EMPOWERING BIG CITY HEALTH DEPARTMENTS TO FULLY BE THEIR COMMUNITY'S CHIEF HEALTH STRATEGIST

Opportunities for a New Administration and Congress

BIG CITIES HEALTH COALITION

DECEMBER 2016

BACKGROUND

The Big Cities Health Coalition ("BCHC" or "Coalition") is a forum for the leaders of America's largest metropolitan health departments to exchange strategies and jointly address issues to promote and protect the health and safety of the 54 million people they serve. The mission of the Coalition is to advance equity and health for present and future generations. Our vision is healthy, more equitable communities through big city innovation and leadership.

Our members are on the front lines of public health in urban America, working every day to make it easier for people to get and stay healthy, and be safe. Big cities address a wide range of everyday threats, including chronic and infectious disease, environmental hazards, and drug abuse. These big city health leaders are already, in many ways, the "Community's Chief Health Strategist," focusing on prevention, laying the groundwork for healthy choices that keep people from getting sick or injured, and convening key stakeholders. Finally, big city health leaders help build strong resilient communities, respond when public health emergencies occur, and lend support through the recovery process.

Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention, and detection and control of infectious diseases. Overall, public health is concerned with protecting the health of entire populations. Having a public health system that works well, matters now more than ever.

- While the U.S. spends the most of any nation in the world on health care, it does not see a comparable return on investment in health outcomes. In fact, our nation ranks 43rd globally in life expectancy.[1]
- While 97% of healthcare costs are spent on medical care delivered in hospitals, we know that only 10% of what determines life-expectancy takes place within the four walls of a clinic.[2]

These, and many other facts like them, show that the way we spend our health dollars is not working. We need to invest in creating healthier communities that prevent disease from taking root in the first place, and break the status quo, where one's health is predominantly determined by the zip code in which one lives. Every American deserves to be healthy and safe, no matter where they live.

When we build a strong public health system, we know it improves health outcomes across the board, including for groups that have historically had decreased opportunities for good health. Local health departments, working with state and federal partners, work to reduce the leading causes of injury, illness, disability, and death for Americans. They decrease needless suffering and lower health care costs. By leveraging evidence-based public health knowledge and tools, the governmental public health system makes a difference in people's lives and makes the United States a stronger nation.

THE LOCAL PUBLIC HEALTH ROLE IN AMERICA'S CITIES

The nation's urban local health departments are critical to building a healthier, safer, and more secure nation. Metropolitan areas are now home to almost 83% of Americans, and BCHC member health departments serve about 54 million or 1 in 6 Americans.[3,4] When they are appropriately resourced and staffed, these urban big city health departments have the potential to impact large portions of a population and help create an environment in which the healthy, safe option is the default option.

Policy innovation in cities does not just change the trajectory of health for those local populations. Cities help drive national change as incubators of best and promising practices, which they can share. City health leaders possess a unique and valuable perspective because they are "on the ground" and see firsthand the challenges their communities face. Consequently, leaders at the local level are then best able to understand and implement solutions because they are often directly engaging with residents to find consensus on solutions to move forward.

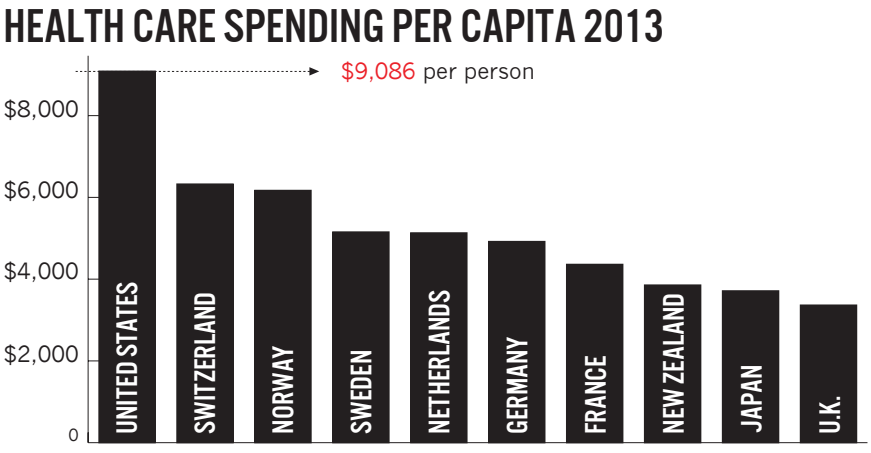
BCHC members are active leaders and partners in addressing the policy and systems change needed to improve their communities. Over the past decade, large city governments have increasingly become incubators of policy innovation and strong executive leadership.[5] Mayors across the country have taken bold stands on health issues ranging from the opioids epidemic to childhood obesity. It is the efforts of these leaders that often become models for their peers and are scaled up to the federal level or are shared with other areas of the country.[6]

What is a Chief Community Health Strategist?

In 2014, the Robert Wood Johnson Foundation's Public Health Leadership Forum, in collaboration with John Auerbach, drafted a concept paper entitled, *The High Achieving Governmental Health Department in 2020 as the Community Chief Health Strategist*. The paper urges health officials to rise to this new role, explaining that in 2020, "State and local health departments will be more likely to design policies than provide direct services; more likely to convene coalitions than work alone; and be more likely to access and have real-time data than await the next annual survey."

This requires many local health departments to develop new skills and tasks in order to fulfill key public health functions while building new policies and strategies in light of the nation's changing health landscape. It highlights the need for local governmental health departments to adapt to an evolving health system, including changes in healthcare needs, financing, and delivery systems, and demographic shifts. The paper also details key roles for governmental public health to promote health and wellness for all people in the community, collect and share data related to the health of the community,

While the U.S. spends the most of any nation in the world on health care, it does not see a comparable return on investment in health outcomes. In fact, our nation ranks 43rd globally in life expectancy.



Source: Organization for Economic Cooperation and Development (OECD) Health Data

assess workforce needs, and collaborate with a range of partners to build an integrated and effective system that leads to healthier communities.

Key takeaways from the paper include:

- BCHC member departments are rooted in the community and have expertise to share. They know how to keep people healthy, which can lead to lower health care costs.
- BCHC member departments are already conveners of people and resources in their communities and need additional capacity to further expand this role.
- Federal dollars should support and facilitate this role in communities across the nation. Congress and the Trump Administration need to break down health-related funding silos, so they are more flexible, and provide more direct funding support for communities.
- The best policy decisions are those that are data-driven. BCHC member departments need resources to continue to modernize governmental public health, in particular local data collection and systems to support them. Public health data systems speak to the health of entire populations in a way that health care data do not. Federal leadership and resources are needed to enable the creation of public health data systems that are as sophisticated as healthcare systems, which have been largely subsidized with federal dollars.

As the public health community has known for years, and others sectors are now realizing, health is influenced by a range of interconnected factors, such as individual health behaviors, social characteristics, and physical environment. A zip code, in most cases, determines more about a person's health than their DNA.[7]

Big city health departments that act as community chief health strategists play an important role in addressing the broader influences that affect health, such as eliminating health disparities, and promoting health equity among all individuals in their communities.

The Department of Health and Human Services' (HHS) 2016 "Public Health 3.0 (PH3) report is similar in its intent and focus on improving the health of whole of the community. This framework defines the need for a "major upgrade in public health practice to emphasize cross-sectoral environmental, policy, and systems-level actions that directly affect the social determinants of health and advance health equity."[8] PH3 underscores the importance of the chief health strategist role, but goes a step further by emphasizing that to truly address the social determinants of health necessary to achieve a healthier nation, governmental public health cannot work alone. It must partner across sectors.

HHH's PH3 recommends that public health departments:

- Play the role of chief health strategist;
- Engage with stakeholders to partner across sectors;
- Achieve "enhanced" accreditation so as to require PH3 activities;
- Ensure timely, accurate, granular public health data are available and accessible; and
- Receive enhanced funding, that is more flexible so decisions closer to the health issues can be more nimble and responsive to need.

Key Policy Issues

> *Opioids Addiction and Overdose Prevention and Treatment*

Big city health departments have always been on the front lines of drug abuse prevention and treatment. As the opioid epidemic spreads to communities both urban and rural, a comprehensive federal response is needed to address it and find common solutions. Overdoses caused by opioids, both prescription drugs and heroin, take more than 70 lives a day. According to the *National Survey on Drug Use and Health,* one in ten people in the U.S. who is misusing prescription drugs will switch to heroin.[9]

WHAT CAN BE DONE?

1. Fully fund the Comprehensive Addiction and Recovery Act (CARA) to expand access to treatment, strengthen prescription drug monitoring programs, and accelerate research on pain and opioid misuse. It is critically important that dollars get to the local level where communities are battling this epidemic.

2. Raise the cap on medication-assisted treatment to 500 patients per clinician. While HHS recently raised the "patient per clinician cap" for those doctors who provide buprenorphine, an evidence-based medication-assisted treatment option, there are still more patients in need, and it should be further raised. One would never limit a doctor to prescribe blood pressure medication, but this is what has been done with buprenorphine. Doing so prevents communities from achieving the full benefit of this lifesaving drug.

3. Ensure greater accessibility to naloxone to reverse overdoses as they occur.

4. Develop an upstream, public health prevention approach to opioid addiction prevention.

> *Community Violence*

Over the past few years, Coalition members have become more and more concerned with violence in their communities. Many big city health departments are working on violence prevention programs or addressing challenges related to this persistent problem. Violence leads to widening health disparities and is the overall leading cause of injury, disability, and premature death.[10] We also know that community trauma leads to poor health and educational outcomes,[11] and that it can be prevented at the community level.[12]

Violence and trauma can be prevented at the community level using a public health approach. Local health departments leading on this issue include Boston,[13] Kansas City,[14] and Minneapolis.[15] While each city uses different and inherently local methods and approaches to successfully reduce violence in the community, they are all

VIOLENCE

Violence leads to widening health disparities, and, with injuries, is the overall leading cause of disability and premature death among those age 1 to 44.

199,800 deaths
FROM INJURIES AND VIOLENCE IN THE U.S. PER YEAR

$671 billion spent
IN MEDICAL COSTS AND WORK LOST PER YEAR

Source: Centers for Disease Control and Prevention, Injuries andViolence in the U.S. by the Numbers, 2013. http://www.cdc.gov/injury/wisqars/overview/key_data.html

seeing positive results. Unfortunately, few local health departments have dedicated resources to focus on violence in their communities. Funding is needed for more timely, accurate local level data, and additional violence-related research is needed. More information can be found in BCHC's Preventing Violence in the Big Cities paper.

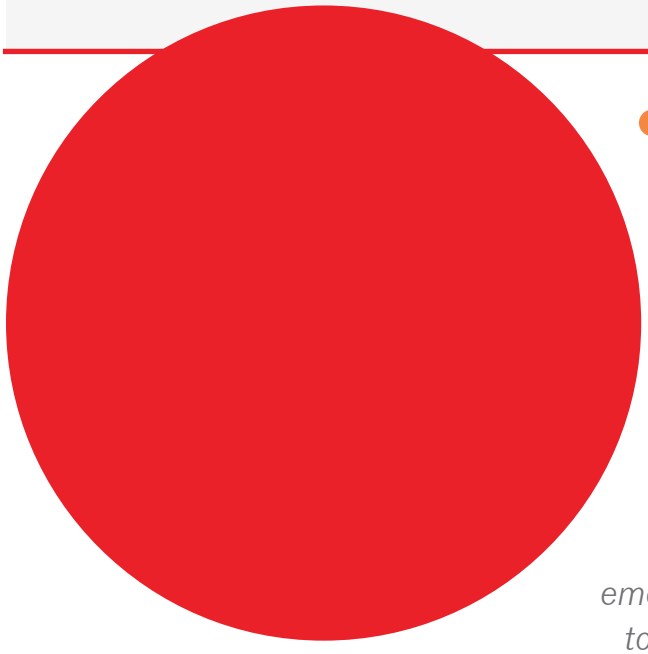
WHAT CAN BE DONE?

1 **More timely, accurate, local level data are needed**. Further, in addition to those that measure injury and death, indicators should capture a community's strength and resilience. To this end, some big city health departments are experimenting with identifying more positive measures, ensuring that survey data does more than paint a negative picture of a community and its residents. For example, New York City and Seattle-King County are developing survey questions to capture this kind of information.

2 At the federal level, additional resources for **violence-related** research are needed. "Best practice" information is also needed to guide local policy and program development to curb violence.

3 Additional work is needed to ensure **evidence-based programs and policies work in concert** to reduce community violence. Data must be gathered to determine the costs associated with continuing ineffective initiatives, as well as what could be gained by starting or expanding effective policies. For example, cities should be able to capture the costs of the criminal justice system, in addition to the anticipated savings that could be made from decreasing violence in the community.

4 Finally, **community-led, place-based interventions** are needed. Place-based interventions are those that aim for comprehensive community-wide



$2.5 MILLION—DOLLARS CDC CAN IMMEDIATELY ACCESS FOR EMERGENCY RESPONSE

$13 BILLION—DOLLARS FEMA CAN IMMEDIATELY ACCESS FOR EMERGENCY RESPONSE*

*CDC states that of the $14 billion in their annual budget, all but $2.5 million is already designated for specific programs, and therefore unavailable for immediate use in the event of a disaster. During emergencies such as the recent Zika outbreak, CDC is forced to wait for Congress to either grant them permission to shift existing funds or to allocate new funds to respond. In stark contrast, Congress appropriates approximately $13 billion annually to the Federal Emergency Management Agency (FEMA) to respond to natural disasters.**

*FEMA dollars can be accessed once the President issues a major disaster or emergency declaration under Stafford Act

Source: USA Today, "Zika virus 'not controllable': CDC director's grim warning," October 25, 2016.

changes. They aim to produce change by affecting the whole community, not just the individuals touched by a funded program.[16] Addressing violence requires multi-faceted solutions that center residents as experts. By learning from other jurisdictions' place-based strategies, cities can craft better prevention strategies both with and for communities.

SUPPORTING LOCAL PUBLIC HEALTH

The following recommendations from the Big Cities Health Coalition are specific to large, urban health departments, but also speak to larger needs across the entire governmental health enterprise. Implementing these recommendations will help provide the support needed to prepare local health departments to fully act as a chief health strategist and enable their communities to meet their health goals.

> *Fully Fund "all-hazards" emergency preparedness and response at the local level.*

A critical component of protecting and securing our nation's public health and national security is having local, state, and territorial agencies prepared to prevent, detect, respond to, and rapidly recover from a variety of threats. The Centers for Disease Control and Prevention (CDC) and the Assistant Secretary for Preparedness and Response (ASPR) at HHS provide federal public health emergency preparedness funding to large metropolitan health departments either directly (as is the case in New York City, Los Angeles County, Chicago, Washington, D.C.) or through state health departments. These funds are critical to preparing for and building capacity to respond to public health emergencies, including terrorist threats, infectious disease outbreaks, natural disasters, and biological, chemical, nuclear, and radiological emergencies. However, these funds alone are not adequate for ensuring that our communities are resilient and able to recover from disasters and emergencies. The nation needs a robust public health system built through sustained funding, and public health emergency response funding that can be deployed to address the unique and unforeseen challenges of each particular disaster.

WHAT CAN BE DONE?

1. **Provide Public Health Emergency Preparedness (PHEP) funding and ensure dollars flow to local communities** rather than sit at the state level. In recent years, local health departments have faced a myriad of emerging infectious diseases, including Zika, Ebola, H1N1, SARS, and MERS, in addition to large scale multi-state food-borne illness outbreaks. Since all disasters strike locally, local health departments are a critical part of any community's first response to disease outbreaks, emergencies, and acts of terrorism. It is also extremely important that CDC is able to track how federal preparedness dollars are distributed and used in states to local communities.

2. **Fully fund a Public Health Emergency Response Fund**. To ensure that federal, state, and local governmental public health can effectively respond to emerging infectious diseases and other natural and man-made disasters, BCHC supports a Public Health Emergency Fund. Doing so would provide surge funding for immediate response and assist in preventing incidents from becoming even more deadly and costly. Given the challenges and significant time it took Congress to pass supplemental funding to address the

Ebola and then Zika viruses, an emergency fund could enable the expeditious deployment of resources to the federal government and out into the field.

When this fund is appropriately supported and accessible, local health departments will be better able to respond to public health disasters that demand quick action. This pool of dollars will likely not be large enough to fund an entire response to every event, but it can give health departments a running start when an emergency strikes. Congress will still have oversight by demanding accounting and reporting – and deciding whether to allocate additional dollars to the effort in the months and years to come. **More information can be found in BCHC's** Public Health Emergency Fund **paper.**

> *Direct federal funding to the local level, enabling greater flexibility to adapt to conditions on the ground.*

The majority of federal funding for public health goes to state health departments. The federal government also directly funds a few large urban health departments. State health departments allocate funding to local health departments with great variability around the country. The primary federal agencies that fund public health are the Centers for Disease Control and Prevention (CDC), the Office of the Assistant Secretary for Preparedness and Response (ASPR), and the Health Resources and Services Administration (HRSA). Notably, 13 percent of CDC's budget comes from the Prevention and Public Health Fund.

Congress and the Trump Administration should issue clear language to states to foster more flexible funding, and require greater accountability and clarity around how much is passed through to local communities.

WHAT CAN BE DONE?

1 Congress, through Report Language, and the Trump Administration, through directive guidance to grantees, can increase accountability and create more guidelines on how to allocate funds to big city health departments. We have seen some success in regards to directing more emergency preparedness funds locally, thanks to Congressional support for higher accountability standards. Some success has also come from local programs that are supported by the Prevention and Public Health Fund, due to stricter reporting requirements on dollars spent from the Fund.

2 Community benefit dollars need to be better leveraged in local communities and the Trump administration can ensure this happens through clearer guidance and/or rulemaking.

To maintain their tax-exempt status, nonprofit hospitals must provide benefits to the communities they serve. Historically, hospitals' community benefit activities have focused on providing charity care and other forms of uncompensated care. The Federal Government has established standard requirements for nonprofit hospitals concerning community benefit reporting, community health needs assessments, and strategies to improve the health of the communities they serve. IRS figures show that in 2011, hospitals allocated slightly less than $2.7 billion out of nearly $62.5 billion in community benefit spending to community health improvement. BCHC seeks to ensure that community benefit activities are more responsive to the most pressing health needs of the people they serve, and go beyond only providing uncompensated care. These are significant resources that should be utilized to achieve population health outcomes in the communities in which the hospitals serve.

> *Funding and other resources are needed to build a 21st century public health data infrastructure, along with an appropriately trained workforce that can collect and analyze cross-sector data.*

It cannot be emphasized enough that effective public health practice depends on having reliable and current information regarding the health of every community. Data is critical to partnerships with community-based organizations, clinical providers, and other government agencies. Without it, the impact of policy change can neither be measured, nor targeted to the populations most in need.

America has a fragmented governmental public health system in which activities are funded mostly for categorical programs (i.e. cancer or diabetes) but few dollars are available for infrastructure or technology. Thus, data systems often do not keep up with the times. Despite an approximately $30 billion federal investment to various health care sector entities to incentivize electronic health records and build data capacity, those efforts have done little to modernize data systems in the public health sector.[17] In addition, by and large, governmental public health departments have seen no federal investment in infrastructure that allows for data sharing to better monitor the overall health of the community and pinpoint emerging health threats.

This lack of investment has created an uneven patchwork of data that is fragmented and of limited use. Data that are collected across cities vary to such a degree that they often cannot be appropriately compared. The Coalition is addressing this problem by developing a consensus on the practical definitions of key health indicators and widely disseminating those conventions. We have also standardized data collection methods so that the data is comparable between jurisdictions.

WHAT CAN BE DONE?

1. **Provide funding for data infrastructure and for an appropriately trained workforce** that can work with and analyze cross-sector data.

2. **Increase data availability for a set of key health indicators so that analyses can be made at a number of levels – from cities to street corners.** In part, this can be done by creating consensus definitions for certain health data where they do not exist, starting with those that are more likely to be defined differently across local jurisdictions.

ENDNOTES

1 Commonwealth Fund, U.S. Health Care from a Global Perspective, Spending, Use of Services, Prices, and Health in 13 Countries, published 2014, http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective.

2 Baltimore City Health Department, BCHD White Paper: State of Health in Baltimore, published 2016. http://health.baltimorecity.gov/state-health-baltimore-winter-2016

3 United Nations Department of Economic and Social Affairs. World Urbanization Prospects: The 2011 Revision: File 1: Population of urban and rural areas and percentage urban (table), published 2012, http://esa.un.org/unup/CDROM/Urban-Rural-Population.htm

4 http://bigcitieshealth.org

5 Hearne, Shelley DrPH et al. "The Future of Urban Health: Needs, Barriers, Opportunities, and Policy Advancement at Large Urban Health Departments." The Journal of Public Health Management & Practice: January/February 2015, Volume 21, Issue p s4-s13.

6 Ibid.

7 Harvard T.H. Chan School of Public Health. Zip code better predictor of health than genetic code, published 2014, https://www.hsph.harvard.edu/news/features/zip-code-better-predictor-of-health-than-genetic-code/

8 https://www.healthypeople.gov/2020/tools-resources/public-health-3

9 Hedden, S. L., Kennet, J., Lipari, R., Medley, G., & Tice, P. (2015, September). Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health (SAMHSA). Retrieved July 14, 2016, from http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf

10 http://www.cdc.gov/injury/wisqars/overview/key_data.html

11 http://www.nctsn.org/resources/audiences/school-personnel/effects-of-trauma#q7

12 https://www.preventioninstitute.org/sites/default/files/publications/Adverse%20Community%20Experiences%20and%20Resilience%20Executive%20Summary.pdf

13 http://www.bigcitieshealth.org/case-study-boston-violence

14 http://www.bigcitieshealth.org/case-study-kansas-city-violence

15 http://www.bigcitieshealth.org/case-study-minneapolis-violence

16 The Urban Institute. Evaluating Place-Based Programs, published July 3, 2013. http://www.urban.org/urban-wire/evaluating-place-based-programs

17 Comments by U.S. Sen Lamar Alexander, http://www.help.senat.gov/chair/newsroom/press/alexander0information-blocking-is-standing-in-the-way-of-patients-promise-of-electronic-health-records.