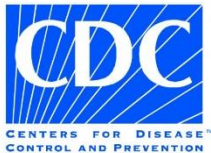


Becoming the Chief Health Strategist: The Future of Public Health

John Auerbach

Associate Director for Policy

Acting Director, Office for State, Tribal, Local and Territorial Support
Centers for Disease Control and Prevention



CDC Strategic Directions

Improve health security at home and around the world



Better prevent the leading causes of illness, injury, disability, and death



Strengthen public health/healthcare collaboration

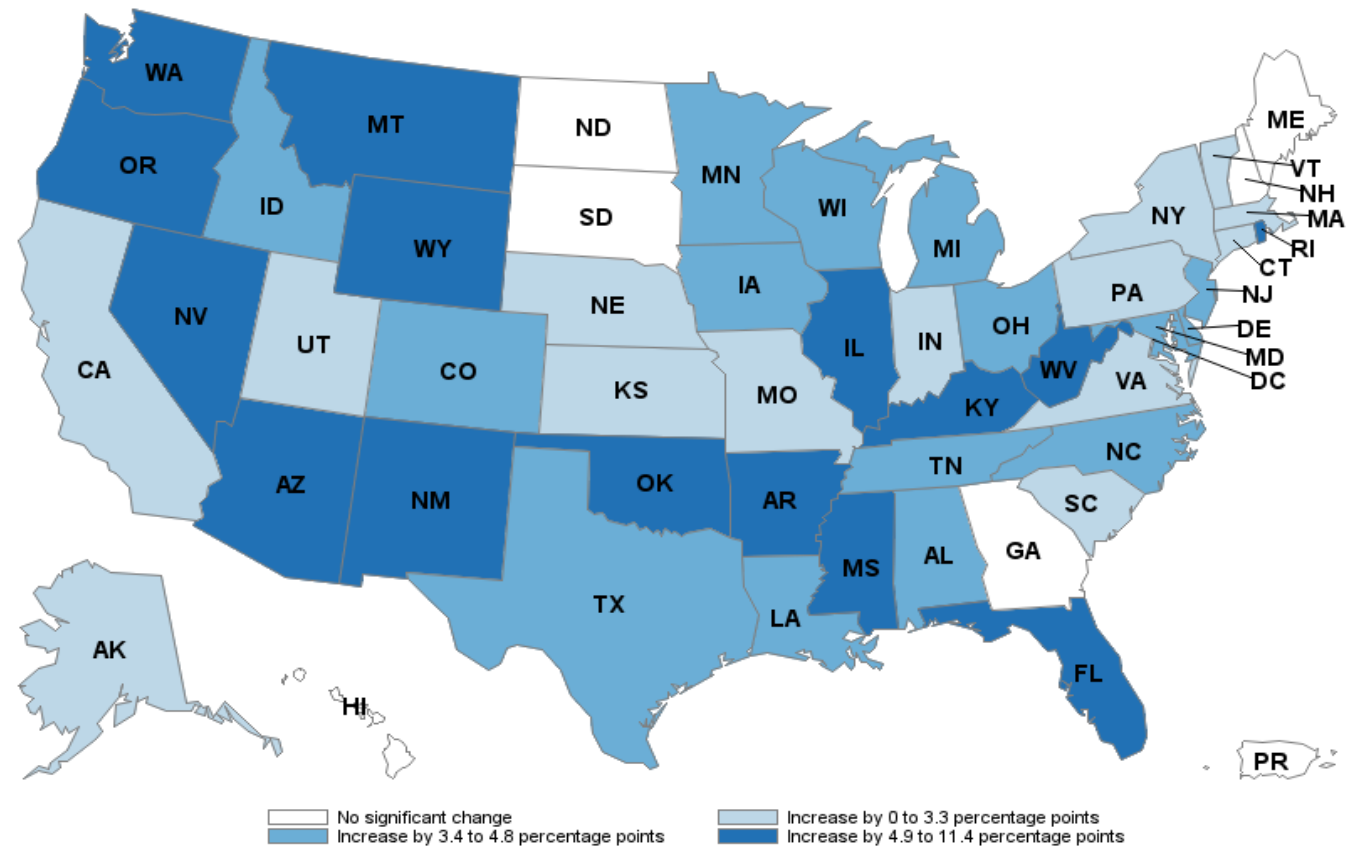


National Trend #1: Increased Access

20 million Americans
have gained insurance
for the first time

Meaning for Public Health

Decreased need for public health
safety net programs and services

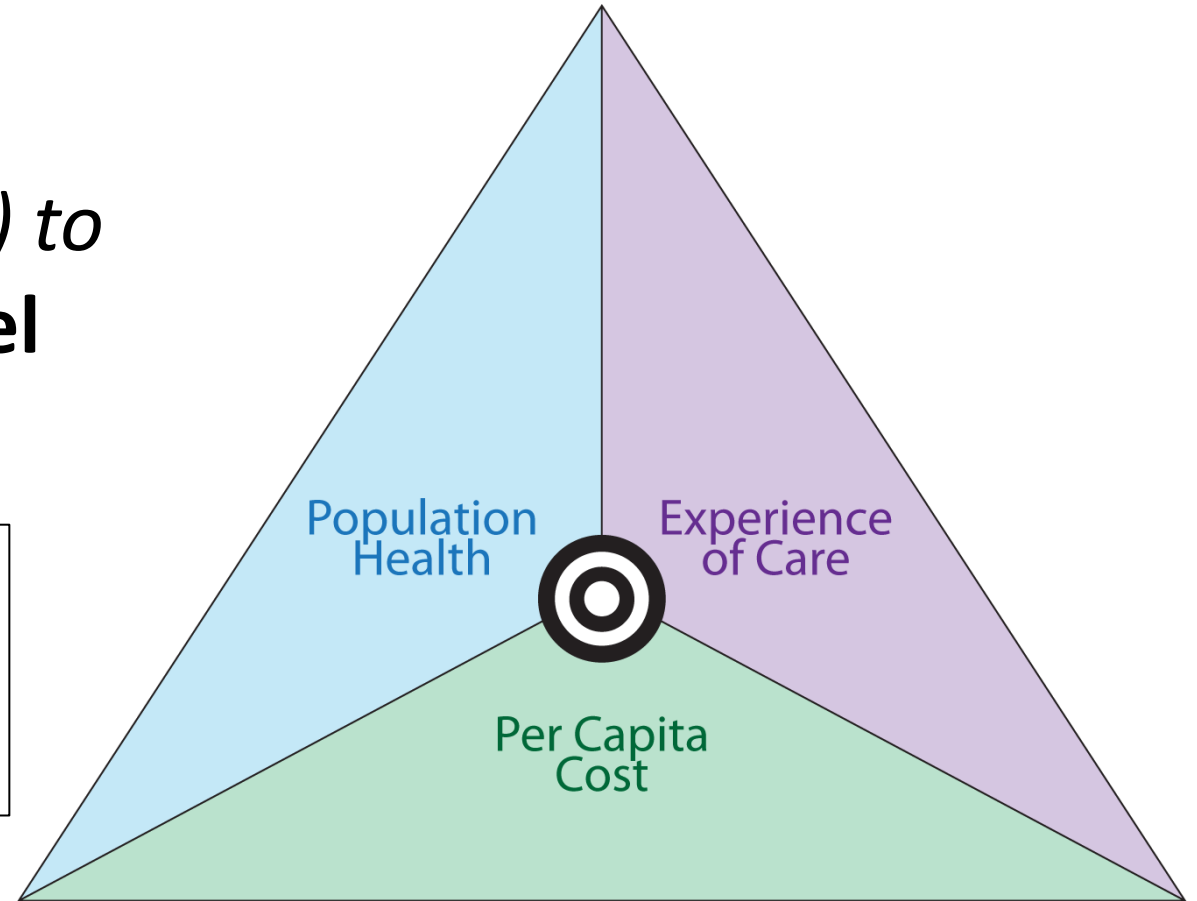


National Trend #2: Payment Reform Is Widespread

Shift from “*Volume-Based*”
Payment Model (Fee-for-Service) to
“**Value-Based**” Payment Model

Meaning for Public Health

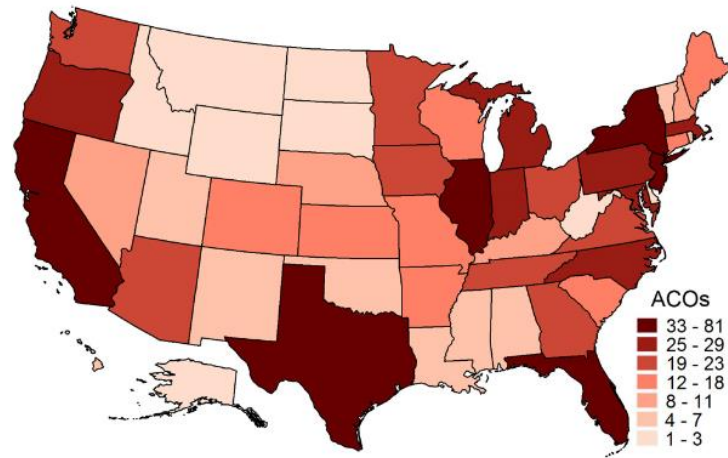
Possibility of paying for more
preventive services



National Trend #3: Emerging Clinical Care Models

50 million patients are currently being served by federally qualified health centers and accountable care organizations

Figure 3. Number of ACOs by State, January 2015

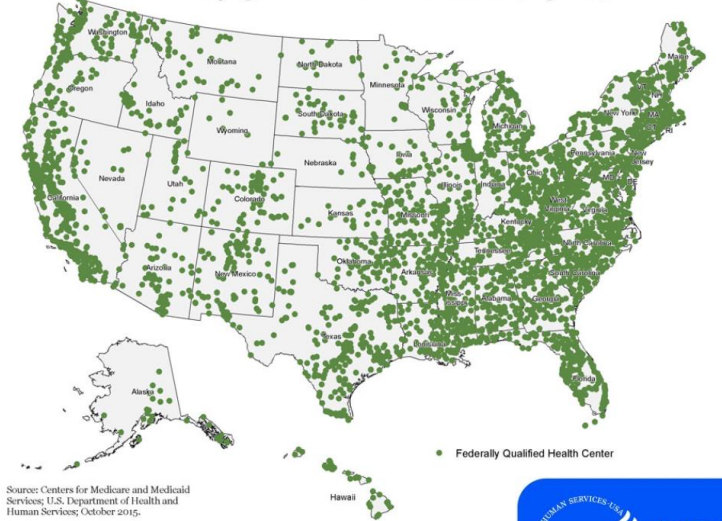


Source: Leavitt Partners Center for Accountable Care Intelligence

Meaning for Public Health

Increased opportunities to link clinical care and communities

Federally Qualified Health Centers (FQHCs)

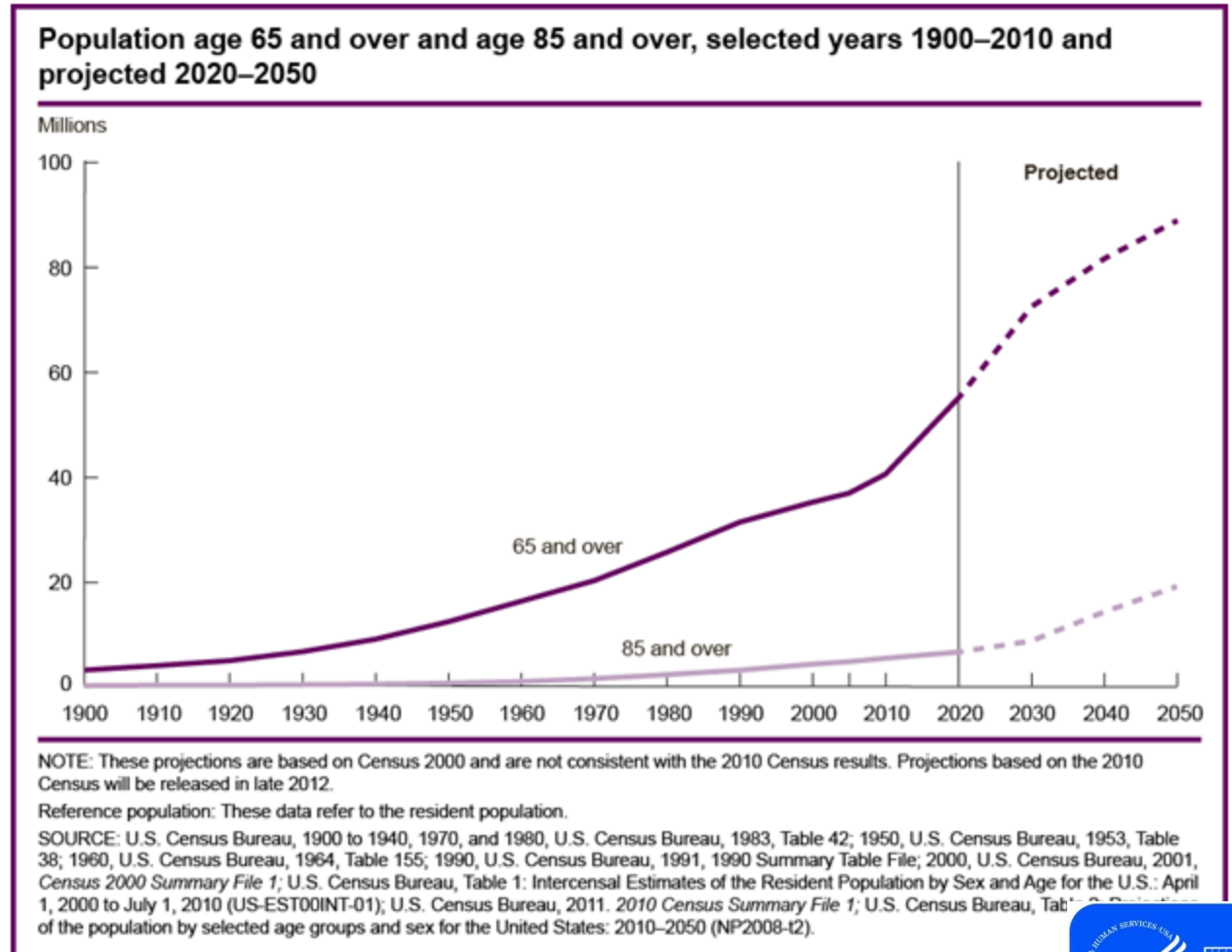


National Trend #4: Other Conditions Demand an Overhaul

Demographic characteristics and healthcare needs of the US population are changing

Meaning for Public Health

Alignment of public health policies and services to address these changing needs



National Trend #5: Public Health Evolution

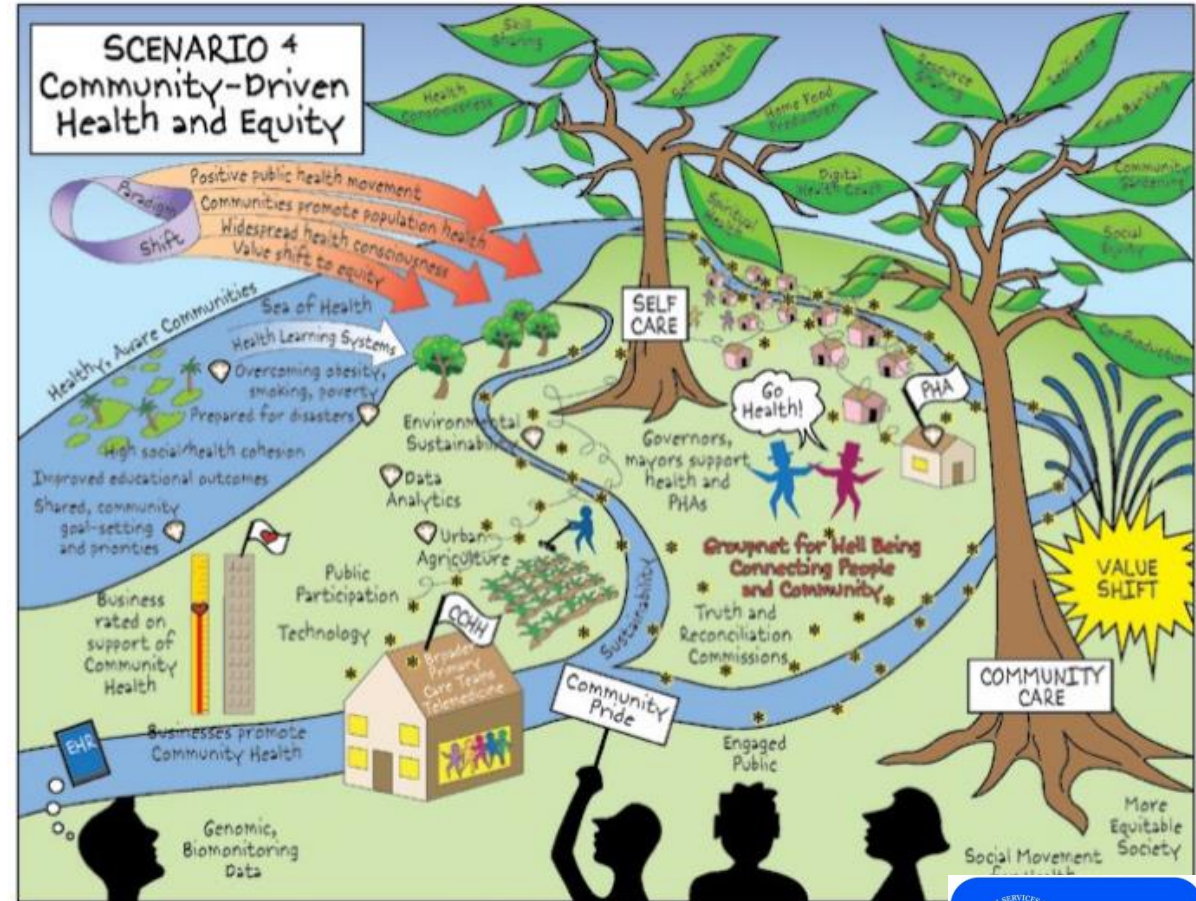
**Public health funding
has been declining
since 2008**

Meaning for Public Health
Evaluation of core public health
functions



Public Health as Chief Health Strategist

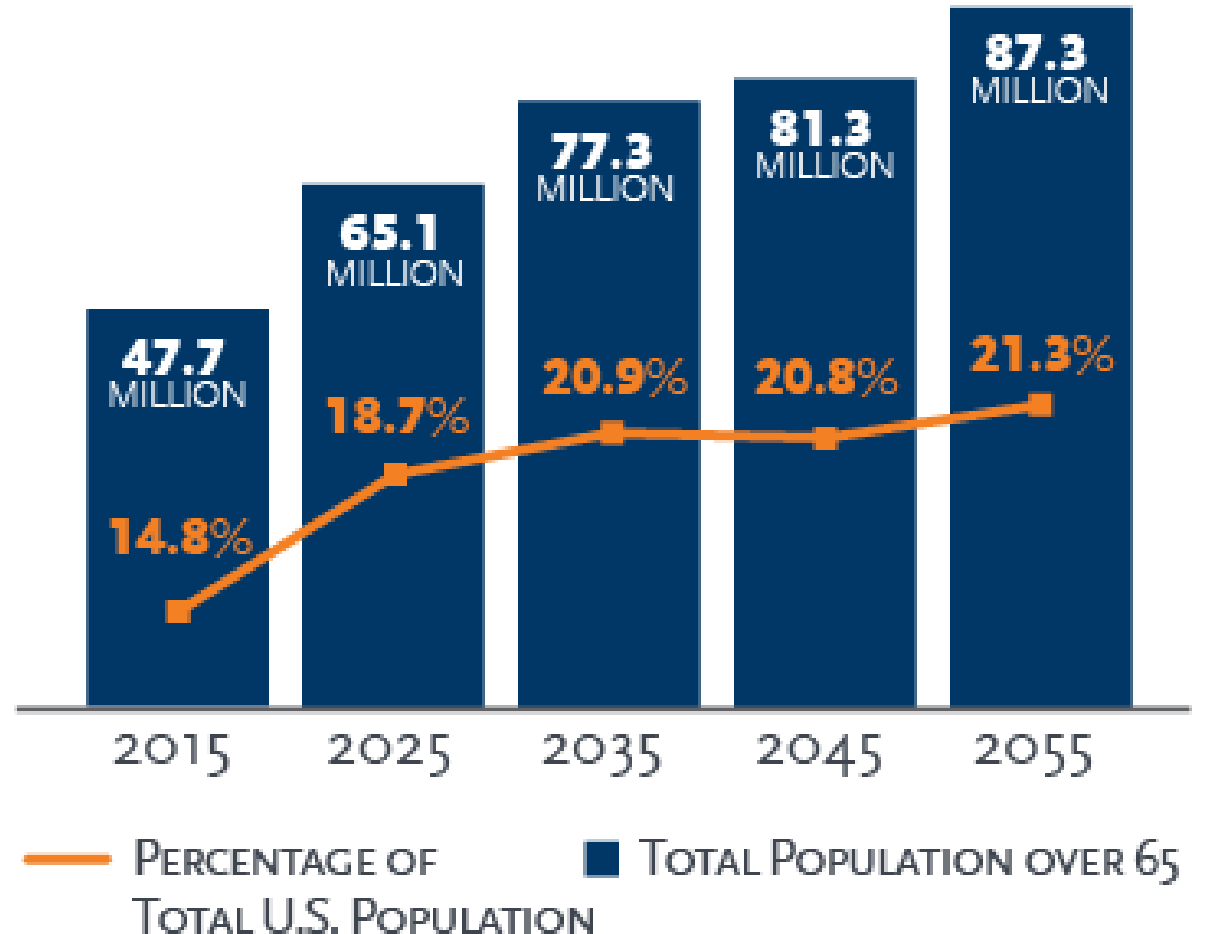
- Less direct care—more policy
- Programs tailored to emerging needs & populations
- Convening coalitions
- Partnering with healthcare and diverse sectors
- Upstream focus
- Real-time and new data



Key Practices of the Chief Health Strategists of the Future

Practice #1: Adopt and adapt strategies to combat the evolving leading causes of illness, injury, and premature death

Population Growth Over the Age of 65

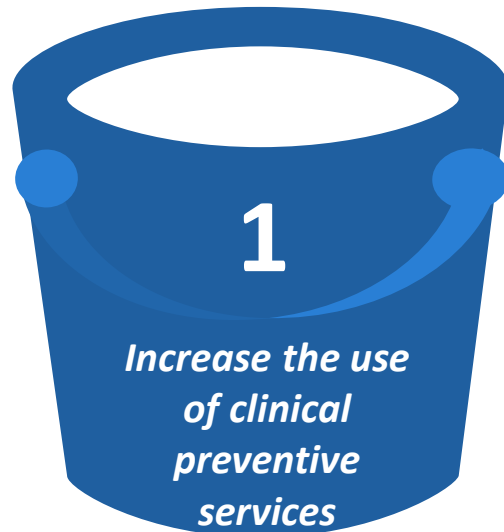


Key Practices of the Chief Health Strategists of the Future

Practice #2: Develop strategies for promoting health and well-being that work most effectively for communities of today and tomorrow

The 3 Buckets of Prevention

Traditional Clinical Prevention



Innovative Clinical Prevention



Community-Wide Prevention



 Health Care

Public Health 

Key Practices of the Chief Health Strategists of the Future

Practice #3: Identify, analyze, and distribute information from new, big, and real-time data sources

**Data Across
Sectors** for Health



DASH is a national Robert Wood Johnson Foundation program

Key Practices of the Chief Health Strategists of the Future

- **Practice #4:** Build a more integrated, effective health system through collaboration between clinical care and public health

High-burden
health
conditions

6 | 18

Evidence-based
interventions that
can improve health
and save money

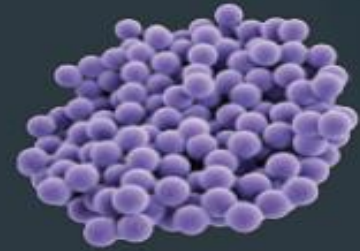
SIX WAYS TO SPEND SMARTER FOR HEALTHIER PEOPLE



REDUCE
TOBACCO USE



CONTROL
BLOOD PRESSURE



PREVENT HEALTHCARE-
ASSOCIATED INFECTIONS (HAI)



CONTROL ASTHMA



PREVENT UNINTENDED
PREGNANCY



CONTROL AND
PREVENT DIABETES

Examples of 6 | 18 Interventions

Bucket 1 Examples: In Clinical Settings

Improve access to medications (e.g., via elimination of cost sharing)

Expand access to comprehensive tobacco cessation treatment

Remove barriers to use of long-acting reversible contraceptives

Bucket 2 Examples: Outside of Clinical Settings

Self-measured home blood pressure monitoring

Diabetes Prevention Program

Home visits for asthma care (to reduce home triggers)

Key Practices of the Chief Health Strategists of the Future

- **Practice #5:** Collaborate with a broad array of allies—including those at the neighborhood-level and the non-health sectors—to build healthier and more vital communities



Addressing the Social Determinants of Health **Community-Wide Health Improvement Initiatives**



Coming Soon! Population Health Initiative

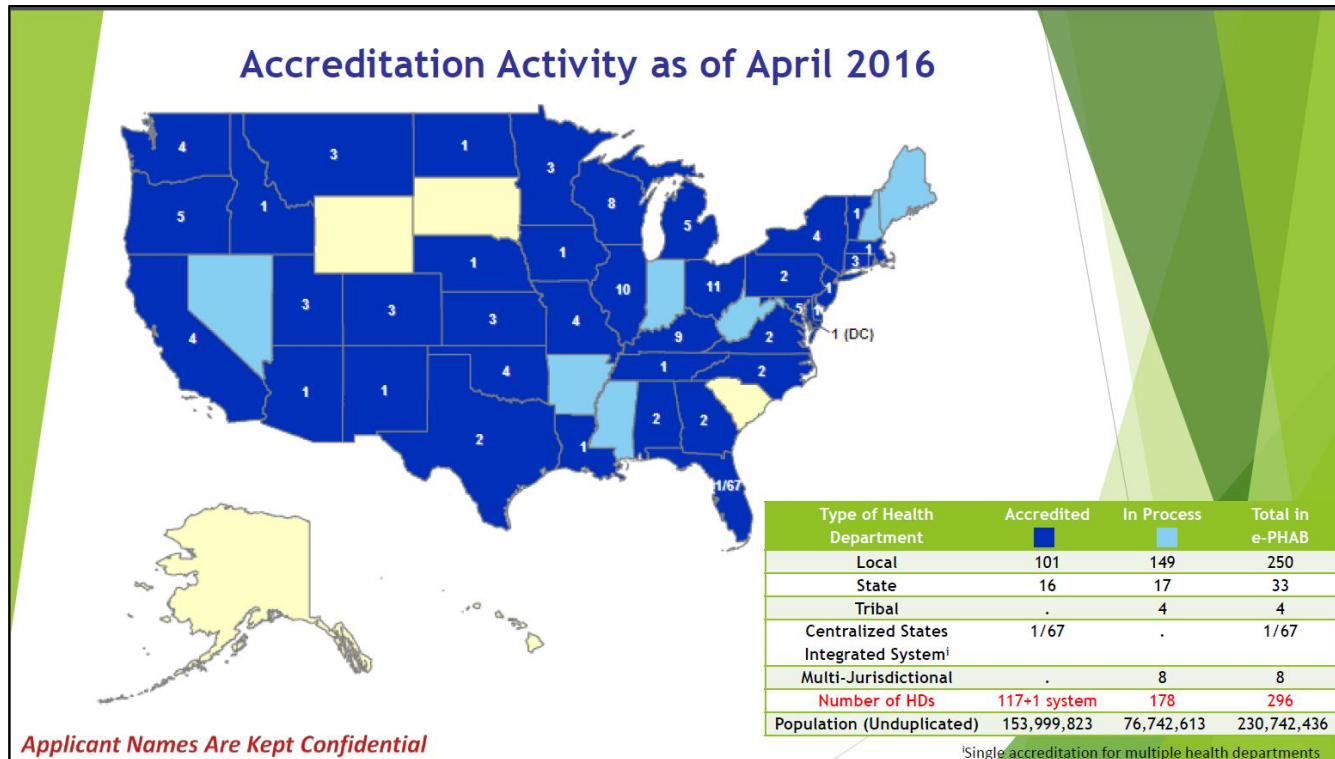
A core set of 24 evidence-based community population health interventions that aim to

- Improve the health of the larger community (as contrasted with approaches that are clinical and patient-oriented)
- Demonstrate health and cost impact
- Address social, economic, or environmental conditions



Key Practices of the Chief Health Strategists of the Future

- **Practice #6:** Replace outdated organizational practices with state-of-the-art business, accountability, and financing systems



Key Practices of the Chief Health Strategists of the Future

- **Practice #7:** Work with corresponding federal partners—ideally, a federal chief health strategist—to effectively meet their communities' needs

Public Health 3.0: Time for an Upgrade

It is time to boldly expand the scope and reach of public health to address all factors that promote health and well-being, including those related to economic development, education, transportation, food, environment, and housing. Despite nearly \$3.0 trillion in annual health care spending, the United States ranks 27th in the world in life expectancy, and relatively low in many other measures of health and well-being.^{1,2} Worse yet, for the poor in this country, life expectancy is actually decreasing.³ Given these trends, and persistent gaps in health status, it's time for a major upgrade to Public Health 3.0.

PUBLIC HEALTH 1.0

The public health system in its modern sense began to take shape after the industrial revolution in the late 19th century. During the 20th century, public health was empowered by extraordinary scientific advances in our understanding of disease, powerful new prevention and treatment tools such as vaccines and antibiotics, and expanded capability in areas such as epidemiology and laboratory science. We refer to this period as Public Health 1.0.

Yet, by late in the century, the capacity and effectiveness of public health agencies varied enormously across the country, with little consensus about what should be expected of public health. In 1988, the Institute of

Medicine (IOM) declared in *The Future of Public Health* that "this nation has lost sight of its public health goals and has allowed the system of public health activities to fall into disarray."⁴

PUBLIC HEALTH 2.0

We conceive of Public Health 2.0 as beginning with this IOM report and continuing to the present day. The IOM Committee characterized the mission of public health as fulfilling society's interest in assuring conditions in which people can be healthy, and defined the core functions of governmental public health agencies as assessment, policy development, and assurance. This seminal report was enormously influential in shaping and reenergizing public health (e.g., by spurring national deliberations leading to the clear articulation of the essential services of public health). However, there was little emphasis on how public health leaders might work across sectors to address social, environmental, or economic determinants of health.

A CHANGING LANDSCAPE FOR PUBLIC HEALTH

Several developments are driving the need to re-envision public health practice once again. Health trends in the last 30 years are such that the leading causes of death and illness are now

attributable to behaviors (e.g., smoking, sedentary lifestyle, and eating patterns) that are powerfully driven by the social and physical environments in which people live, learn, work, and play.

Today, the largest part of many state and local agency budgets are federal grants, giving state and local public health departments limited flexibility in how best to meet local needs.⁵ Most health departments have not seen their budgets or functional capacity fully restored since the sharp and sustained budget cuts to public health at every level which followed the Great Recession in the United States (2007–2009).

The Affordable Care Act (ACA) improved access to health care for all. Today, 17.6 million people have access to affordable health care that did not have access before. This development is facilitating public health's transition away from clinical care provider of last resort to primary prevention and health promotion.

The ACA also catalyzed movement away from fee-for-service to

value-based payments, potentially innovative prevention and health-promoting care models.⁶ The ACA's requirement that nonprofit hospitals must do community health needs assessments has increased collaboration between medicine and public health.

In the past decade, there has been a widening embrace of health department accreditation as one strategy to improve public health agency performance. As of November 2015, 33 states plus the District of Columbia have a health department accredited by the Public Health Accreditation Board (PHAB), reaching 45% of the US population.

Finally, there has been increasing recognition in recent years that we—in public health and beyond—must find ways to directly address the broad social and environmental determinants of health, through collaborative, cross-sector efforts. Elected and civic leaders have also become more aware of the importance of community health, realizing that a healthy community is one with a strong educational system, safe streets, effective public transportation, and affordable, high-quality food and housing.

ABOUT THE AUTHORS

Kenn B. DeSalvo is Acting Assistant Secretary for Health with the US Department of Health and Human Services (HHS), Washington, DC. Patrick W. O'Carroll is Acting Deputy Assistant Secretary for Health (Science and Medicine) with the Office of the Assistant Secretary for Health, HHS. Denise Coia is Assistant to the Acting Assistant Secretary for Health, HHS, on detail from the Centers for Disease Control and Prevention (CDC). John M. Auerbach is Associate Director for Policy with CDC, Atlanta, GA. Judith A. Mansour, MD, is Director, Office for State, Tribal, Local and Territorial Support with CDC.

Correspondence should be sent to Patrick W. O'Carroll, Regional Health Administrator, 701 Fifth Avenue, MS 20, Seattle, WA, 98121. (e-mail: patrick.w.ocaroll@hhs.gov). Reprints can be ordered at <http://www.ajph.org> by clicking the "Reprints" link.

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A Reminder About the Issues . . .

Meet Fran Edwards

- Newly insured
- At MD for first physical in 5 years
- 55 years old, married, smokes, overweight, little exercise
- Asthmatic, high blood pressure
- Stopped taking medications in past due to cost



Insurance and Quality Care Help . . . **But the Following Also Contribute to Her Health**

- **Income**—Low-income family of 5
- **Barriers to fitness**—Rising crime rate, few parks, no nearby supermarket
- **Under stress**—Child with behavioral health concerns, worried about money
- **Sub-par housing**—Mold and ventilation problems



How Can Each Sector Help Ms. Edwards?

- **Payers and providers**

- **Bucket 1:** No co-pay for her medications
- **Bucket 2:** Home visits to reduce asthma

- **Hospitals**

- **Bucket 3:** Invest in healthy housing options; support for community policies

- **Public health**

- **Buckets 1 & 2:** Participate in meetings of insurers; support for 6 | 18
- **Bucket 3:** Support for equity; health-promoting policies in lower-income communities





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Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333

Phone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348

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Web: www.cdc.gov