Traveler, your footprints are the path, and nothing else.
Traveler, there is no path. A path is made by walking.
A path is made by walking, and in looking back one sees the trodden road that never will be set foot on again.
Traveler, there is no path, but wakes on the sea...

Caminante, son tus huellas el camino y nada más.
Caminante, no hay camino, se hace camino al andar.
Al andar se hace el camino, y al volver la vista atrás se ve la senda que nunca se ha de volver a pisar.
Caminante no hay camino sino estelas en la mar.

Antonio Machado
Team Up Take Action Conference

Partnerships and Leadership: Key Strategies for Population Health

José Thier Montero, MD, MHCDS
Director, Center for State, Tribal, Local and Territorial Support
Centers for Disease Control and Prevention

October 2, 2019
Disclaimer

- The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
Today

1. Tell you a little bit about how I look at the health system
2. Discuss how we can improve outcomes through complex adaptive system change
3. Share a little bit about how can CDC support this process
4. Reflect together on what we’re learning about creating complex adaptive system change to advance population health, well-being and equity
THE STAGGERING COST OF DIABETES

Today, **4,660 Americans will be diagnosed with Diabetes**

Nearly **30 million Americans have diabetes**

**86 million Americans have prediabetes**

More than the population of the east coast from Connecticut to Georgia

**Diabetes and prediabetes cost America $322 billion per year**

1 in 5 health care dollars is spent caring for people with diabetes

1 in 3 Medicare dollars is spent caring for people with diabetes

People with diagnosed diabetes have health care costs **2.3 times higher** than if they didn’t have the disease

Learn how to combat this costly disease at [diabetes.org/congress](http://diabetes.org/congress)

American Diabetes Association

STOP DIABETES®
The Mission of Public Health

- “Fulfilling society’s interest in assuring conditions in which people can be healthy.”
  —Institute of Medicine

- “Public health aims to provide maximum benefit for the largest number of people.”
  —World Health Organization
The Always Changing Health System

An opportunity to decrease cost & promote health

Collaborative focus on prevention and wellness
Partners in Population health
Is this enough?
Public Health 3.0: A Renewed Approach to Public Health

- **Public Health 1.0**
  - Tremendous growth of knowledge and tools for both medicine and public health
  - Uneven access to care and public health

- **Public Health 2.0**
  - Systematic development of public health governmental agency capacity across the United States
  - Focus limited to traditional public health agency programs

- **Public Health 3.0**
  - Engage multiple sectors and community partners to generate collective impact
  - Improve social determinants of health

Timeline:
- Late 1800s
- 1988 IOM *The Future of Public Health* report
- Recession
- Affordable Care Act
- 2012 IOM *For the Public’s Health* reports
Pathways to Population Health: Six Foundational Concepts of Population Health Improvement

1. Health and well-being develop over a lifetime.
2. Social determinants drive health and well-being outcomes throughout the life course.
3. Place is a determinant of health, well-being, and equity.
4. The health system needs to address the key demographic shifts of our time.
5. The health system can embrace innovative financial models and deploy existing assets for greater value.
6. Health creation requires partnership because health care only holds a part of the puzzle.

What creates health? How can health care engage?
How do we get there?
Who leads?
How Does a System Change (or Resist Change)?

Six Conditions of Systems Change

- Policies
- Practices
- Resource Flows
- Relationships & Connections
- Power Dynamics
- Mental Models

Structural Change (explicit)

(semi-explicit)

Transformative Change (implicit)

Definitions

Policies
- Government, institutional and organizational rules, regulations, and priorities that guide the entity’s own and others’ actions.

Practices
- Espoused activities of institutions, coalitions, networks, and other entities targeted to improving social and environmental progress. Also, within the entity, the procedures, guidelines, or informal shared habits that comprise their work.

Resource Flows
- How money, people, knowledge, information, and other assets such as infrastructure are allocated and distributed.

Relationships & Connections
- Quality of connections and communication occurring among actors in the system, especially among those with differing histories and viewpoints.

Power Dynamics
- The distribution of decision-making power, authority, and both formal and informal influence among individuals and organizations.

Mental Models
- Habits of thought—deeply held beliefs and assumptions and taken-for-granted ways of operating that influence how we think, what we do, and how we talk.

https://www.fsg.org/publications/water_of_systems_change
Key Practices for a Successful Strategic Health Leader

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

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

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

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

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

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

- Administration for Children and Families (ACF)
- Agency for Healthcare Research and Quality (AHRQ)
- Administration for Community Living (ACL)
- Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Health Resources and Services Administration (HRSA)
- Food and Drug Administration (FDA)
Governmental Public Health

*Under the US constitution State and Local Health Departments Retain the primary responsibility for Health*
Institutional Components of the Public Health System in the US
Components of the Public Health System in the US

- Individuals
- Families
- Communities

- Clinical Care Delivery Systems
- Government Agencies (Other than Public Health)
- Community-Based Organizations
- Private, Nonprofit Associations
- Media
- State
- Local
- Federal
- Tribal
- Territorial
- Educational Institutions
- Private Industry

Societal Values

Culture
Practice #1: Adopt and adapt strategies to combat the evolving leading causes of illness, injury, and premature death
Innovation
2019

A Bold Promise to the Nation

CDC Strategic Framework & Priorities

Secure Global Health & Domestic Preparedness

Eliminate Diseases

End Epidemics

Data & Analytics | Laboratory Capacity | Workforce | Outbreak Response | Global Capacity

Pandemics, Bioterrorism, Vector-borne diseases

HIV/AIDS, Vaccine-preventable diseases, Hepatitis C

Opioids, Influenza, Antimicrobial resistance, Diabetes

Not inclusive of all CDC’s vital, complex work.
The Winnable Battles Philosophy

- Address data challenges
- Enable progress
- Identify opportunities
CDC Winnable Battles - Current Topic Areas, 2018-2023

- Antimicrobial Resistance
- Opioids
- HIV Elimination
- Viral Hepatitis
- Million Hearts
- Vaccine Preventable Diseases
State Strategies

TO IMPROVE HEALTH AND CONTROL COST WITHIN 5 YEARS

The State Strategies Project offers resources and technical packages on comprehensive tobacco control, asthma control, and prevention of tooth decay. These tools are designed to help states spend strategically to improve population health and control cost within 3 to 5 years.

Increase the return on investment through these proven population health strategies. Find technical packages and expert-vetted tools at

www.cdc.gov/policy/hst/statestrategies
Prevention and Population Health Framework: The 3 Buckets

1. Traditional Clinical Prevention
   - Increase the use of clinical preventive services

2. Innovative Clinical Prevention
   - Provide services that extend care outside the clinical setting

3. Community-wide Prevention
   - Implement interventions that reach whole populations

How Do I Develop Strategies?

- **Adapt and adopt**
- **Innovation**
  - Reverse Innovation
  - Disruptive innovation
- **Best practices**
- **Evidence based public health resources (examples):**
  - Community Guide
  - The Practical Playbook II: Building Multisector Partnerships That Work
  - National Academy of Medicine, Population Health Roundtable
3 Waves of the Rise in Opioid Overdose Deaths

- **Other Synthetic Opioids**: e.g., Tramadol and Fentanyl, prescribed or illicitly manufactured
- **Commonly Prescribed Opioids**: Natural & Semi-Synthetic Opioids and Methadone
- **Heroin**:

---

**Wave 1**: Rise in Prescription Opioid Overdose Deaths

**Wave 2**: Rise in Heroin Overdose Deaths

**Wave 3**: Rise in Synthetic Opioid Overdose Deaths

Opioid overdoses went up 30% from July 2016 through September 2017 in 52 areas in 45 states.

The Midwestern region saw opioid overdoses increase 70% from July 2016 through September 2017.

Opioid overdoses in large cities increased by 54% in 16 states.

Opioid overdose ED visits continued to rise from 2016 to 2017. Detecting recent trends in opioid overdose ED visits provides opportunities for action in this fast-moving epidemic.

PERCENT CHANGE
- Decrease
- Increase 1 to 24%
- Increase 25 to 49%
- Increase 50% or more
- Data unavailable

SOURCE: CDC’s Enhanced State Opioid Overdose Surveillance (ESOOS) Program, 16 states reporting percent changes from July 2016 through September 2017.
CDC’s Approach: Opioid Overdose Prevention

- Conduct surveillance and research
- Empower consumers to make safe choices
- Build state, local, and tribal capacity
- Support providers, health systems, and payers
- Partner with public safety
More Specific, Timely, Localized, and Actionable Data
Enhanced State Opioid Overdose Surveillance (ESOOS)

Non-Fatal Data
- Use syndromic surveillance and hospital billing data to establish an early warning system to detect sharp increases or decreases in non-fatal opioid overdoses.

Fatal Data
- Capture detailed information on toxicology, death scene investigations, and other risk factors that may be associated with a fatal overdose.

Data for Action
- Rapidly disseminate surveillance findings to key stakeholders working to prevent or respond to opioid overdoses
Public Health/Public Safety Partnerships

- **HIDTA**: Overdose Response Strategy (ORS)
- **ONDACP**: Combating Opioid Overdose Through Community-Level Intervention Initiatives (COOCLI)
- **Bureau of Justice Assistance (BJA)**: Rural Communities Initiative & Overdose Detection Mapping Application (ODMAP) Pilot Sites
- **National Governors Association (NGA) Center for Best Practices**: Reducing Overdose Risk among Justice Involved Populations
- **Bloomberg RxStat Opioid Initiative**: Leveraging Public Health/Public Safety Partnerships to Reduce Opioid Overdose: Best Practices Toolkit
- **Organized Crime Drug Enforcement Task Forces (OCDEFT)**: Improving Public Health Surveillance by Rapid Testing of Unknown Substances
Practice #2: Develop strategies for promoting health and well-being that work most effectively for communities of today and tomorrow
Ending the HIV Epidemic – Key Strategies:

Achieving elimination will require an infusion of resources to employ strategic practices in the right places targeted to the right people to maximize impact and end the HIV epidemic in America. Key strategies of the initiative include:

**Treat:** Implement programs to increase adherence to HIV medication, help people get back into HIV medical care and research innovative products that will make it easier for patients to access HIV medication.

**Diagnose:** Implement routine testing during key healthcare encounters and increase access to and options for HIV testing.

**HIV Healthcare Force:** A boots-on-the-ground workforce of culturally competent and committed public health professionals that will carry out HIV elimination efforts in HIV hot spots.

**Respond:** Ensure that states and communities have the technological and personnel resources to investigate all related HIV cases to stop chains of transmission.

**Protect:** Implement extensive provider training, patient awareness and efforts to expand access to PrEP.
Ending the HIV Epidemic: A Plan for America

**GOAL:**
- 75% reduction in new HIV infections in 5 years
- and at least 90% reduction in 10 years.

**PHASE 1:** Focused effort to reduce new diagnoses by 75% in 5 years

**PHASE 2:** Widely disseminated effort to reduce new diagnoses by 90% in the following 5 years

**PHASE 3:** Intense case management to maintain the number of new diagnoses at <3,000 per year
Whole-Of-Society Initiative

- Federal Partners
- State Health Departments
- Professional Associations
- HIV Organizations
- Patient Advocacy Groups
- Non-profit Organizations
- County Health Departments
- People Living with or at Risk for HIV
- Academic Institutions
- Local Health Departments
- Faith-based Organizations

Your Name Here
Practice #3: Identify, analyze, and distribute information from new, big, and real-time data sources
CDC Public Health Data Strategy

- **Why?** Data are the foundation of our nation’s public health network. We must have the capacity to generate and utilize timely, accurate, and accessible data to meet the health challenges of today and tomorrow.

- **Why now?** Data is moving slower than disease. We are too slow –
  - Getting data
  - Analyzing data
  - Sharing data

- **Moving data modernization forward requires**
  - Leadership - How do we do this together?
  - Data Sharing - How do we build a flexible approach built on trust and verification?
  - Funding/Resources - How do we plan together to identify and wisely use resources?
  - Capability to Meet Evolving Technologies - How do we keep from trapping ourselves in a closed technology box?
Data for Decision Making

- **Syndromic surveillance**
  - 65% of ED visits captured
  - 75% of ED reports received in 24 hours

- **Notifiable diseases**
  - >120 notifiable diseases
  - 2.7M reported each year from 3,000 local health departments to state health departments
MISSION: To provide information from a nationwide network of integrated health and environmental data that drives actions to improve the health of communities.
DASH is a national Robert Wood Johnson Foundation program
Using Data to Evaluate Differently

- Transformation in community systems and processes
- Improvements in lives improved based on a community’s theory of change

<table>
<thead>
<tr>
<th></th>
<th>Not yet started</th>
<th>Starting – “We’re in the early stages and are still figuring things out”</th>
<th>Gaining skill – “We’re getting the hang of this!”</th>
<th>Sustaining – “This is who we are and how we do our work”</th>
<th>Spreading and Scaling – “We are actively scaling change across our region”</th>
<th>Now</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Community members have access to the community’s data and use it to help us reflect and improve.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data can come from numbers and stories.</td>
<td>Members of our community do not have access to our community’s data.</td>
<td>We are working to display our data for all community members to see in a couple of initiatives.</td>
<td>Members of our community know where to access and view data for several major initiatives. The data is easy to understand and reflect on.</td>
<td>Members of our community know where to access and view data on our impact. We regularly use these data to reflect as a community.</td>
<td>The community feels a sense of ownership over the data. Community members contextualize the numbers with stories to create greater insight.</td>
<td>Members of our region have ownership over our data, and know where to access and view data on our impact. We have regional processes in place to regularly reflect on our data. Community members help to contextualize this data.</td>
<td>0</td>
</tr>
</tbody>
</table>

100 Million Healthier lives. Pathways to population health. IHI Framework.
HIPMC improved in 3 areas between September 2017 and March 2018

- **Vision**
  - Co-Design

- **Applying improvement methods**
  - Willingness to adopt change created by others

- **Sustainability & scale-up**
  - Organization of community collaboration
  - Communication and conflict resolution
  - Shared stewardship
  - Collaboration
  - Growing leadership of those affected by inequity
  - Distributing power and leadership
  - Taking effective action to improve equity

Source: SCALE Community Transformation Map (CTM), 4 responses
Practice #4: Build a more integrated, effective health system through collaboration between clinical care and public health
High-burden health conditions | 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

<table>
<thead>
<tr>
<th>Bucket 1 Examples: In Clinical Settings</th>
<th>Bucket 2 Examples: Outside of Clinical Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve access to medications (e.g., via elimination of cost sharing)</td>
<td>Self-measured home blood pressure monitoring</td>
</tr>
<tr>
<td>Expand access to comprehensive tobacco cessation treatment</td>
<td>Diabetes Prevention Program</td>
</tr>
<tr>
<td>Remove barriers to use of long-acting reversible contraceptives</td>
<td>Home visits for asthma care (to reduce home triggers)</td>
</tr>
</tbody>
</table>
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
HI-5
HEALTH IMPACT IN 5 YEARS

Changing the Context
Making the healthy choice the easy choice

Social Determinants of Health

→ Counseling and Education
→ Clinical Interventions
→ Long Lasting Protective Interventions

→ Early Childhood Education
→ Clean Diesel Bus Fleets
→ Public Transportation System
→ Home Improvement Loans and Grants
→ Earned Income Tax Credits
→ Water Fluoridation

→ School-Based Programs to Increase Physical Activity
→ School-Based Violence Prevention
→ Safe Routes to School
→ Motorcycle Injury Prevention
→ Tobacco Control Interventions
→ Access to Clean Syringes
→ Pricing Strategies for Alcohol Products
→ Multi-Component Worksite Obesity Prevention
Public Health Law – Healthy Neighborhoods

- Growing evidence shows that our neighborhoods play a strong role in our health.
- Housing, workplaces, streets, and transportation all provide opportunities to promote safety, physical activity, access to healthy food, community engagement, and affordable living.

https://www.changelabsolutions.org/sites/default/files/ChangeLab_Solutions_Tools-for-Change-Resource-Catalog_FINAL_201801_0.pdf
Public Health Law – Health Care

- Health care systems and hospitals have opportunities to get involved in community public health initiatives.

- Partnering with advocates and local agencies, providing healthier foods and beverages, and leveraging community benefits allocations from hospitals can all help keep people healthy and out of the emergency room.

: https://www.changelabsolutions.org/sites/default/files/ChangeLab_Solutions_Tools-for-Change-Resource-Catalog_FINAL_201801_0.pdf
Addressing the Social Determinants of Health
Community-Wide Health Improvement Initiatives
CSTLTS National Nonprofit Awardees
Building a Connected Ecosystem Across Organizations to Improve Health, Well-being and Equity at Scale

1. Key Frameworks and Tools
2. Connections Across Networks
3. Connected Capability Building
4. Spread and Scale of Proof Points
5. Connected Technology Tools & Supports
6. Shared National Strategies
1. Key Frameworks (and associated tools)

1. **Community transformation**: Community of Solutions framework

2. **Health system transformation**: Pathways to Population Health

3. **Equity**: Equity program brief

4. **Measurement**:
   1. **Well-being In the Nation** (WIN) - National Committee for Vital and Health Statistics
   2. **100MLives Measurement framework**
Community of Solutions Approach

Community of solutions skills

- Leading from within (LW)
- Leading together (LT)
- Leading for outcomes (LO)
- Leading with equity (LE)
- Leading for sustainability (LS)

Community of solutions behaviors, processes, systems

- How people relate to themselves, one another, and to those affected by inequity
- How the community approaches the change process
- How the community creates abundance

Culture of health outcomes

- Health as a shared value
- Thriving cross-sector partnerships
- Healthy, equitable communities
- Improved population health, wellbeing and equity outcomes

www.100mlives.org/initiatives
Practice #6: Replace outdated organizational practices with state-of-the-art business, accountability, and financing systems
## Accreditation Activity as of August 30, 2019

### Type of Health Department

<table>
<thead>
<tr>
<th>Type of Health Department</th>
<th>Accredited</th>
<th>In Process</th>
<th>Total in e-PHAB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local</td>
<td>236</td>
<td>146</td>
<td>382</td>
</tr>
<tr>
<td>State</td>
<td>36</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Tribal</td>
<td>3</td>
<td>3</td>
<td>6</td>
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<tr>
<td>Territorial</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Centralized States Integrated System</td>
<td>1/67</td>
<td>.</td>
<td>1/67</td>
</tr>
<tr>
<td>Multi-Jurisdiction</td>
<td>.</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Army</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Number of HDs</strong></td>
<td><strong>275+1</strong></td>
<td><strong>164</strong></td>
<td><strong>440</strong></td>
</tr>
<tr>
<td><strong>Population (Unduplicated)</strong></td>
<td><strong>248,001,475</strong></td>
<td><strong>31,286,061</strong></td>
<td><strong>279,287,536</strong></td>
</tr>
</tbody>
</table>
CSTLTS Mission

- Improving Community Health Outcomes by Strengthening State, Tribal, Local, and Territorial Public Health Agencies
CSTLTS — What We Do

- Technical Assistance to STLTs
- Internal CDC Coordination and Support
- Build/Develop Partnerships to Improve PH System
- Capacity Building
- Performance Improvement
## Center for State, Tribal, Local, and Territorial Support — Strategic Map

### Improving Community Health Outcomes by Strengthening State, Tribal, Local, and Territorial Public Health Agencies

<table>
<thead>
<tr>
<th>Goal 1:</th>
<th>Goal 2:</th>
<th>Goal 3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance public health system coordination and collaboration to advance public health priorities</td>
<td>Fortify public health infrastructure and core capabilities of STLT health departments</td>
<td>Put public health systems science into action to achieve public health impact</td>
</tr>
</tbody>
</table>

#### Goal 1: Enhance public health system coordination and collaboration to advance public health priorities

<table>
<thead>
<tr>
<th>Strategy 1.1:</th>
<th>Strategy 1.2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitate coordination and collaboration among national and STLT partners in support of public health priorities</td>
<td>Improve CDC capacity to identify and respond to emerging and emergency STLT needs</td>
</tr>
</tbody>
</table>

#### Goal 2: Fortify public health infrastructure and core capabilities of STLT health departments

<table>
<thead>
<tr>
<th>Strategy 2.1:</th>
<th>Strategy 2.2:</th>
<th>Strategy 2.3:</th>
<th>Strategy 2.4:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimize resource planning and use by STLT health departments</td>
<td>Support and improve public health accreditation</td>
<td>Provide surge support for addressing public health system emerging and emergency issues</td>
<td>Provide training and service learning assignments that develop STLT workforce competency and expand public health agency capacities</td>
</tr>
</tbody>
</table>

#### Goal 3: Put public health systems science into action to achieve public health impact

<table>
<thead>
<tr>
<th>Strategy 3.1:</th>
<th>Strategy 3.2:</th>
<th>Strategy 3.3:</th>
<th>Strategy 3.4:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve public health system information for decision making</td>
<td>Promote and support efforts to build evidence of what works to strengthen public health core infrastructure and capabilities</td>
<td>Study and support STLT implementation of evidence-informed practices/policies</td>
<td>Facilitate STLT access to new knowledge, evidence, and data through platforms, tools, and forums</td>
</tr>
</tbody>
</table>
Our Attributes

- Adaptable
- Flexible
- Efficient
- Cross-cutting
National Committee on Vital and Health Statistics (WIN) Framework

- National Committee on Vital and Health Statistics (NCVHS) is a Federal Advisory Committee – reports to secretary of HHS
- Goal was to identify *multi-sector* measures to support population and community health and wellbeing and address social determinants of health
- Report from January 2017
- Accompanying letter w/ recommendations to HHS Secretary (May 2, 2017)

This document was developed by the NCVHS Population Health Subcommittee drawing from a wide range of evidence, including an environmental scan conducted by the Committee, and with input from the public through a year-long, iterative process. This version of the Framework incorporates feedback received during the NCVHS Population Health workshop held in September 2016. In its capacity as a Federal Advisory Committee, the Committee has turned over the Framework to a non-governmental organization (NGO) whose leadership volunteered to steward its ongoing development, maturation, pilot, implementation and ongoing refinement in collaboration with federal, state, local governmental and non-governmental organizations. For questions, please contact NCVHS at ncvhs@mail.cdc.gov.

People Reported Well-Being

- Cantril’s ladder - Two simple questions
- Administered 2.7 million times, highly validated
- Relate to morbidity, mortality, cost
- Useful for risk stratification
- Work across sectors

Common Measures for Adult Well-being

% people thriving
% people struggling
% people suffering

Age
Sex
Race/Ethnicity
Education
Zip code
Veteran status

www.winmeasures.org
Leading Indicators
Indicators with strong validity, importance, and data availability

Demographics  Community Vitality  Economy  Education
Environment and Infrastructure  Food and Agriculture  Health  Housing
Equity  Public Safety  Transportation  Well-being of People
How many people lack health insurance coverage in Suffolk County, Massachusetts?

Coverage Status: Uninsured

<table>
<thead>
<tr>
<th>Coverage Status</th>
<th>Uninsured</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>4.1%</td>
<td>22.11%</td>
</tr>
<tr>
<td>Black, Non-Hispanic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2+ Races, Non-Hispanic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White, Non-Hispanic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, Non-Hispanic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

www.winmeasures.org
What Is the HD of the Future?

- ?????
- Tied to jurisdictional political decision making and resourcing
- Integrated approach, not only categorical and programmatic
- Foundational or core capabilities
- Strategic engagement on government
- Multi-lingual: Human development language, economical improvement language, etc, etc
What Are We Trying to Do?

- **Lead from within** – Go on an internal journey to take an equity lens to your work – at the level of the person and at the level of program and policy implementation.

- **Leading together** – Partner across agencies and with people with lived experience of inequities and encourage public health departments to do the same; act as facilitative leaders and team members.

- **Leading for outcomes** – Be willing to embrace a different way to measure and evaluate that supports a whole person, whole community orientation; evaluate for system change as well as population outcomes.

- **Leading for equity** – Disaggregate your data and make it available to communities; build the capability of the public health workforce to lead for equity.

- **Leading for sustainable system change** -- Engage in an equity in all policies approach and build the capability of public health to do that.
Key Practices for a Successful Strategic Health Leader

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

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

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

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

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

Practice #6: Replace outdated organizational practices with state-of-the-art business, accountability, and financing systems
But I have promises to keep,
and miles to go before I sleep,
and miles to go before I sleep.

Robert L. Frost
For more information, contact CDC
1-800-CDC-INFO (232-4636)

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
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