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## Finding the Voice of Public Health in the National Health Reform Dialogue

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**Finding the Voice of  
Public Health in the National  
Health Reform Dialogue:  
*An Integrative Model for Health  
System Transformation***

June 2008





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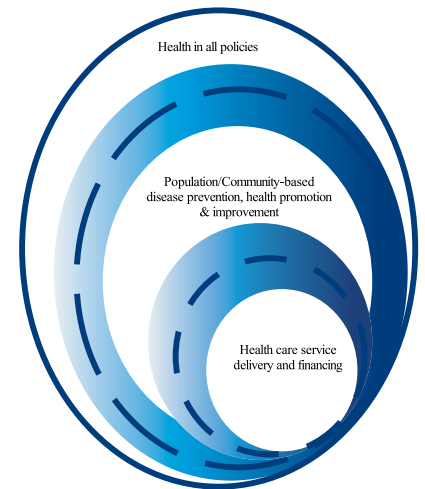


## Executive Summary

In the summer of 2007, the Centers for Disease Control and Prevention (CDC) engaged the Georgia Health Policy Center (GHPC) to establish a framework for Public Health to become part of the health reform debate. The first phase of this work involved background research, focus groups, and key informant interviews with internal and external stakeholders to identify common priorities and strategies for achieving health improvement. The second phase consisted of a Think Session with key stakeholders from local, state, and national groups. Organizations represented in the Think Session convened meetings with their own constituents to discuss strategies and policies that could be implemented across sectors, then reconvened to share their experiences.

A Levels of Reform model was used to define and visualize three levels of reform efforts. In the model, health care service delivery and financing is located within more comprehensive levels of reform for population/community-based strategies and *health in all policies*. By broadening the health reform conversation to include a consideration of the impact of all policies – health, social, economic and others – on individual and population health, an intersectoral process emerged to engage stakeholders at every level as instruments of reform.

Recommendations to the CDC were shared and discussed by state and local constituents during the reconvening meeting and informed by subsequent national meetings and the GHPC's insights in facilitating the process. The recommendations are organized according to the intersections between the different levels of reform, highlighting the windows of opportunity for Public Health to bridge the different levels. Some of the key recommendations include:



Levels of Reform

### Public Health attains a seat at the health reform table

- Lead the dialogue on the role of health promotion and prevention in reform
- Seek equitable collaborations with the private sector
- Promote integration of primary care and population health

### Health reform dialogue incorporates health promotion and disease prevention

- Create clear, concise, relevant policy messages and social marketing tools for use by partners
- Develop the business case for health promotion through compelling return on investment messages
- Design demonstrations of the effective integration of primary care and population health

### Health reform has intersectoral and multi-level partners

- Convene a summit to build cross-sector, multi-level partnerships to model *Health in All Policies*
- Promote health impact assessments
- Leverage existing resources by bringing together national health transformation efforts

### Health transformation comes through *Health in All Policies*

- Create a clearinghouse of best practices on community health improvement strategies
- Adopt the *Health in All Policies* message
- Develop a curriculum targeting policymakers on *Health in All Policies*

The overall process energized participants, who are now committed to helping CDC build new partnerships in pursuit of a transformed health system.

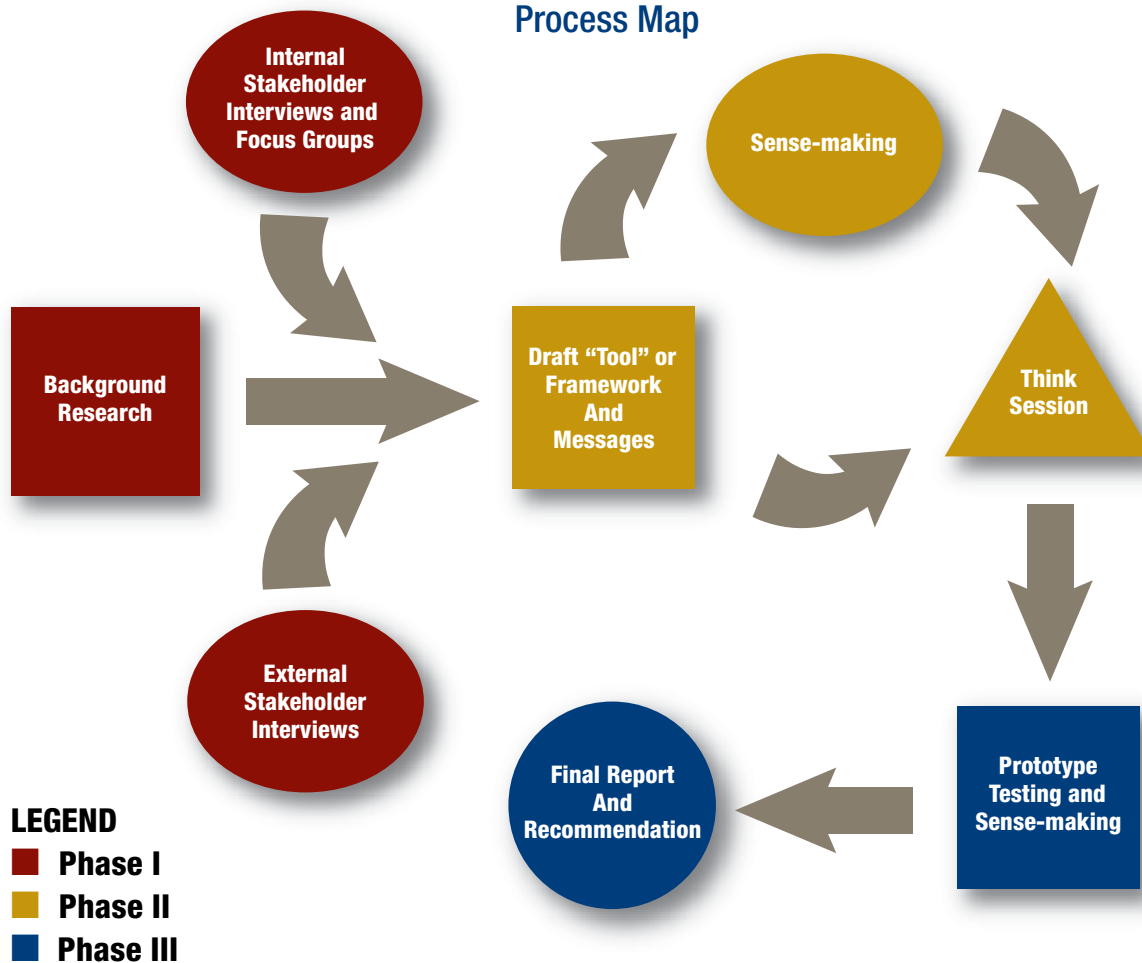
## Project History

US health reform policy discussions have routinely focused on expanding access to health care, containing costs, financing the system and delivering quality care. Within the Public Health community, much of this conversation is perceived to be occurring without a full consideration of the value of prevention and population-based approaches to improved health.

Given that backdrop, the context of new opportunities for dialogue in a presidential election year, and feedback from the 2007 Leaders to Leaders Conference, the Centers for Disease Control and Prevention (CDC) determined that the Office of Strategy and Innovation (OSI) would create an intra-agency Health System Transformation (HST) Work Group to consider ways in which Public Health might become part of the reform debate. Initially, the primary objective of this group was to develop a framework or tool for policy analysis that would measure the public health impact of national health reform proposals.

In the summer of 2007, the HST Work Group engaged the Georgia Health Policy Center (GHPC) to assist in the tool development effort. The GHPC organized this work into three connected phases using a whole system engagement process that valued input from a wide cross-section and multiple levels of health leadership (See Figure 1).

**Figure 1**  
**Process Map**



## Phase I

### Background Research

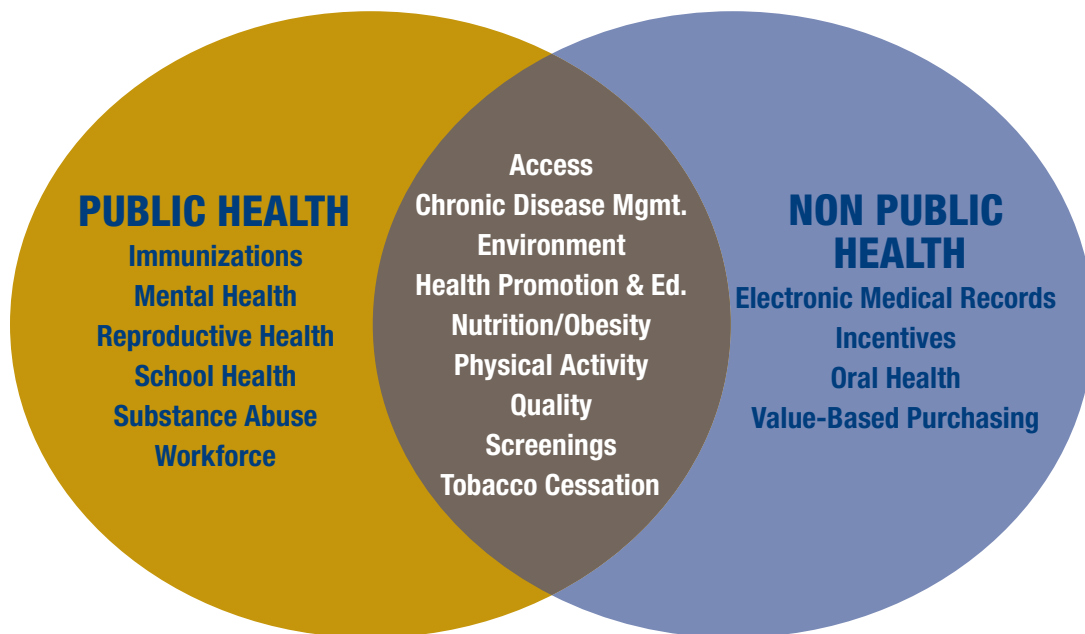
The GHPC began the first phase of the project by conducting background research in order to:

- understand the range of health improvement priorities and health reform proposals that existed in both the Public Health and non Public Health sectors.
- summarize the health improvement priorities that resonated across groups.
- investigate other tools, frameworks and/or algorithms that were currently used to assess reform proposals.

The GHPC gathered information about the health improvement priorities of more than 80 US-based and international stakeholder organizations by reviewing published, printed and/or electronic records in the public domain. Stakeholder organizations were broadly categorized as being Public Health or non Public Health in nature, and comparisons of their health improvement priorities were made.

Based on the available information, the review concluded that both the Public Health and non Public Health communities share a significant number of common priorities, though some were emphasized more by Public Health, and some more by non Public Health (See Figure 2).

**Figure 2**  
**Common Themes**





Additionally, the GHPC reviewed and analyzed proposed and current state-level reforms and reform proposals from presidential candidates leading at the time (November, 2007). Findings revealed that while most presidential candidates across the ideological spectrum addressed the need to reform the way in which health care is delivered and financed, only a few candidates proposed specific approaches to transforming the nation’s health system from one that treats illness to one that emphasizes prevention of illness and promotion of health. In lieu of national action in this matter, many states are already in the process of proposing and/or enacting reforms focused on health promotion and disease prevention. Some examples are summarized in Table 1 below.

**Table 1**  
**State-Level Reforms**

<b>State</b>	<b>Population Health components of proposed/enacted reform</b>
AZ	Health information exchange expected to increase use of preventive services
CA	Rewards for practicing healthy behaviors in Medi-Cal Healthy Families program
DE	Population/Disease specific programs; state employee wellness program with incentives. Funding set aside to improve prenatal care, reduce infant mortality and reduce disparities
LA	Establishing medical homes with an emphasis on preventive care
ME	Discounts to nonsmokers; worksite wellness programs
MI	Promotion of healthy lifestyles as part of a cost reduction strategy
NE	Addresses wellness of state employees - physical activity, nutrition and smoking cessation
NH	Committee established to develop wellness program for state employees/ retirees, encourage healthy lifestyle and evaluation measures
OH	Healthy Ohio Initiative - increasing efficiency in prevention programs and emphasizing preventive and wellness benefits in plans
WI	Benchmark Plan – to cover dental, mental, substance abuse, preventive services and smoking cessation. No out-of-pocket costs for preventive services; incentives for healthy living
WY	Establishing and expanding work-site wellness programs that promote physical activity during the work-day and healthy food choices

*Adapted from National Governor’s Association Issue Brief, July 11, 2007.*

## Internal Stakeholder Interviews and Focus Groups

A second component of Phase I consisted of tapping into internal CDC expertise. Three focus groups were conducted with Associate Directors of Policy and Financial Management Officers, Coordinating Center Directors and health economists within the agency. Additionally, the GHPC conducted five key informant interviews with CDC chronic disease prevention and environmental control leaders. These CDC public health experts were interviewed to generate a list of the best evidence-based approaches to health improvement. CDC health economists were included to discuss the potential short- and long-term economic impact of health improvement initiatives.

### *The key themes that emerged were:*

- **Address social determinants of health** – In both the focus groups and the interviews, CDC staff reinforced the importance of what many considered to be the most “upstream” of approaches, with the potential for greatest impact to move the needle on health.
- **Focus on prevention** – Participants believed that by emphasizing prevention, reductions would occur on the demand side of the health care delivery equation and ultimately impact delivery costs. Many also suggested that this focus should include adequate reimbursement for preventive services.





- **Link health care delivery, Public Health, health care financing and the community at large** – Throughout the conversations, there was a prevailing sentiment that the present fragmentation in the health care system was significantly hampering efficiency from being achieved, and ultimately would have to be addressed in the interest of better health status.
- **Promote ownership of health by the whole society and not just the individual** – CDC staff strongly believed that the socio-ecological model was important in understanding and addressing the social responsibility for the nation's health. In that model, health and well being are the responsibility of all individuals, groups, organizations and sectors. In a few instances, focus group participants referenced the Transportation and Farm Bills as opportunities for other sectors to participate in addressing the problem.
- **Make the case for both upstream and downstream approaches** – Some of the focus group participants believed that, to engage other partners (both traditional and non-traditional) in the health improvement journey, Public Health would have to do a better job of advocating not just for the upstream prevention approaches, but also for some of the more “downstream” interventions, especially around coverage and access. Some of the participants in the health economist conversations believed that this would entail, at least in part, a rigorous assessment of cost and benefit of prevention. In another focus group, participants saw this request for return on investment (ROI) as an example of a double standard, as many intervention approaches have not been shown to have any significant ROI.
- **Make known the evidence for “upstream” approaches** – Some of the discussion groups recognized that there was still a perceived disconnect between CDC and non public health partners about the value of upstream approaches. Some suggested that the agency and other public health practitioners do more to improve the usefulness of prevention guides and recommendations.
- **Enhance access to health-promoting environments and resources** – In some of the conversations and interviews, CDC staff pointed out that from a policy and environmental perspective, there was still more to be done to ensure that consumers had easy access to healthy foods, physical activity and timely health risk/status assessments.
- **Encourage worksite initiatives** – Some participants suggested that the present energy around workplace wellness programs is a good leverage point for getting greater business engagement in the health improvement process.

## External Stakeholder Interviews

During the third component of Phase I, structured interviews were conducted around the country with thought leaders from the academic, government, business, philanthropic and broader health policy communities. The leaders of these external stakeholder organizations were asked about the strategic focus areas, beyond financing, that they considered important in achieving health improvement. They were also asked what it would take to have Public Health representation “at the health reform table”, either in the form of CDC representatives or other stakeholders representing health promotion and disease prevention.

An analysis of the interviews revealed that many of the represented organizations valued including prevention approaches in the health care finance and delivery reform conversation. As one participant stated, “I think business and government agree on the importance of prevention.” Some of these organizations were already actively engaged in advocating for and implementing prevention approaches in their own spheres of influence.





*Overall, the key themes of the external stakeholder interviews were:*

- **Utilize effective Public Health leadership** – External stakeholders had conflicting opinions about whether Public Health was represented in past health care reform attempts, but most saw an important role for Public Health in the upcoming health care reform agenda, especially in providing the evidence of what works. Stakeholders viewed effective Public Health leadership as critical to achieving inclusion in this agenda. Specific suggestions included identifying existing Public Health leaders, working with legislative champions in a non-partisan way, and establishing a Health Advisor on the President’s staff or a congressionally mandated body analogous to the Federal Reserve that would have responsibility for wellness policy across all agencies and sectors.
- **Promote a socio-ecological model of responsibility for health** – The socio-ecological model of health suggests that the health status of an individual is influenced on multiple levels – the individual’s own attitudes, beliefs, and practices; the influences of the individual’s family, friends, and peers; the community areas and organizations where the individual interacts with others; and the societal influences such as economic policies and cultural beliefs that affect the individual. This model is consistent with the views of the external stakeholders, who felt Public Health should emphasize that everyone has a role in health care: individuals, health care providers, government, and business. They suggested the health system, through its policies, should enable every American to take personal responsibility for his/her own health, while linking personal responsibility to that of the wider community and demonstrating that it can be empowering to all. Simultaneously, participants felt the larger society should understand that health is a necessary pre-condition of a secure and prosperous United States. Participants indicated that individuals, clinicians, health economists, and other stakeholders should all be involved in policy development. They discussed ways in which multiple sectors could be engaged in health-related policy, looking for the intersections among topics such as environmental health, nutrition, and physical activity and ways to address these topics through multiple sectors such as the Departments of Education and Parks and Recreation, the Farm and Transportation Bills, etc.
- **“Just tell us what to do”** – Many participants were not able to articulate specific strategic actions within the health improvement focus areas they selected for discussion. Some expressed the view that the details of such actions should emanate from the CDC, whose research and experience in best practices continues to be highly regarded. They felt the CDC had been effective in communicating the importance of the health topics, and now they wanted further detail on the action steps to take. However, there was a consistent observation made that CDC publications were not easily understood and frequently, if not always, had to be translated into more user-friendly language. The tendency to “caveat” everything has led to the perception that the CDC is hesitant to take a stand on anything. Many said “just tell us what to do”; don’t overwhelm us with multiple explanations or disclaimers about a particular practice or tool. Specifically, participants were looking for a roadmap with sequential steps or toolkits for dissemination to multi-level stakeholder groups.

While stakeholders valued the participation of Public Health in the reform dialogue, some were quick to point out that their success would be predicated, at least in part, on Public Health’s ability to shed the image of being “preachy”. Public Health must recognize that it is fragmented, under-resourced, and unable to improve population health without assistance from the traditional health care system. The sentiment that “our way is the only way” is perceived as being a “bit missionary”. This tends to offend others who are trying hard to do good work, but doing it in a way that may be different from traditional Public Health. As one respondent stated, “The public health community thinks of themselves as doing God’s work laboring in the vineyards, which is not an effective way to generate change.” Public health professionals are encouraged to be receptive to collaborations that might produce efficiencies in the health care system rather than do their work in isolation. For example, Public Health could use their expertise in community outreach to connect individuals to traditional medical care homes, where their needs can be addressed in one setting. They should also use every opportunity to educate partners and communities on proven solutions for addressing health care problems.

## Phase II

After GHPC presented the Phase I findings to the HST Work Group, the ongoing conceptualization of the project’s purpose grew. The focus was broadened to explore a health reform framework by:

- developing consensus across multiple stakeholders about the preliminary target areas for health promotion and disease prevention,
- advancing the national health reform conversation to include health promotion and disease prevention messages, and,
- positioning Public Health leadership for active and strategic participation in the next administration.

Thus, Phases II and III of the GHPC Process Map were refocused on the Think Session and Sense Making activities. The purpose of these activities was then expanded to include key stakeholders from local, state, and national groups.

As a starting point for these expanded conversations, in the Fall of 2007, GHPC staff began synthesizing some of the information gathered from Phase I. Recommendations from internal stakeholders included consideration of the costs and benefits of prevention and use of “upstream” approaches; external stakeholders supported the inclusion of disease prevention initiatives; and background research identified the common disease prevention/health improvement themes in the Public Health and non Public Health sectors related to health care reform. The staff reasoned that leading causes of death and years of potential life lost are often used to approximate the costs of disease, while leading health indicators, as defined in Healthy People 2010, are a more upstream measure of health improvement strategies that can prevent such costs. The leading health indicators were then compared to the health improvement themes identified in the background research, as a means of narrowing the conversation to the most relevant topics for all participants. (See Table 2).

**Table 2**  
**Five Focus Areas**

<b>Leading Health Indicators*</b>		<b>Common Themes from Public Health &amp; Non Public Health Sectors</b>
Obesity	↔	Nutrition/obesity
Physical activity	↔	Physical activity
Tobacco and substance abuse	↔	Tobacco cessation
Environmental quality	↔	Environment
Access to health care	↔	Access
Responsible sexual behavior		Health promotion and education
Mental health		Screenings
Injury and violence		Chronic disease management
Immunization		Quality

\* Source: <http://www.healthypeople.gov/lbi/lbiwhat.htm>



This comparison revealed that five evidence-based areas of focus were common to both lists and would thus be relevant to Public Health and non Public Health sectors and still lend themselves to disease prevention, cost/benefit, and upstream approaches. These five focus areas were identified as: physical activity, obesity and nutrition, tobacco cessation, environment, and access.

On January 9 and 10, 2008, 48 individuals representing local, state, and national public and private organizations convened in Washington, DC for a Think Session to begin to advance a dialogue to integrate health promotion, health improvement, and disease prevention into health transformation at the local, state, and national levels. Attendees represented local health initiatives, state public health institutes and state health policy centers, national organizations, and the Centers for Disease Control and Prevention. (See Table 3 for a detailed list of sectors represented by attendees.)

**Table 3**  
**Sectors Represented by Think Session Attendees**

<b>Sector</b>	<b>Number of Attendees</b>
Academia	2
Advocacy	3
Business	3
Community Health Initiative	5
Government Local	1
Government National	5
Government State	6
Payor	1
Philanthropy	2
Provider	5
Public Health Institute	12
Think Tank	3
<b>Total</b>	<b>48</b>

Collectively, the group was charged with incorporating a strong health promotion/improvement component in health transformation by:

- Having input into a framework and messages for building a strong health promotion/improvement component in health transformation from national, state, and local leaders of business, government, health, philanthropy, and research;
- Planning strategies for the national, state, and local testing of the framework/messages that lead to a dissemination plan;
- Beginning to identify influential leaders who can further the dialogue; and
- Committing individually to advance the dialogue within their spheres of influence.



## The Process

The meeting was facilitated by staff from the Georgia Health Policy Center and Dannemiller Tyson Associates using a converge/diverge facilitation technique. The group converged as one for common learning around specific information and then diverged into groups in order to process and build on that information. The smaller groups then came together again throughout the meeting to share what was learned with the larger group.

Participants first shared with each other their personal stories of why a new kind of health transformation dialogue is necessary. From these stories, common themes emerged. They then heard an update of the project to understand the background and perspectives brought to the process by the CDC, and the concept of *health in all policies* surfaced and resonated with many participants. In order to be inspired that a new kind of health transformation dialogue is possible, a “panel of possibilities” was presented. The panel included John Clymer (Partnership for Prevention), David Helms (AcademyHealth), Andy Hyman (Robert Wood Johnson Foundation), and Guy Clifton (New America Foundation). At the end of day one, participants worked together to brainstorm strategies and policies that crossed sectors to address the pre-selected, evidence-based areas of focus.

On day two, participants shared their insights and reflections on the previous day’s work. They were then taken through a process of how to create compelling messages that would engage people and build interest in attending a local, state, or national meeting to further the health promotion/improvement dialogue. The stakeholders present also were coached in designing the meetings they would have in their spheres of influence over the next two months.

## Lessons

The Washington meeting was designed to learn how to have a larger, national conversation about health transformation that includes health promotion, health improvement, and disease prevention, and much was learned.

### *The Policy Window of Opportunity*

A key learning for those present was that an assessment needs to take place within a sphere of influence to determine the degree of opportunity for advancing the health transformation dialogue. Conversation centered on determining whether a policy window of opportunity was wide open, cracked open, or completely closed. This assessment could take place for any of the areas of focus. For example, a state like Massachusetts probably has a policy window of opportunity that is wide open for a discussion of access and how elements of health promotion and disease prevention can be incorporated into various coverage options because of the state’s move to an individual mandate for health insurance. However, a school system that promotes the sale of soft drinks and snacks in schools to raise money for band uniforms probably has a policy window of opportunity that may only be cracked open or completely closed for a discussion about nutrition and physical activity.

### *Levels of Reform*

In their shared learning, participants categorized conversations about health reform into three levels:

- Health care system reform is primarily where the current dialogue is taking place at the local, state, and national levels. It addresses health care delivery and financing.
- Community-based reform is familiar to many local health initiatives and community-based organizations. It focuses on health promotion and disease prevention in practice.

- Social reform is the furthest “upstream” conversation. It centers on social determinants of health such as income and race.

The group agreed that the greatest opportunity for progress in advancing the health transformation dialogue is at the margin of health care system reform and community-based reform. At this margin lies the opportunity for a discussion of disease prevention within the primary health care setting.

### ***Primary Care***

As described by one of the panelists during his presentation on the panel of possibilities and endorsed throughout the two days by the work of individual groups, primary care is perhaps the setting in which the worlds of population health and health care delivery have the greatest opportunity for collaboration in advancing a dialogue on health promotion, health improvement, and disease prevention within the current dialogue on health transformation. The business case for population health might likely begin to resonate here.

### ***A Mark on the Wall***

Participants were at first tentative about the idea of influencing a national dialogue on health transformation that is already well established. Many thought a rallying cry which would have the support of individuals at the local, state and national levels should be a necessary first step in the process. Such a cry might be similar to President John F. Kennedy’s call to send a man to the moon by the end of the decade in the 1960’s. Participants warned that, historically, these rallying events were quite rare and pointed out that the country rallied together after the attacks of 9/11, but the coming together was motivated by the feeling that we all, as a nation, were under attack. There was agreement that in order to move ahead, there needed to be a “mark on the wall” for health, but that the motivation for moving ahead toward that mark needed to be greater than the resistance of staying in place.

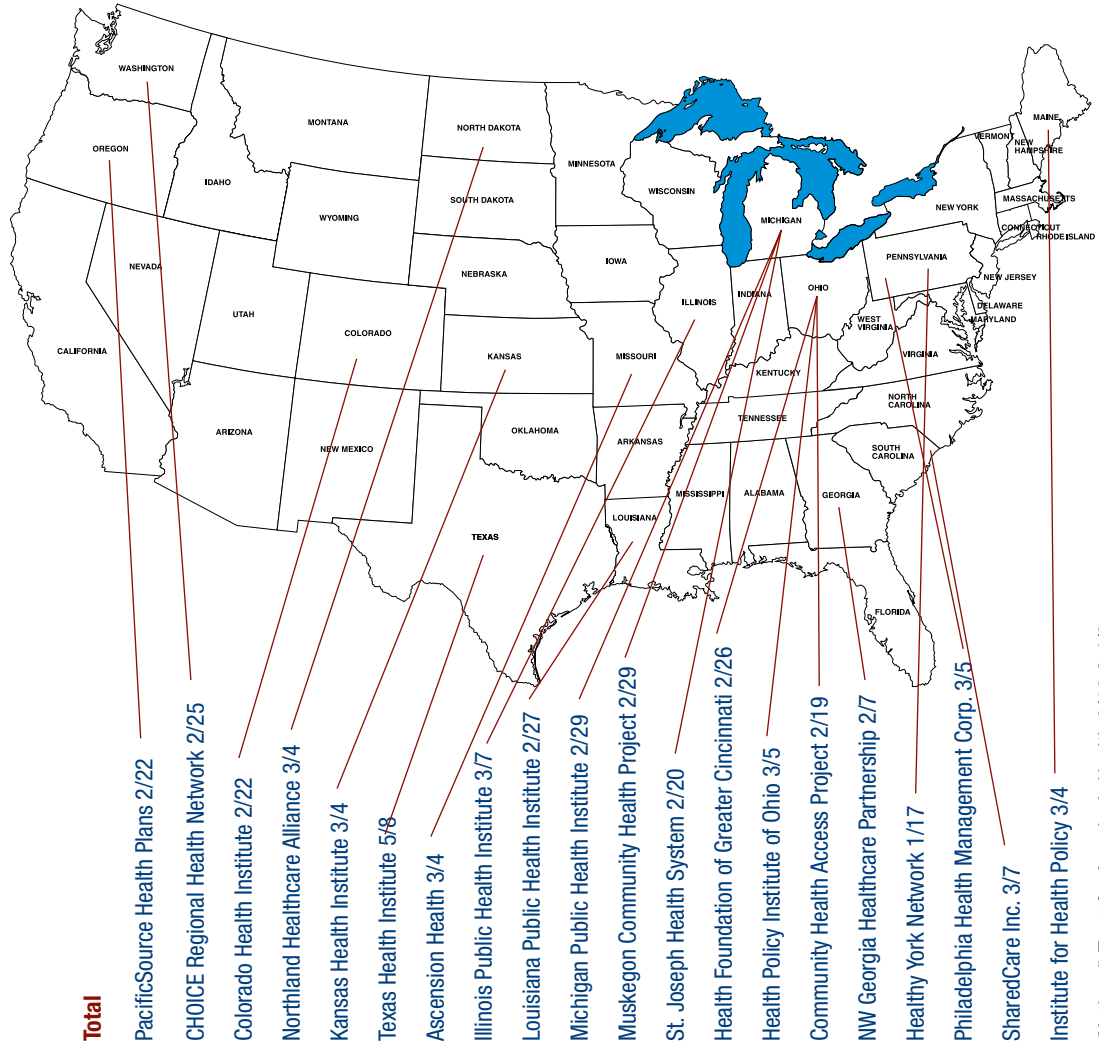
### ***Public Health versus the Public’s Health***

Attendees suggested that the image of Public Health needed to be revamped to overcome the perception that it is a government system responsible for taking care of poor people. In general, attendees warned that, presently, governmental Public Health is not perceived to be a leader in health promotion and disease prevention and that couching a dialogue on health promotion and disease prevention in strictly Public Health terms will not achieve the desired outcome. While acknowledging that Public Health is a critical partner, participants pointed to the many community-based health organizations that are already in action around the country making a difference in physical activity, nutrition, access, tobacco, and the environment. As the health transformation dialogue broadens, the focus should be on the public’s health and not on Public Health.

## **State and Local Constituent Meetings**

Twenty of the organizations represented in January returned to their respective communities or states to convene a total of ten community-level meetings and ten state or regional meetings. Some national organizations also convened meetings. Over 500 individuals attended these events, with meetings ranging from 8 to 53 individuals and an average attendance of 25. Participants representing the health community included health care providers from both the public and private sectors—hospitals, community centers, physicians, public health practitioners, health insurance companies, and local community coalitions. Elected officials and their representatives at both the local and state levels also attended several of the meetings as well as advocates and association lobbyists. A number of meetings also had representation from the business, philanthropic, and faith communities and many sectors of government including labor, environment, transportation, and education. A few of the meetings had members of the local media in attendance. (See Figure 3).

**Figure 3 Health Transformation Discussions – January Through May 2008**



	Total	551	27	13	8	12	23	19	18	24	25	33	53	34	31	23	22	24	33	18	37	10	28	36
Provider	77	4	2	1	1	1	2	3	5	1	5	12	10	2	7	3	3	4		5	3	1	2	
State Government	60	6		1	3	8	2		9	8	4	2		1	2	1		1	2	2	1	3	4	
Local Government	59	1	5				2		1		2	12		7		4	4	5	3	4		3	6	
Community Health Initiative	52		2		1				1	2	2	18	3		2	3	3			15				
Academia	48				6	3	2	1	1	4	6	5		6	2		1		1	1	3	4	2	
Business	47			4	1		2	5			2	7		1	1	2	10	1		5		2	4	
Public Health Institute	39	3		2		3	8		1	5	3				3				8		1	1	1	
Advocacy	33	5						2	3	3	4	2			4	2						4	4	
Social Service Nonprofit	26		1					1	1		2	6		2	2	1		5	2	1		2		
Philanthropy	24	3				2			1	1		1		7		1	1	2	1		1	2	1	
Payor	22	5					1	5	1		3							6						1
Education	18		2			2				1			6		1	2	2			1		1		
National Government	15													1	1	1			1		1	1	9	
Faith Group	10								1			3		1		1		2		2				
Think Tank	8						1		1													4	2	
Citizen	5		1		1							1			1	1								
Agriculture	4					2												2						
Media	4					1										2				1				



Most of the conveners used the template provided by the GHPC in the January meeting to design and structure their meetings around one of the five focus areas. Some of the meetings kept attendees together to discuss one or more of the focus areas while others held break-out sessions specific to the chosen focus area. Of the five recommended focus areas, 11 of the meetings focused on *Nutrition*, 11 on *Physical Activity*, 11 on *Access*, 2 on *Tobacco Cessation*, and 2 on *Environment*. The most popular focus areas—*Nutrition*, *Physical Activity*, and *Access*—were chosen by conveners to complement efforts already underway in their respective states or communities.

**Table 4**  
**Discussion of Focus Areas**

	<b>Nutrition</b>	<b>Physical Activity</b>	<b>Tobacco Cessation</b>	<b>Environment</b>	<b>Access</b>	<b>Other</b>	
	<b>11</b>	<b>11</b>	<b>2</b>	<b>2</b>	<b>11</b>	<b>5</b>	
Ascension Health					✓		
CHOICE Regional Health Network					✓		
Colorado Health Institute						✗	Promoting health in the workplace
Community Health Access Project					✓		
Health Foundation of Greater Cincinnati	✓	✓		✓	✓		
Health Policy Institute of Ohio	✓				✓		
Healthy York Network	✓	✓					
Illinois Public Health Institute	✓	✓	✓		✓		
Institute for Health Policy						✗	Health promotion/disease prevention
Kansas Health Institute	✓	✓					
Louisiana Public Health Institute	✓	✓	✓		✓		
Michigan Public Health Institute	✓	✓			✓		
Muskegon Community Health Project	✓	✓		✓			
Northland Healthcare Alliance						✗	Tactics to improve health/health system
Northwest Georgia Healthcare Partnership		✓					
PacificSource Health Plans	✓	✓			✓		
Philadelphia Health Management Corp.					✓		
SharedCare Inc.	✓	✓					
St. Joseph Health System	✓	✓					Nominal focus on obesity
Texas Health Institute						✗	Social determinants of health
(National) Trust for America's Health					✓		Prevention-oriented insurance reforms
(National) Healthiest Nation Alliance						✗	Health promotion/disease prevention





Typically, the goal of the meeting was communicated as a way to build a strong health promotion, health improvement and disease prevention component into the health reform debate. Meeting organizers utilized the prominence of the CDC and advertised the meetings as an opportunity to be a part of a national dialogue that CDC would be advancing with its partners. Generally, meeting attendees were asked to discuss strategies that could be implemented across sectors to address the chosen focus area as well as identify the national, state, and/or local policies that must be in place to facilitate the implementation of the strategy. Many meetings also discussed simple messages for advancing this dialogue and key leaders who needed to be engaged.

### March 12th Reconvening

On March 12th, 48 individuals reconvened in Atlanta, Georgia to share experiences from their constituent meetings. Attendees included 25 representatives from convening agencies represented in the January meeting, 12 CDC officials, and 11 Georgia Health Policy Center staff who facilitated the meeting with a representative from Dannemiller Tyson Associates. This meeting also represented an opportunity for conveners to provide direct feedback to CDC and recommend next steps for advancing the collective dialogue.

The specific objectives of this reconvening were to:

- Continue to build a strong health promotion/improvement component in health reform,
- Integrate what was learned from individual meetings,
- Learn how each constituent group communicated about themes, and what the themes were,
- Reconcile common themes from the meetings about the Mark on the Wall,
- Inform CDC about the process; give them the framework/messages to take the information further in a dissemination plan,
- Share with CDC what they can do to help the local and state constituents in their convening role and in CDC's science role,
- Identify next steps to continue to advance the dialogue within each constituent's sphere of influence, and
- Expand the number of influential leaders who are advancing the dialogue.

Facilitation techniques similar to those used in January were designed to maximize the learning from all attendees. Participants were given time in the morning to reconnect and share wisdom from their meetings, both in terms of content and process. During a working lunch, the "Mark on the Wall" workgroup presented their vision for a simple-to-understand rallying cry that would engage the general public in health promotion and disease prevention efforts: "Make America Number 1 in the world in health status by 2012". Meeting participants reacted to this vision and made several recommendations to the workgroup for future revisions. The afternoon was devoted to a discussion of "Our role going forward" (see Recommendations section for participant suggestions and the Appendix for a list of key messages). Overall, conveners reported positive feedback on their meetings; they felt that meetings were an overwhelming success in terms of attendance and engagement of participants given the limited timeframe (about 2.5 months) in which to plan and execute the meetings.

Figure 4



*Participant Discussion at March 12th Reconvening*

## Common Themes

The following themes include those taken from the summary reports of each constituent's meeting as well as the feedback gathered during the March 12th debriefing meeting.

### ***Coordination***

Coordination of effort was a key theme, whether participants were talking about coordinating between private and public sectors, coordinating among local, state, and national governments, or providing an overall coordinating figure or governing body at the presidential cabinet level. There was a call to build on existing activities while promoting coordination at the local, state, and national levels. Communities naturally focused their attentions on the actions to be taken from diverse perspectives and sectors, while most of the state and regional groups focused on linking similar state initiatives, aligning policies and interest groups, and seeking multi-sectoral representation on workgroups and planning committees. Most local, regional, and state groups did not find it difficult to convene members from diverse sectors. Participants challenged the federal government to model the behavior they seek by working more closely with other cabinet departments to bridge silos between sectors and create new opportunities, developing creative ways to fund programmatic work that links funding streams, and designing grants that encourage vertical and horizontal integration and networking among agencies and sectors.

### ***Accountability***

Accountability – the need to create a coordinated system that ensures each entity is responsible for contributing its share – was a second key theme. Participants recommended policies that assure each player is given an incentive to promote health. They discussed aligning incentives among local, regional, and national groups and the health care sector to achieve more efficient use of resources and better health outcomes. There was a sense that everyone should be part of the solution and policies should be put in place to reward everyone for their contributions. Participants overwhelmingly recommended rewarding positive action rather than penalizing inaction.

In some of the meetings, the accountability issue caused some dissension among participants. The debate was usually reduced to a discussion about individual responsibility versus the role of government in influencing healthy behavior and choices (i.e., how far the government, community, business, etc. should go to intervene in individual choices). In all meetings where this issue was debated, participants were able to move past the issue; however, it highlights an area where partisan political opinions may impede the dialogue. Further, depending on the mix of political views held by constituents, it may serve as a reason for some individuals to disengage from the health reform conversation.

### ***Children and the Education Sector***

Participants came up with a full range of strategies and supporting policies to address each of the five focus areas specific to their state or local context. One population group targeted repeatedly for health promotion and disease prevention strategies and policies was children. There seemed to be less resistance to government intervention focused on children, probably because fewer people hold children completely responsible for their choices. The education sector – one of the best settings for intervening with children – was the sector most commonly identified when discussing intersectoral strategies such as physical education in schools and providing more nutritious food choices in cafeterias. This sector may serve as a good place to start when developing future intersectoral collaborations, however participants also discussed challenges to working in this sector, such as requirements of the “No Child Left Behind” legislation and competing funding priorities.

### ***Economic Case***

Another key theme that emerged from the constituent meetings was the need to make the economic case for disease prevention and health promotion. There were requests from national, state and local organizations for more information from CDC for the economic and social impact of initiatives, projects, or simply not doing something. Often participants specifically mentioned making the business case for prevention, or used the term “return on investment” to describe the economics of health investments. The question of “who pays for health?” was also raised in constituent meetings which linked the Economic and Accountability themes. In at least one case, a meeting convener indicated that the business community became part of the reform conversation when they realized how much we are all paying for the health outcomes we have today. There was a call to CDC to invest in the research to support the linkage between economics and health promotion and disease prevention.

### ***Medical Home and Primary Care***

The linkage between primary care and Public Health continued as a theme from both the Phase I information gathering and the January meeting. Sometimes the dialogue was about Public Health working with the private sector to create a medical home for individuals, while other times it was about reorganizing the current health care system around the primary care model of health delivery. Primary care physician groups were mentioned as potential allies in any population-based health reform conversation.



### ***Disparities and Targeting Those Most at Risk***

The theme of disparities was prevalent in many of the meetings. It usually surfaced when individuals discussed the traditional approach of Public Health--targeting populations “most at risk”. These “at risk” individuals tend to reside at the extremes of a population distribution rather than represent the individuals who cluster toward the middle. Proponents argue that the best approach to achieving better health outcomes is by decreasing the disparities between these outliers and the norm by focusing most of the resources and energy on those most at risk. Others argue that a more inclusive strategy aimed at the general population is what is needed to really drive a culture change that will begin to make average Americans healthier. Participants cautioned that this debate can become entangled in politics, and therefore should be pursued cautiously as there is likely no right or wrong approach.

### ***Pursuing Strategies within the Health Care Service Delivery and Financing System***

Consistent with Phase I findings, almost all meeting participants recommended implementing at least one disease prevention/health promotion strategy within the health care and financing system. In particular, the most popular strategy was to incorporate prevention and wellness benefits into health insurance design. This included assuring adequate reimbursement for the providers of preventive services as well as incentives to encourage and reward health-promoting consumer behavior. From the business perspective, once the economic case for prevention is made, this work would be included in “value-based purchasing”.

### ***Positive, Simple Messaging***

Participants agreed that messages should be positive and simple, even if different messages are used for different audiences. Most also felt that messages should move people to action and make being healthy “cool”. Besides the continued positive reaction to *Health in All Policies* which would likely target policymakers, several meeting participants proposed messages for a more general audience such as: “Make the Healthy Choice the Easy Choice”, “No Child Left Indoors”, and “Health: Start early, end late”.

### ***Visual Models of Health Reform***

Several visual models were used by participants during the meetings to conceptualize their vision of health reform. A triple layer chess analogy was used to describe the alignment of local, state and national policy, while a visual depiction of the levels of reform was used to define the scope of reform efforts. Each of these models attempts to more clearly define areas of mutual vision and potential coordination.

The Levels of Reform figure (see Figure 5), originally contributed by a participant in the January meeting, was refined and edited based on feedback throughout the process. Reforms targeting the delivery and financing of services to individuals are in the innermost circle. These topics have largely dominated the national health reform debate, contributing to a sense among Public Health leaders that if they want to advocate for population-based strategies to improve health they must have a “seat at the health reform table”. During this discovery process, however, the notion of “the table” has evolved. A new way of conceptualizing the vision and scope of health reform has revealed other opportunities for influence.

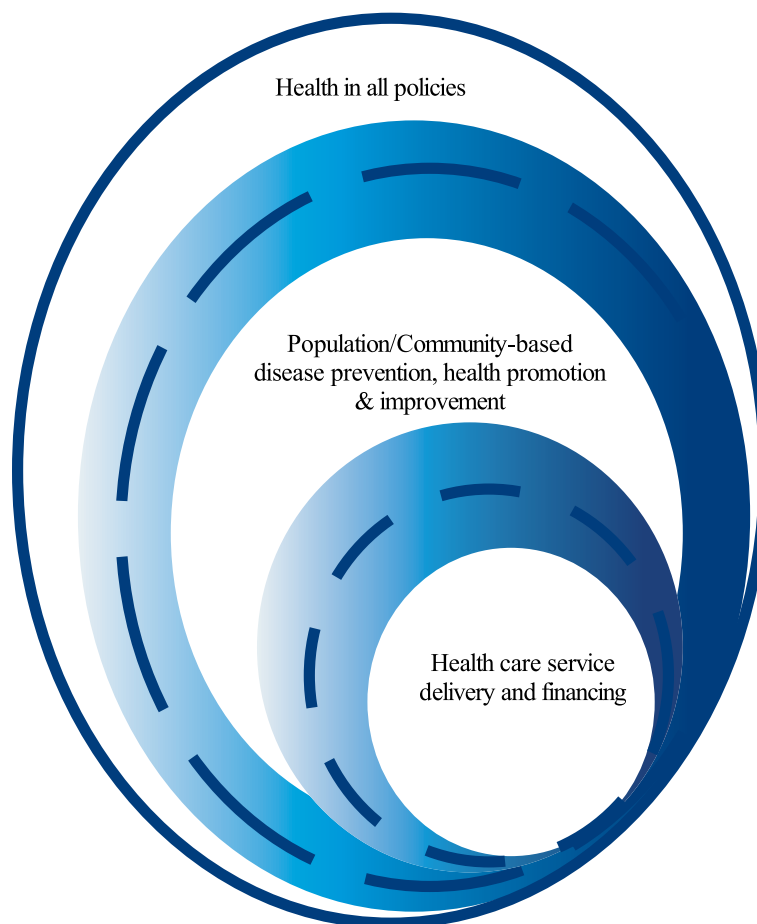
Population/community-based health strategies for prevention and health promotion comprise a second more comprehensive level of reform. This level moves beyond curative care and focuses on behaviors, lifestyles, chronic disease management and community-based interventions.

*Health in all policies* represents the most comprehensive level of health reform. Initially labeled as “social reform”, *health in all policies* broadens the definition of health reform to include a consideration of the intentional or unintentional impact of all policies – health, social, economic and others – on individual or population health. Research shows that lifestyle and behavior, environment, socioeconomic background, and biology all affect health. Consequently, most all policies impact health, positively or negatively.



Reform that targets *health in all policies* highlights the need to put challenges into context, to understand the relationship between various problems, and to think in advance about both the immediate and more distal consequences of policy decisions. It recognizes that there are multiple realities within a system and that all are valid. This moves the reform rhetoric away from “either/or” or “right/wrong” to a more inclusive “both/and” view of proposed interventions. By broadening the health reform conversation to include the *health in all policies* level of reform, an intersectoral process emerges that creates “seats at multiple tables for everyone”, engaging a broad range of stakeholders at every level to serve as instruments of reform.

**Figure 5**  
**Levels of Reform**



Thus, the Levels of Reform model can provide an integrative framework for guiding Public Health’s short- and long-term policy strategies on multiple levels. It locates service delivery/financing and population/community-based strategies within the larger context of *health in all policies*, emphasizing the need for remedial action at multiple levels simultaneously. The three levels are not seen as mutually exclusive - as indicated by the perforated lines - rather they are viewed as additive and inextricably linked. The shaded areas of the diagram are meant to draw attention to the opportunities Public Health may have to bridge the connection between each level of reform. Further, the circles are depicted as tangential to illustrate that there may be reforms which target all elements of the system simultaneously.



## National Meetings

Three national organizations identified opportunities to discuss health transformation during meetings that were held in the Spring of 2008.

### *Trust for America's Health*

Trust for America's Health is a non-profit, non-partisan organization that focuses on prevention, protection, and communities. This national organization convened two group meetings in Washington, DC on March 13, and April 2, 2008 with a total of 28 participants. One meeting focused on how to integrate disease prevention into the realm of health care reform and insurance, while the second meeting focused on how to organize health in the next administration.

### *Healthiest Nation Alliance*

The Healthiest Nation Alliance is a group of local, state and national entities focused on building the type of integrated health system needed for the US to become the healthiest nation in the world. This organization convened a meeting of 36 public health officials and leaders from a diverse group of national organizations on April 16, 2008 to discuss health transformation on a local, state, and national level. The facilitated meeting engaged participants in discussions about what a transformed health system should include, how achievements could be measured, and the roles of represented organizations and governmental Public Health in reaching these goals.

### *National Network of Public Health Institutes*

The National Network of Public Health Institutes (NNPHI) is a membership organization that fosters networking and collaboration among 28 public health institutes and multi-sector partners to address critical and emerging public health issues. This organization elected to devote the majority of its annual meeting agenda to furthering the health transformation dialogue, creating the title *Unlocking Hidden Potential for Health Policy Reform* for its May 14-16, 2008 meeting. National leaders and senior staff from public health institutes and health policy centers shared insights and experiences regarding the integration of health promotion, improvement and disease prevention in national, state and local health system reform. Panelists shared case studies demonstrating the unique roles and capacities of public health institutes to address the population health agenda in their states. Roundtable discussions engaged representatives from public health institutes, health policy centers and national partner organizations in further discussions on these subjects. Featured speakers addressed the health promotion/disease prevention gaps in the current system and the steps it would take to improve and transform the system to produce equitable health care for all.

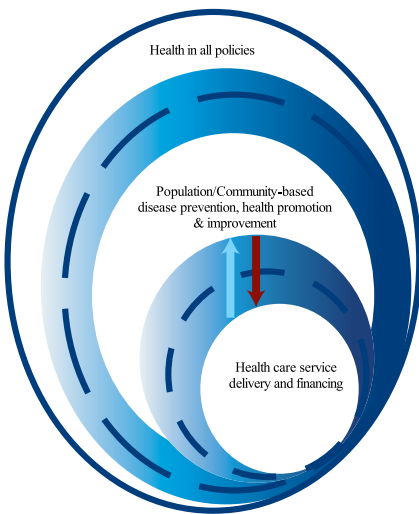
Findings from the Washington, DC, state, local, and Atlanta meetings were shared with participants, including the Levels of Reform figure, which was featured in Conference Chair Dr. Karen Minyard's opening remarks. This figure resonated strongly with presenters and participants alike, with numerous presenters referring back to it during their speeches and remarking on its relevance to their own topics. There were also several synchronicities between previously identified themes and topics discussed by conference speakers. For example, the theme of making the economic case for health improvement was repeated by several presenters. Local and state leaders provided specific examples of communities losing job opportunities because of the poor health of their workforce while featured speakers emphasized the importance of engaging the health care finance and policy-maker communities by utilizing an economic rationale. Intersectoral linkages, upstream approaches, framing key messages ("Imagine Muskegon Healthy", "Leave No Child Indoors", "Leave No Generation Behind") and beginning with a focus on children were also themes that were identified in previous meetings and repeated by the speakers and participants of this forum. Overall, the meeting highlighted the common health reform goals that many sectors share, the fragmentation of the current system and the need for coordination, the need for local data and the technical assistance to utilize the data appropriately, and the opportunity to capitalize on the current enthusiasm for health transformation through a Public Health champion.

## Recommendations

Capitalizing on the current enthusiasm related to health transformation also means taking action based on the information gathered through this process. The following section features key recommendations to the CDC from state and local constituents as shared and discussed during the Atlanta reconvening meeting and informed by the subsequent national meetings and the GHPC's insights in leading this process. Building on the Levels of Reform model conceived by participants, the recommendations are grouped according to the shaded areas of the diagram, highlighting the windows of opportunity for Public Health to bridge the connections between service delivery/financing and population/community strategies as well as the connections between population/community strategies and *health in all policies*. The sections titled in red represent recommendations that would engage Public Health in the health transformation dialogue by initiating relationships with non-traditional partners in the health care financing and all policies sectors, while the sections in blue represent recommendations that would create opportunities for those same non-traditional partners to approach and engage Public Health. Recommendations marked with an asterisk indicate opportunities for immediate action by the CDC.

### Public Health attains a seat at the health reform table

- Lead the dialogue on the role of health promotion and prevention in reform\*
- Seek equitable collaborations with the private sector



- o Design an educational module for Public Health leaders on how to be effectively present in working with the health care financing community
- Involve medical/nursing schools in training more traditional and non-traditional providers on prevention
- Promote integration of primary care and population health
  - o Expand the health promotion role of primary care providers
  - o Pay more for the delivery of high value clinical preventive services
  - o Change incentives to promote interdisciplinary primary care practices
- Model the vision of transformational health by organizing around health rather than disease

### Health reform dialogue incorporates health promotion and disease prevention

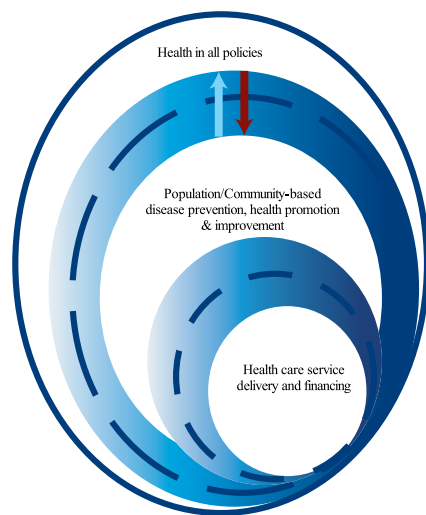
- Leverage existing resources and partner with health care financing efforts such as Commonwealth Fund and Partnership for Chronic Disease
- Create clear, concise, relevant policy messages and social marketing tools for use by partners
- Develop the business case for health promotion through modeling tools and compelling return on investment messaging
- Design demonstrations of the effective integration of primary care and population health through the use of scholarships and community grant programs
  - o Support Public Health and primary care providers in coordinating local services

\* Opportunity for immediate action by the CDC



- o Establish Health Resource Centers to support coordination between Public Health and primary care
- o Integrate prevention and promotion in primary care centers
- o Integrate prevention and promotion in FQHC services
- o Engage business partners in advocating for the concept of the “medical home” and using it as a means to deliver prevention and promotion services to employees

## Health reform has intersectoral and multi-level partners



- Build cross-sector, multi-level partnerships with non-traditional sectors to model *Health in All Policies*
  - o Promote cross-sector collaboration through grant financing requirements\*
  - o Engage cross-sector partners in planning and strategy sessions
  - o Create cross-sector training and learning opportunities
  - o Be a convener across sectors at the federal (cabinet) level
  - o Ensure cross-board membership on boards of health, school boards, zoning boards, etc.
  - o Insert the grass roots messages into the conversation
  - o Convene an action-focused summit that would broaden and deepen national, state, and local engagement in the issue of health transformation
- Promote health impact assessments
  - o Build capacity for health impact assessment expertise at federal, state and local levels
  - o Ensure every government grant has a health impact assessment requirement
- Leverage existing resources by bringing together multiple, national efforts related to health transformation, such as:
  - o Unnatural Causes
  - o Archimedes
  - o Robert Wood Johnson Foundation

## Health transformation comes through *Health in All Policies*

- Create a clearinghouse of best practice briefs on state and community health improvement strategies\*
- Produce a white paper to guide policymakers on the topic of a population health trust by gathering and synthesizing information from other countries as well as key thought leaders in the US
- Adopt the *Health in All Policies* message
  - o Promote the message to constituents
  - o Encourage alignment of efforts
- Include the work of this process in any near-term meetings related to health
- Develop a curriculum targeting policymakers on *Health in All Policies* (National Council of State Legislatures)

## Appendix

### March 12th Closing Session: Key Messages

- A key message that emerged from the meetings in Washington and Atlanta is that health should be considered in all policies at the local, state, and national levels.
- Policies at the national level should be informed by, and aligned with, work that is happening around disease prevention and health promotion at the local levels.
- From the work at the local, state, and national meetings, it is clear that opportunities exist across sectors (local/state/national, Education/HHS/Agriculture, etc.) to prevent disease and promote health.
- Exciting conversations were held at the Atlanta meeting about potential tools available from the CDC and from the local, state, and national partners that may help advance the disease prevention/health promotion dialogue.
- Participants sensed that the CDC valued the process of conducting meetings at the local, state, and national levels to learn about advancing a disease prevention/health promotion dialogue and evaluating that process as a group in Atlanta.
- In the process of learning together how to advance the disease prevention/health promotion dialogue, local input mattered.
- One potentially helpful tool identified to advance the disease prevention/health promotion dialogue in Atlanta was a sample op-ed that can be adapted for the local and state levels.
- There is an opportunity for leveraging the messages coming out of the PBS series “Unnatural Causes” to advance the disease prevention/health promotion dialogue.
- The members of this new partnership will continue to work together to develop additional tools to further the disease prevention/health promotion dialogue.
- So far in the process, the members of this new partnership are like-minded in a vision for disease prevention and health promotion to be a part of the national health reform dialogue.
- Community-level groups need to continue the dialogue with others at the local level and with those at the state and national levels in order to continue to learn from each other.
- As we advance the disease prevention/health promotion dialogue, it is important to continue to bring new voices into the conversation.
- As recommendations for advancing the disease prevention/health promotion dialogue are brought forward, they need to be acted upon.
- To ensure that we move forward in making the disease prevention/health promotion dialogue part of the national dialogue on health reform, it is recommended that each participant in this new partnership and those who attended a local, state, or national meeting be asked to make a commitment to at least one concrete follow-up action.



This project was sponsored by the Centers for Disease Control and Prevention.

The Georgia Health Policy Center is a leading independent resource for public and private organizations and government entities seeking evidence-based research, program development and policy guidance to improve health status at the community level. The Center was established in 1995 as a research division of Georgia State University's Andrew Young School of Policy Studies in Atlanta, Georgia.

For more information about the Center, go to [www.gsu.edu/ghpc](http://www.gsu.edu/ghpc).

NNPHI is a membership organization that fosters networking and collaboration amongst twenty-eight public health institutes and multi-sector partners. Together with its members and partners, NNPHI fosters innovations in health that address critical and emerging public health issues.

For more information about NNPHI, go to [www.nnphi.org](http://www.nnphi.org).