Transcript of the Socially Determined Podcast

"Public Health 3.0"
with Dr. Karen DeSalvo, former Acting Assistant Secretary for Health at HHS and Co-Convener for the National Alliance for the Social Determinants of Health
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ANNOUNCER:
Welcome to Socially Determined, a podcast about the social determinants of health. This podcast is hosted by Dr. Gabriel Kaplan, Board President of the National Association of Chronic Disease Directors. Today Dr. Kaplan speaks with Dr. Karen DeSalvo, former acting assistant secretary for health at HHS. Dr. DeSalvo is co-convener for the National Alliance for the Social Determinants of Health. Through this podcast, we'll explore the concept of Public Health 3.0 and resources available to communities that are tackling some of the underlying causes of health disparities in the United States. Thank you for joining us. Enjoy the program.

DR. GABRIEL KAPLAN:
Doctor – Karen, let me ask you – I know from your previous experience you worked as the commissioner for public health for the city of New Orleans. And I wondered if you could share with the audience how your experiences in New Orleans shaped your understanding of the social determinants of health and their importance in public health work.

DR. KAREN DESALVO:
Thanks Gabriel, I'm so excited to start there because the experiences that I had not only as health commissioner but leading up to it really still continue to be impactful and drive a lot of my thinking in the work that I do.

You know one of the traumatic events that happened to New Orleans was Hurricane Katrina. So in 2005 I was here working in academics, in academic medicine, and though I was in academic public health as well, I really had I think more of a non-practice, but research thinking about the drivers of health for my community, and as I think it was, was good work around improving access and quality to care it just became all so evident to me when we were all literally thrown on the streets in trying to think about not only how to meet immediate need, but rebuild a health system that would better serve the population. It was just so clearly obvious that we had to attend to more than medical care. People needed housing, and an educational system, and transportation, and public safety, and clean air and soil, and all of it was knocked down and we had to rebuild it up from the ground after Hurricane Katrina. And those first few years I was really focused on building a great health care system, which we did and we're very proud of.

It only took a very short period of time for my public health gene to have an epigenetic phenomena, I usually say, like I just realized that health care was only going to get us so far and just we had to really have to work across sectors that would make sure that the public's health had every opportunity. And that meant not just medical care but really making sure that we were building strength and all those other social determinants and drivers of health, so it was this ramp up.

And when I became Health Commissioner, it was just a terrific opportunity for putting public health front and center of making sure that all those sectors were working together and that we were also doing that on behalf of the public, lifting up their voice and their priorities, kinda driving forward this health agenda for a community that frankly really deserved it and really needed it in that time of crisis.

DR. KAPLAN:

Tell us about the work you did at HHS creating this idea of Public Health 3.0.

DR. DESALVO:

Well it grew out of all those experiences, and I make it sound like public health, like I just sort of stepped into the role of health commissioner and everything went smoothly, but reality was, like many local health departments in the U.S., our health department and New Orleans had been in decline not just from Katrina but from just years of underfunding related to the Great Recession, because of changes in dynamism around the Affordable Care Act where some of what local public health did was clinical practice and that was a source of revenue that would change when coverage expansion started and public health staffing got smaller, the focus of it shifted out of the kind of clinical needs of the underserved into really more broader public health opportunities and challenges. And I think the other big thing that was happening to local public health was the greater demands around the social determinants as a big driver of morbidity and mortality, of suffering and death in communities. And we as a country have conquered, by and large, communicable disease infections, we've conquered a lot of the suffering from chronic disease—I'm not saying that we solved it all, but we've found better systems to doing it.

But now these challenges around the bigger social determinants that are a lot of the driver for health problems in a community. And so our local health department in New Orleans was very much like others across the country—more demand for our our work, but less resources to do that work to meet the challenges of the public's health. And as health commissioner, what I was able to do with my team on the ground was transform our local health department into one that was modern and able to meet the 21st century challenges around health, and that involved a set of actions that we took in a strategic way. When I got to HHS and began to learn even more about what was happening in local public health around the country, two things became really clear to me—one was I was not alone. There was a lot of transformation and innovation happening into this what I called a Public Health 3.0 model, this 21st century model.

But it was also sort of an unclear, unsung effort that needed to be lifted up and there need to be clarity about what could sustain, not just that that could sustain that modernization beyond a charismatic leader or a catastrophe that sort of drives and marshals a community. How could we see that every American had the kind of public health protection of a 21st century health department and so I used that time at HHS to learn about and lift up that movement that was already happening on the front lines and to put out a set of recommendations that I had to sustain it.

DR. KAPLAN:

Great. Thank you. So what are some of the prime examples you can give of public health engaging on this topic and working with various sectors to advance progress in this area?

DR. DESALVO:
Let me start off, I sort of, I want to say a word about what are the key components to this Public Health 3.0 model because it will give you some sense of some models, I'll give you examples in some of those areas. What we found very recurrently was that there were five key areas that mattered when local communities were working to modernize public health. And by the way, most of this is focused on local public health like, cities and counties, though very applicable to states, and which we learned from states and also have seen a lot of states taking up this kind of framework. The five areas are thematic across the country. One is about strong leadership and workforce, especially leadership that takes this model of a chief health strategist working outside of the bounds of a health department.

The second is they're all developing strategic partnerships that were often unexpected partnerships, so not just you know maybe health care, but they were working with technology providers or the business sector on the front lines to find ways that they're partners with like interests and missions. The third area was they found a way to have sustainable and flexible funding. Sometimes that was through pooling resources, sometimes it was by finding a local philanthropy, sometimes it was through local increases in tax dollars to support the work that was happening.

The fourth was making use of timely data that was not stale, you know because it was two years old, but something that was relevant and near term that could really create a more of a quality improvement kind of environment. And the final one was about infrastructure. Some of that relates to accreditation, so moving through the public health accreditation process, which is just a way to create a strong infrastructure of a health department. There are also a lot of communities that were creating these umbrella structures, where they were working across sectors to create new organizations that could share money and governance and align missions and vision.

And this was very much what we did in New Orleans in many ways, but thematically I saw some really interesting strengths in other places. For example, in Allegheny, Pennsylvania, which is the county around Pittsburgh, they have formed a multi sectoral collaborative that has its own infrastructure for governance and for data sharing and for resource sharing that has been sustained now for years and allowed them, the community, to work together to solve challenges that arise and do that in a sustained fashion. They're not alone. You find those kinds of models in places like San Antonio or even smaller communities like Erie, Pennsylvania and those very sophisticated models like what New York City's done around, leveraging data to do some hot spotting and really go to ground to identify the health needs of communities.

So one real drive home point I want to make, Gabe, is that what I have had the chance not only to see when I was at HHS in the development of the report—we did these listening sessions all across the country—but also what I've seen since is that in every time zone, every temperate zone, communities large and small, this kind of innovation is happening and thematically it takes the five big area to sustain. And that's the work we have to do as a country going forward is to

make sure that they have an opportunity, those local communities, to have this work not just be one-off but really be a part of the 21st century public health infrastructure.

DR. KAPLAN:
That's great. Thank you. So a key concept in public health is this concept of primary, secondary, and tertiary prevention, and at a recent conference for NACDD members we talked about the social determinants of health as sort of the primary prevention strategies before primary prevention. So there's sort of the primary primary prevention strategy. If smoking, obesity, physical activity, nutrition are primary prevention activities, what are the activities before that that we could potentially engage in?

I think for programs that are working in the chronic disease prevention and management space however, it is hard to persuade our funders of the connections across these areas and I know just from recent experience with funding, Congress struggles to sort of navigate the relationship with CDC and direct CDC somewhat in how money should be distributed across primary, secondary, and tertiary prevention; and there's a particular focus in some of the chronic disease areas like cardiovascular disease and diabetes to focus on some secondary and tertiary prevention strategies.

How can public health make the case for work in the social determinants area as being connected to chronic disease prevention and management being sort of an evidence-based part, if you will, of primary prevention and an appropriate use of resources from the federal government in chronic disease?

DR. DESALVO:
This part of the—this is what's exciting to me about this transformation of public health into a modern version, a 21st century version, this 3.0 model, because what it is evolving is local public health that has the capacity and capability to address the policy, and environmental, and systems level drivers of health challenge.

And that's like a mouthful of wonky language, but what it means is that, I think public health was in a space for a while out of necessity of, for example, doing a smoking cessation program work where it was helping set up quit lines and embed evidence-based programs in partnership or by itself in the clinical environment—that someone comes into a clinic and they've got asthma or emphysema or heart disease—and we want them to quit smoking, or we want, we want to prevent them from getting those complications of smoking. Where this 3.0 model and this transformation of public health allows us as a field to be a better partner to the healthcare system and to the community in a place like smoking is; it gives public health the bandwidth to take on policies like tobacco 21, or smoke-free communities, or smoke-free campuses for colleges.

And this is, this is you know I think the purview of how there is good evidence to show that one of the most important things we can do is prevent people from starting smoking in the first place and do that at a systems or a policy or an environmental level. And public health in many communities across the nation has been able to bring stakeholders to the table sometimes. Maybe it's the university environment, maybe it's the entire city, maybe parks and playgrounds. You know, maybe it's the business environment and systematically you're saying in the case of smoking prevention a lot of really good, broad foundational work that is evidence-based and

isn't about supporting a single individual—important as that is—that it really creates a healthier context that allows that person to make healthy choices. Smoking is but one example.

When you look at examples in food, in air quality, and I get, as you might be able to tell, really excited about this because I think like health care and I'm a doctor and I really appreciate and respect what we can do in medicine, but I'm also a public health professional and I respect and appreciate what we can do in public health. And I think together the synergy of supporting an individual's health, but making sure that they're in a healthy context and have the opportunity to make the healthy choice the easy choice…this is where we really start to make some significant gains in the public health.

I mentioned some other players in there, Gabe, and I want to call them out again. It's not just about medicine and public health—the business sector, the educational sector, faith-based, all the other parts of our community coming together. That's how we create the conditions in which everyone can be healthy, which is truly the definition of public health.

DR. KAPLAN:
That's great. So it's almost as if public health programs should have a checklist of community partners and think about, how often am I checking in with these folks, how aware am I of the kinds of things that they're doing, the kinds of things they can offer to me and to my programs, and sort of making a ritual or habit, if you will, of checking in with them to keep those kinds of conversations alive and surface opportunities for sectors to come together, convene and partner to advance issues in this area.

DR. DESALVO:
You're so right. I want to point to maybe one personal example and then a reference for the listeners if they want to learn more about how to do that. This is one of the things for me as the health commissioner in New Orleans that I learned was just what you're saying. I have set a table—either I have to convene it or had to find the right parties to convene it—but I had to be at the table, and we had to meet regularly and share information and share data so that we have a shared fact base, and then could take action upon it. And I think sometimes communities think well we have to have the one single table. One of the lessons I learned was you do need to, sometimes when you're starting these relationships, find a win that you think you can all get together. And so for example in New Orleans we had folks who were very interested in mental health issues and we made that a priority for my community.

So we created a special behavioral health table which continues to this day. I started it back in 2010 and I've been gone for years and it's still moving forward because there's enough win and interest in sharing information. And similarly we did this around something called Fit NOLA, which was about physical, and nutritional, and fitness, but it also expanded beyond that. So sometimes you need multiple tables, because even if it's, I found some of the same actors at the same table, you want the wins to feel palpable and proximate and it forces a regular check-in. That takes resources, for a health commissioner, for my staff—it's not something you can do on the skinny. And this is one of the reasons one of the five areas of Public Health 3.0 transformation is about having flexible, sustainable funding. We've recently put out, last fall we put out a report on the funding it would take to support that kind of public health infrastructure and protection for everybody in the country.

The amazing part of the number, is that the cost of that is thirty-two dollars a person a year, which is, you know, basically less than a cup of fancy coffee a month, for everybody in the country to have that kind of multi-sectorial collaborative at work, resourced, and supported in the community. To the second point you made about how do you know who to invite, where do you go, to say one resource but I'll tell you two: one is the Practical Playbook which the de Beaumont Foundation publishes and there's a series of chapters about the how to do this on the front lines; and there's a richness of resources in there for anyone interested in being involved in this work, whether you're in public health practice or the business sector or others, including evidence-based practices that are known to return investment.

And another group I've had the chance to spin off from Public Health 3.0 work and that is something called PHRASES. It's also supported by the de Beaumont Foundation. The work we're doing is to create messaging and communication toolkits, particularly for public health but also for others you might engage because your just sitting at the table isn't enough, you have to have a conversation. And that sounds so simple, but it turns out to be difficult when you speak different languages and you have different priorities because housing is seeing the world in a certain way, or the business sector, or payers, or public health. So there could be two kind of concrete resources for folks who want to get involved in the work that I would point them to, but that work takes resources and I just want to make sure people also realize that, that this, transforming public health—it's going to require some sustained investment.

DR. KAPLAN:

So that's an actual publication from the de Beaumont Foundation, one is the Practical Playbook. And the other is called Phrases?

DR. DESALVO:

Phrases is actually a set of tools. It's PHRASES as in all caps, Public Health Reaching Across Sectors. And people should be on the lookout because in July this year we're going to release a whole new suite of tools for use, but yeah, PHRASES is not—is an ongoing effort to help create communication tools for local public health folks and others that want to engage in multi-sectoral collaboration. The Practical Playbook I think this is the second or third iteration of it and it has, there is a website where the chapters are made available, and it pushes people to concrete evidence-based resources and examples of what works.

DR. KAPLAN:

Oh that's great. That's going to be so useful.

DR. DESALVO:

Pracitcalplaybook.org, the website is practicalplaybook.org. The other is phrases.org.

DR. KAPLAN:

Great. So that should be easy for our listeners to navigate to, and that really does provide a very valuable resource that connects to my President's Challenge, which really is about how do we implement, how do we implement, how do we actually go from our understanding to taking

action. One of the things that I was going to ask you about is in the article “Public Health 3.0” you talk about the role of local health as conveners. What do you see as the role of state public health in this space, and would the Playbook and PHRASES and with those resources help people find their way, or are there other things that from a state perspective working at the state level they should keep in mind?

DR. DESALVO:
I want to make sure that the listeners know is that we have, state by state, very different structures of public health across the country. Some states have a more centralized state level dominance of driving public health in their community and then in the other states it’s more local. So Massachusetts would be a great example of a community where they have a lot of local public health. And Louisiana would be an example where there's pretty strong central public health. What all that means is that in the U.S., based upon where you live, there's gonna be a different stronger leader for the kind of public health work that needs to get done.

And so to answer your specific question, in my mind we have to be thinking about local public health and transitioning to 3.0 and the kinds of tools I mentioned as being useful for whatever is the of structure in the context of local public health. I have seen states that have made really good use of the framework, like Virginia or South Carolina as examples, of this 3.0 framework. And some of the people will read about, for example in the Practical Playbook, which are these models of how to partner Medicaid and the state public health are really designed for state-based strategy.

So the short answer is yes. These are good tools for the state. States are moving to a 3.0 model, they're recognizing that the 21st century health challenges that populations face are bigger than any one sector and require multisectoral collaboration, and require modernization of approaches to leveraging data, and really being able to take more timely action for the health of communities. Frankly, it is a really exciting time in public health and for me in many ways a call to action that the country needs us. And we're stepping up in many ways now. I think it's the country's turn again to come back to public health and say we're ready to help, continuing to support your modernization as you strive to meet the challenges of the 21st century.

DR. KAPLAN:
That's great. I'm looking at the Practical Playbook website and it's just such a wonderful valuable place of resource and as you said there are multiple iterations of a playbook and you can see on the first page an example of partnerships that aligned in the Bronx to cut asthma triggers in housing and a partnership in Kansas between Sedgwick County Public Health and the Academy of Family Physicians to save tobacco-free Wichita. So are there any particular chronic disease interventions that our listeners should be aware of, or opportunities that they should think about potentially importing into their state? Perhaps something where there's a nutrition and diabetes program partnership. Can you think of any that come to mind that really represent partnership opportunities that our folks have to advance work in this area?

DR. DESALVO:
I want to pick two to talk about, but since you mentioned diabetes, I will just highlight that I think programs like the Diabetes Prevention Program are a nice example of how we're trying to meet people where they are at community, and use a resource like a YMCA or some other kind of

model that feels more comfortable and part of your life flow for your chronic disease treatment. But as you say there has to also be coupled with opportunities around access to healthy food and there is a burgeoning amount of work happening, I think, through leveraging data to better map access to healthy food in communities and see that we're making sure that people are able to for example, especially if they're low income or use SNAP, or what we used to call food stamps, to access farmer's markets.

There's also interesting models about bringing healthy food around to community and/or getting them healthy food at places like federally qualified health centers through partnerships. That's been done in small communities like Jonesboro, Arkansas. But I want to point out two particular things that I very much would love to see replicated. And I'll tell you why.

One of them—it does have import for chronic disease because it's informational and this is this project called Macroscope which New York City, the New York City Health Department has been engaged in and it's a way that they're using electronic health record data from the city health department clinics as a proxy for the rates of chronic disease, particularly obesity, diabetes, and hypertension – in the New York City broad population.

And they've basically shown that they don't have to do individual random sampling surveys in their community that take a long time, and then the data is kind of stale by the time you get it, but rather they can dip in and take anonymous data from a non-random sample, an electronic health record, and know enough about where the community is with respect to those chronic diseases and use that to do some hot spotting, some mapping, to go to ground and really put intervention programs where they need to in a timely fashion.

I would love to see other communities take that strategy, so rather than waiting for a field survey to be finished and the data is already two or three years old by the time public health has it, but to start to show that we can, we can be more timely in understanding the challenges and map them in a community so we know where to target the next healthy food option or the next [inaudible] program that really meets needs of population, so that's a data that's an infrastructure and I think a more, a smarter, cheaper, faster way to provide public health interventions that can be a partnership between a variety of actors and address chronic disease before it gets too far out of control.

The second I want to mention something called Louisville Air, which is one that is a paper published, Macroscope, by the way have published so there's, there's literature out there, people could see it and replicate it and I know New York's been really open about wanting to share with people how they're doing their data work. But the Louisville one was about asthma, and the way that they took on this work is to say we want to improve asthma outcomes, but we don't want to just do it by treating people in the clinical environment.

So they put these little technology indicators on the inhalers so they could tell when and where people were using their inhalers more often, kids and adults, and then used that data. They mapped the data from the little geo-coded inhalers to figure out where they had air quality challenges in the community, and then based upon what they found from that mapping, not only did they address the individual's needs around the chronic disease of asthma and change care

plans where necessary, but they also did things like plant trees or change truck routes to reduce that environmental exposures to poor air quality.

So this is to me a really interesting example of technology, medicine, and public health working together to improve chronic disease in that community. I would love to see that kind of work replicated as well.

DR. KAPLAN:
That sounds great. Well that's been really, very helpful and very enlightening. You said Macroscope?

DR. DESALVO:

Yeah. Macroscope. M A C R O, Macrosope.

DR. KAPLAN:

They've released, um, organized, written up, some of the results from this kind of work that folks should look for.

DR. DESALVO:

One of the reasons I really like it is because, if you just Google on macroscope New York City you find it. One of the reasons I like their work is because they've done, they have been very meticulous in making sure that they can validate their findings and pretty transparent in their methods. So that's, that's one of the reasons. Massachusetts has done similar work and there are other states that are starting to take it out there. I guess for the listeners, what I'm trying to get to you is there's a lot of good stuff out there now instead of trying to invent everything brand new for ourselves.

Let's build upon the evidence that exists, so Practical Playbook gives a lot of examples for the things that we know are population level, evidence-based strategies that can impact chronic disease. Let's test those in the field and report out on our findings and what works and doesn't, and share that information broadly. We don't need to keep reinventing an approach, but we do need to get smarter about data. One of the rate limiting steps in transformation 3.0, addressing social determinants, working in a multisectoral fashion, is not having good data about the status of their populations' health not only at baseline, but after intervention. And public health just needs to be able to have more rapid cycle of improvement for lots of reasons—this could be another podcast. The data part—for some people they might say, "we have data"—you don't have good data, and I'm just, I feel so strongly about that.

Public health has got—this is the foundational important work that we can do, but we need to be a lot more timely and actionable in the information that we have because that's how we can be a really strong partner not just to health care but to the rest of the community, is to really make sure we've got a current and strong set of facts from which we can all act to improve the public health and know we can make progress.

DR. KAPLAN:
That's a great note to end on, is that surveillance very often gets neglected. When we started talking about moving upstream, just because we don't tend to track a lot of those upstream issues as well in our surveillance systems, and because there's such a dire need for action and people are urgent, feel a sense of urgency about acting that I think very often they neglect the investments that we need to make in surveillance to sort of properly orient ourselves before we get started, to make sure that we are, as you said, directing the resources to the places of the most dire need to the places where there is greatest opportunity.

And with Macroscope for instance, there is so much opportunity to really connect medical information, clinical information, to local information that relates to the environment and where people live, and what are the environmental challenges that ,and by environment I mean sort of broadly both the built environment and the natural environment, how that's impacting their health.

DR. DESALVO:
Exactly. Exactly. And then everybody can step in and take the part that they do best. But doing that collaboratively is really what that future looks like to me. I'm excited about honestly how, how much the various sectors are recognizing that they have strengths but those strengths begin and end somewhere.

And so doing this work going forward in a collaborative fashion is kind of the new fad if you will. And I hope it's not a fad, I hope it's just the way we start doing business again as a country and not having everybody in their little silo. It really, uh, the stakes are high. We have a lot of work to do for this country's health and the best way to do this is doing it together.

DR. KAPLAN:
I couldn't agree more. I think the growing gaps in income inequality and social service deprivation to really broad sectors of our populations and regions and geographic locations is probably one of the biggest challenges public health has in a sense. As we improve in our sophistication, clinically and with respect to tertiary and secondary prevention in public health, it concerns me that some of those primary primary prevention needs are getting worse, and they really require some desperate attention by this country.

I hope we can we can do that, and in doing that I hope people remember your call to not reinvent the wheel that there is—you're not alone out there. And as you and your partners at a local level and as a state at a state level begin to think about these challenges and opportunities, you're not the first ones to do this and you should stand on the shoulders of the giants who've come before. And there are resources out there such as the Practical Playbook, PHRASES, the places you've pointed us to that the de Beaumont Foundation is doing some really important work, and there are places folks can go learn about how to do this work at a practical level and particularly in the chronic disease space.

So thank you so much for your time Karen. This has been a fascinating conversation and I just wish we could keep talking.

DR. DESALVO:

Well thank you so much for your interest and good luck with everything during your presidential year.

DR. KAPLAN:

Thank you so much.

ANNOUNCER:

Thank you for listening to Socially Determined, a podcast brought to you by The National Association of Chronic Disease Directors. Please visit www.chronicdisease.org to listen to more podcast like this one.

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