. The State of US Health, 1990-2010: Burden of Diseases, Injuries, and Risk Factors. *JAMA*.2013;310(6):591-606. doi:10.1001/jama.2013.13805.

11 Robert E. Drake, et al., Social Security And Mental Illness: Reducing Disability With Supported Employment, *Health Affairs* May/June 2009 vol. 28, no. 3 761-770.

- And we face expanding challenges in behavioral health, as evidenced most dramatically in higher suicide rates among some segments of the population, as well as the rising epidemic of opioid use and related accidental death by overdose.

Overcoming these challenges should be the major focus of the next Administration. The clinical care delivery system, no matter how effective or efficient, is an incomplete remedy. As demonstrated in the graph in **Figure 1**, health behaviors, the physical environment, and socioeconomic variables also greatly influence health outcomes.

There are new studies that suggest that these differences (especially as compared to other wealthy nations) are explained by an imbalance of investment: the US spends more on health care than any other country in the OECD but less on social programs (including public health) that might more directly address the determinants of health. (See **Figure 2**) Similar research has shown this differential applies *within* the United States when comparing state spending and health outcomes.¹²

Figure 1

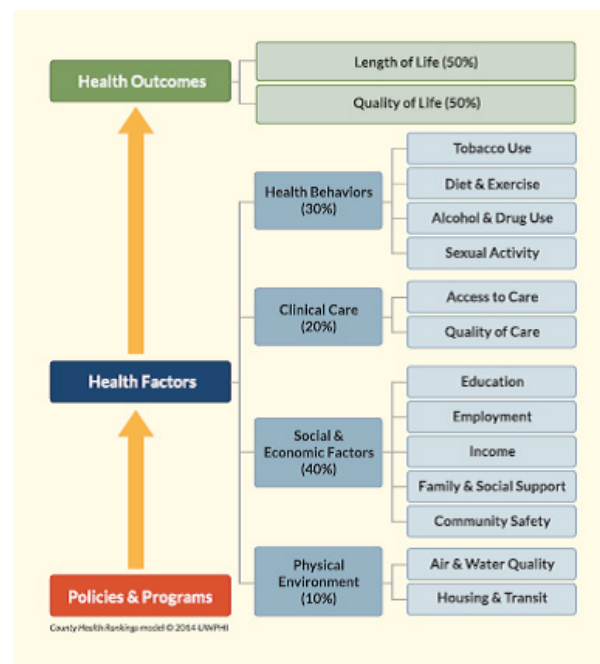
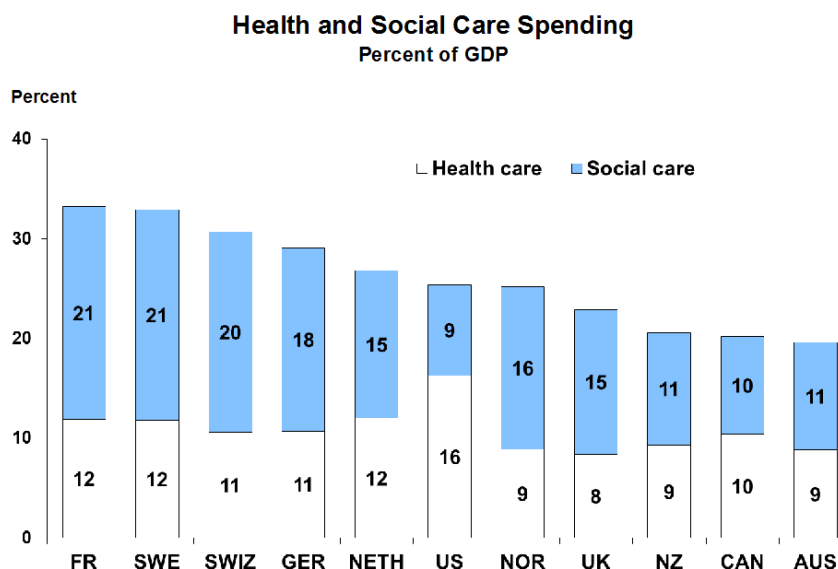


Figure 2



Source: E. H. Bradley, L. A. Taylor, and H. V. Fineberg, *The American Health Care Paradox: Why Spending More is Getting Us Less*, Public Affairs, 2013.



12 E. H. Bradley, L. A. Taylor, and H. V. Fineberg, *The American Health Care Paradox: Why Spending More is Getting Us Less*, Public Affairs, 2013. Elizabeth Bradley, et al., Variation in Health Outcomes: The Role Of Spending On Social Services, Public Health, and Health Care, 2000–09, *Health Affairs*, 2016.

2. The urgent need for cost control

The US now outspends, by far, every other nation in the world on health care as a percentage of gross domestic product (GDP). In 2014, the US spent 17.5% of its GDP on health care; by 2025 this number is expected to rise to 20.1%, a significant drain on the nation's economy.¹³ The impact of cost can be seen in various ways. For example:

- **Employers:** Employer health care costs make American-made products and services less competitive with those of other countries.¹⁴
- **Individuals:** Poor health is also a source of individual economic distress; even with higher rates of insurance over 17% of Americans are having difficulty paying medical bills.¹⁵
- **National security:** An unhealthy nation is also a national security issue; 75% of American youth are ineligible to serve in the military, with obesity the leading cause.¹⁶

In short, the most durable mechanism to prevent disease and associated health care costs is to build healthy communities and a healthy US population.

3. Immediate crises require strong capacity

Staying focused on improving long-term health outcomes is difficult when every Secretary faces immediate unexpected challenges for which the Department and the nation are not well prepared to address. Over the last eight years, the Department has had to deal with infectious disease threats such as H1N1, Ebola, and now the Zika virus; natural and man-made disasters such as Hurricane Sandy and the Flint MI water crisis; and the HIV outbreak in Scott County IN that grew out of the opioid epidemic, and the tuberculosis outbreak in Perry County AL. Whether it's a mosquito-borne disease, a natural disaster or a water crisis, health emergencies are certain to arise again.

Fortunately, we have the knowledge, the resources, and the potential to turn this unhealthy situation around if leadership from the Department of Health and Human Services (DHHS) assumes the Chief Health Strategist role.

With a stronger, modernized public health system, we can improve health, control costs, and be better prepared for emergencies. But because we have allowed our public health system to weaken, we have limited the nation's ability to prevent these crises or to effectively and rapidly respond to these crises. The need to invest new resources at each juncture has limited our public health capacity and effectiveness.

The ability of the nation to respond effectively to these emerging and re-emerging threats is predicated on having healthy, resilient communities. Investments in creating healthy communities, and the state, local and private partners who build them, will ensure that these emergencies are responded to with greater effectiveness and efficiency and, therefore, become less of a diversion.

¹³ Center for Medicare and Medicaid Services, NHE Fact Sheet.

¹⁴ Toni Johnson, Health Care Costs and U.S. Competitiveness, Council on Foreign Relations, 2012.

¹⁵ U.S. Centers for Disease Control and Prevention, National Center for Health Statistics, Problems Paying Medical Bills Among Persons Under Age 65. February 2015.

¹⁶ Mission Readiness, Unfit to Fight.

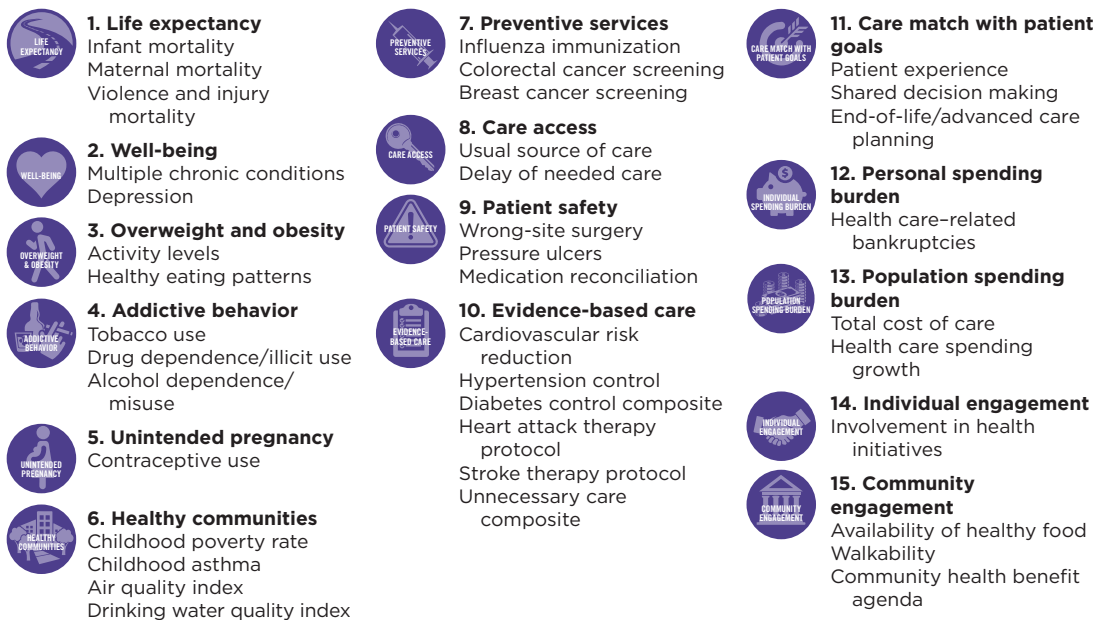
How to Achieve the Goal of a Healthier America

The Secretary, as lead Chief Health Strategist, should set outcome goals for the nation that create a unified vision for the work of all sectors, including all DHHS programs and agencies. We believe that there are two very useful, evidence-based resources that provide menus from which to choose metrics that are central to health and the factors that contribute to life expectancy and quality of life (e.g., addiction deaths, overweight and obesity, depression, walkability)—the Institute of Medicine’s *Vital Signs: Core Metrics for Health and Health Care Progress*¹⁷ and the National Committee on Vital Health Statistics’ *Measurement Framework for Community Health and Well-Being*.¹⁸ We recommend that the Department choose, in addition to life expectancy, three or four additional metrics that will drive program and policy initiatives over the next four years and serve as a basis for measuring the progress of the nation in addressing our overall health and reducing inequities. Whatever measures are chosen, they must be reliable at the neighborhood or census tract level to identify (and address) disparities.¹⁹

The remainder of this paper builds on these areas of change by addressing the policy and systems changes that will enhance the likelihood that DHHS can (a) invest wisely in programs and capacities that improve health; and (b) build a leadership and accountability system associated with achieving these goals.

Figure 3

BOX Core Measure Set with Related Priority Measures



17 Institute of Medicine, VITAL SIGNS: Core Metrics for Health and Health Care Progress, 2015

18 See National Committee on Vital and Health Statistics, Subcommittee on Population Health.

19 See the Virginia Commonwealth University, Center on Society and Health Mapping Life Expectancy project for visualization of the disparities that can exist by neighborhood.

1. Investing wisely in programs and capacities that create or improve health

Across all levels of government, a realignment of systems, programs, and policies is needed so that state and local public health departments are functioning as Chief Health Strategists in their jurisdictions, just as the Secretary is at the federal level and for the nation. As Chief Health Strategists, state and local health officials will need the tools to build the partnerships and put in place the policies and systems that create healthy communities.

That said, it must be recognized that the capacity of state and local health departments across the nation varies dramatically, as does the capacity of the health care delivery system in communities across the country. This diversity sometimes reflects different needs; sometimes it reflects different levels of commitment to public health; and sometimes it reflects different levels of training and robustness in a state or local health department.

The health care system (and in particular DHHS as the manager of key safety net programs such as Medicare, Medicaid, and community health centers) also has a growing stake in the health of communities. As more Americans are insured over their lifespan, many covered by Medicaid, Children's Health Insurance Program (CHIP) and Medicare over extended periods of time, the health system will have more incentive to think about the longer-term impact of prevention and health promotion activities and will share in the return on investment from building healthier communities.²⁰

Therefore, DHHS can:

- A. *Assure every community is served by a health department that is accredited and able to provide the foundational capabilities for effective public health defined by the National Academy of Medicine and others²¹.*

DHHS cannot build healthy, equitable, and resilient communities alone. It requires a strong partnership among the federal government and state and local public health. Indeed, community empowerment will be central to achieving this vision. Whether improving the quality of health, building healthy communities, or addressing ongoing or emergency health challenges in the US, the federal government has an obligation to assure that every community is served *by a public health system that has certain foundational capabilities*. (Note that foundational capabilities are setting the floor of what public health must have and do to promote and protect health in all communities, and on top of which other essential functions must be built. Foundational capabilities do **not** define the ceiling.) The first steps to move this forward could be:

- i. Convene relevant agencies, constituency groups and researchers to agree on a full definition of foundational capabilities and identify the potential cost for assuring them. This should be followed by the identification of financing mechanisms that would help all states and localities achieve accreditation and the ability to deliver foundational public health services, either directly or through cross-jurisdictional collaboration.
- ii. In the meantime, direct HHS agencies to review options within existing grants to provide states/localities flexibility to invest in foundational capabilities where they are already committed to doing so. This action could include permitting state and local

²⁰ Halfon and Conway, "The Opportunities and Challenges of a Lifelong Health System," *NEJM*, April 25, 2013.

²¹ See Public Health Leadership Forum explanation of Foundational Public Health Services, 2014 and Institute of Medicine, and Institute of Medicine, *For the Public's Health: Investing in a Healthier Future*, 2012.

government grantees to include support for foundational capabilities as part of indirect costs.

B. Assure communities have the data, evidence, analytic capacity and flexibility they need to support building healthy, equitable and resilient communities.

- i. Each DHHS agency and program should be assessed to determine how it can contribute to building healthy communities by giving state and local health departments, and other federal grantees, flexibility to coordinate federal funds to achieve agreed upon goals.
- ii. DHHS should also support the information systems, research, and technical assistance state and local officials will need to adopt evidence-informed and evidence-based approaches to creating health.

C. Transform health care and public health investments by the federal government into a Health Promoting System.

All resources committed to health and health care need to be realigned to better support a health system committed to healthy communities. While we recommend an assessment to determine what new resources could strengthen and accelerate achieving this vision, aligning existing resources is also crucial in order to advance the nation's health. Alignment can be achieved by creating financial incentives within the public health and health care systems to hold all players accountable for community health improvement and resiliency and achieving greater equity, including making progress related to agreed upon national metrics.

The first steps to this end are:

- i. **Health system financing:** Leverage existing Center for Medicare and Medicaid Services (CMS) authorities and initiatives (e.g., Accountable Health Communities, State Innovation Models, and Delivery System Reform Incentive Payment Program) to support public health transformation and create a system that incentivizes health care and public health to work together to build healthier communities. All health programs across DHHS should be aligned to leverage other funds and programs addressing the social determinants of health in both the public and private payer systems. The potential to use Medicaid and CHIP authorities to support accreditation and foundational capabilities should also be explored.
- ii. **Behavioral health:** Through DHHS leadership with the Department of Labor (DOL) and the Internal Revenue Service (IRS), ensure recommendations of the President's White House Task force on Mental Health Parity and Addiction Equity Act (MHPAEA) are implemented so patients can receive the coverage improvements for mental health and substance use disorder treatment created under law by parity legislation and the Affordable Care Act (ACA).
- iii. **Community benefit:** Work with the IRS to adapt guidance for non-profit hospital community benefit investments so they are consistent with the vision of healthy communities. Such guidance should promote greater community engagement in the needs assessment process and in determining how resources should be allocated, and in addition to closer collaboration with local health departments who often do community health needs assessments themselves.
- iv. **Information sharing:** Create an internal task force led by Office of the Assistant Secretary for Health (OASH) and Office of the National Coordinator for Health IT (ONC), that would do an HHS-wide assessment of core information needs to align spending

with health-related data and to assure open access within HHS and for state and local public health to the various data systems held by the federal government or generated by the health system. In addition, steps should be taken to promote better alignment of the multiple data sets.

- v. **Investment in data capacity:** Building on the CDC surveillance strategy²², the federal government should undertake an assessment of federal, state, and local public health information systems to assess their capacity to use 21st century informatics to drive decision making and understand the health of the nation down to the neighborhood level. As part of that assessment, DHHS should make recommendations about new investments that are needed.
- vi. **Private sector investment in public health innovation.** Additionally, to catalyze investment and focus on infrastructure development, DHHS can convene entrepreneurs, investors and technology company representatives with public health leaders to catalyze investment in innovative approaches to achieving public health goals.
- vii. **Workforce and culture change:** It is critical to assure that the public health workforce is trained to fulfill the Chief Health Strategist role in building healthy communities. It is also important for the traditional health workforce to understand and be able to contribute to healthier communities. To that end, the Secretary, the Assistant Secretary for Health (ASH) and other relevant officials should be charged with (a) aligning federal public health workforce programs to assure that current and future federal, state, and local public health officials receive the training needed to operate in this new environment, and (b) aligning federal healthcare workforce training programs as well. In addition, as the locus of intervention is increasingly in the community (through community health workers, behavioral health peer workers, etc.), a broader set of workforce programs that also address the diversity and cultural and linguistic needs of communities served locally need to be aligned, including those supported by HHS, Labor and Commerce.
- viii. **Evidence base:** Establish a stronger learning culture within DHHS and among its grantees that enhances state, local and community efforts by promoting discovery and research, translation of evidence-based approaches and rapid cycle evaluation of all healthy community efforts. This improved culture of learning and continuous improvement could be demonstrated by support of public health services and systems research, creation of a “guidelines warehouse” that makes the evidence base available and accessible to communities and provision of technical assistance to those seeking to implement those guidelines, providing support to study interventions in real time (including responses to public health outbreaks), and integration of a public health and healthy communities perspective into the research of the National Institutes of Health (NIH). The CDC’s HI-5 (Health-Impact in Five Years) initiative is one useful framework for showing that there is evidence for broad-based interventions that drive policy, systems, and environmental change to improve health that engage multiple sectors.²³
- ix. **Preparedness:** The White House, working with DHHS and the Office of Management and Budget (OMB), should explore mechanisms for rapidly identifying and dispersing resources to respond to public health emergencies. In addition, quality preparedness programs are essential to having healthy and safe communities. The DHHS must be a leader in improving the preparedness capability of every public health department

22 U.S. Centers for Disease Control and Prevention, Surveillance Strategy, 2014.

23 U.S. Centers for Disease Control and Prevention, Health Impact in Five Years.

through standardized response measures, toolkits, and identifying/disseminating information about best practices and lessons learned. These preparedness programs improve the resilience of communities to face all challenges, not just those associated with a particular emergency.

Accomplishing these objectives will require careful evaluation of all existing programs and funding streams. In some instances, this can be accomplished by creative use of existing resources and authorities. But we also urge the new Administration to assess where new authorities and/or resources may also be needed to achieve these goals.

2. Leadership and accountability systems within DHHS and across the federal government

DHHS should model the transparency, accountability and cross-sector collaboration that is being encouraged in states and localities as they work toward building healthy communities. To that end:

- A. *The Secretary should create or consolidate reporting systems that measure the nation's and individual agency and program progress toward achieving the national health goals adopted, with associated evaluation regarding progress toward the structural changes outlined above.*
- B. *The Secretary should designate key leaders within DHHS whose continued leadership is predicated on making progress toward these goals.*
- C. *The Administration should create within DHHS and across the federal government cross-agency collaboration models. Approaches include:*
 - i. Directing the ASH to conduct a budgetary review of all the Public Health Service Agencies to assure that their respective programs are aligned with the healthy communities vision and to assure maximum impact and empowerment on the ground in communities. The ASH should continue to play a role on the Secretary's Budget Council to participate in reviews of other relevant agencies such as the Administration for Children and Families and other social services programs at DHHS that affect determinants of health.
 - ii. Working with OMB, the DHHS agencies should identify existing authority to give state and local governments (and other grantees) more flexibility in using and coordinating funds by adopting common objectives, utilizing reporting mechanisms across funding streams, and clarifying roles on issues that cross agency jurisdictional lines.
 - iii. Working with the President to create a new Cabinet Working Group or Healthy Communities Council within the Domestic Policy Council²⁴, chaired by the Secretary of HHS, to oversee the implementation of the various government-wide efforts addressing healthy communities – from public health initiatives to addressing broader social determinants of health. This Working Group or Council would receive input from one of the external advisory groups mentioned below to assure a non-federal perspective.

²⁴ The following agencies and offices are currently members of the National Prevention Council: Surgeon General, Council Chair, Department of Health and Human Services, Department of Agriculture, Department of Education, Federal Trade Commission, Department of Transportation, Department of Labor, Department of Homeland Security, Environmental Protection Agency, Office of National Drug Control Policy, Domestic Policy Council, Department of the Interior, Department of Justice, Corporation for National and Community Service, Department of Defense, Department of Veterans Affairs, Department of Housing and Urban Development, Office of Management and Budget, Department of the Interior, General Services Administration, Office of Personnel Management.

D. The Secretary should mobilize public-private partnerships that collaborate on building healthy communities, recognizing that both government and the private sector benefit from thriving communities (a healthier workforce, reduced health care costs, economically more secure, etc.).

Options include:

- i. Revitalizing the Advisory Group on Prevention, Health Promotion and Integrative and Public Health by assuring that its membership is reflective of the broad spectrum of interests needed from both the public and private sectors. While Advisory Group members are appointed by the President, it is chartered by the Secretary; the Secretary can alter the charter to require certain categories, and thus diversity, of membership; though tied to the National Prevention Council (NPC), the Advisory Group could have a broadened mission to advise not just the NPC but any other entity that is created to support the Chief Health Strategist role.
- ii. Establishing under existing Secretarial authority a Forum on Healthy Communities, which would be a public-private partnership co-convened by the Secretary of Health and Human Services and a leading private sector organization (e.g., the Chamber of Commerce Foundation) to catalyze multi-sector approaches at the national and state/local levels. This Forum would demonstrate the need to engage the private sector and that partnership and building healthy communities is not just a governmental function.

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