Five Steps to Health and Well-Being in America:

A Health and Well-Being Policy Agenda for the President and Congress of the United States

2ND EDITION

AHPA
ADVENTIST HEALTH POLICY ASSOCIATION


Adventist HealthCare White Oak Medical Center

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A MESSAGE FROM THE AHPA President

Thank you for your consideration of the health and well-being policy vision outlined in this, the second edition of what was formerly named Five Steps to Health in America. This book and its accompanying executive summary represents the collaborative effort of the five Seventh-Day Adventist health systems that comprise AHPA, collectively the nation's largest Protestant health care provider and our commitment to actively engaging in positively impacting the health and well-being of our nation.

In 2018, AHPA redoubled its commitment to engagement in national health care transformation, by establishing a permanent advocacy and public policy presence in our nation's capital, with the refocused mission of "Promoting wholeness to live God's healing love." In October 2015, under the leadership of AHPA's first President Richard "Rich" E. Morrison, AHPA published and widely shared with members of Congress, candidates for public office and other key stakeholders its health policy agenda in the first edition of Five Steps. That seminal policy agenda engaged a diverse group of participants in advisory sessions and multi-disciplinary writing teams, that ultimately led to the development of the five-point health policy plan that has been revised and updated with implementable recommendations. I offer the deepest appreciation to Rich and the AHPA team that set us out on this journey and developed an enduring roadmap to national health care transformation.

The unprecedented challenges of 2020 have shone a spotlight on the health and well-being challenges facing our society. The COVID-19 pandemic and resulting economic and social impacts have negatively impacted people and communities in ways we can no longer ignore. The Kaiser Family Foundation reported results of a Tracking Poll in July 2020 that indicates that 53% of adults in the United States reported that their mental health has been negatively impacted due to worry and stress. This is significantly higher than the 32% reported in March. The data also shows specific negative impacts on well-being, such as difficulty sleeping, eating, increases in alcohol consumption or substance use, and worsening chronic conditions, due to worry and stress.[1]

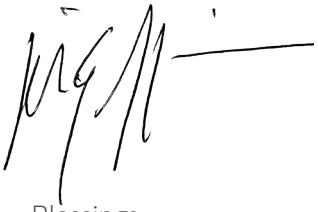
As we, the health systems united through AHPA, considered the evolution of this Policy Agenda, we simply could not ignore our responsibility and commitment to address not only those issues directly related to health care, but also those critical issues related to the well-being of the people and communities we serve. This emphasis is now reflected in the revised title of this document – Five Steps to Health and Well-Being in America. We are aligned to the Gallup definition of well-being, which identifies the distinct statistical factors that differentiate a thriving life from one spent suffering. Together, we are committed to investing in health and well-being creation, and you will see that commitment reflected in these pages.

Continued on next page

A special “thank you” to Dr. Helen Jung, AHPA’S Senior Policy Analyst for the detailed scholarship and practicality she infused in leading the development of this second edition, and to our AHPA Management Committee and the reviewers at each of our systems for their contributions to enhancing this vision.

As you consider the recommendations foundational to each of the Five Steps, please recognize our overarching objective is to foster health and well-being through innovative policies that enhance quality, lower cost and improved access, and measurably and sustainably improve well-being of individuals and communities throughout our nation.

AHPA stands ready to partner with our President, Congress, and other policy makers to champion these recommendations.



Blessings,
Michael Griffin

A MESSAGE FROM THE AHPA Board Chair

Welcome to a movement for health and well-being transformation.

The health systems represented in the Adventist Health Policy Association (AHPA) are committed to health and well-being transformation. That means we understand that health and well-being cannot be separated, and we are collectively committed to solutions that measurably and sustainably improve the health and well-being of the individuals and communities we serve.

AHPA is a coalition of Adventist health care systems united behind the idea that people are more than the sum of their diagnosis and are created children of God, worthy of our love, compassion and care. Advocating for the mission of Christ's healing ministry is part of a movement born from faithful believers who saw health care as the vehicle through which well-being is restored to those created in God's image.

The action steps outlined in the Five Steps to Health and Well-Being in America are designed to be a counterbalance in a culture that has turned health care into "sick care" and not embraced more healthy lifestyle choices or advocated for policies that incentivized healthy living and well-being. The leadership of AHPA believes that if we are able to activate these concepts at the local, state and federal level, we can begin to transform the health and well-being of individuals and communities entrusted to our care.

- Action Step 1: Create a National Well-being Policy
- Action Step 2: Connect Health Care to Well-being
- Action Step 3: Strengthen the Backbone of Public Health
- Action Step 4: Invest in and Prioritize Well-Being Improvement
- Action Step 5: Prioritize Determinants of Health Infrastructure and Investment

Each action step is supported by strategies that invite the necessary public-private partnerships and collaborations to address many pressing needs in communities throughout the United States. This is a movement that requires a non-partisan approach and we are hopeful that our colleagues in local municipalities, state houses and Washington D.C. will join our cause to transform the health of our nation.

Thank you for your consideration and support.

In His service,
Terry Forde

About the Adventist Health Policy Association (AHPA)

The Association is an affiliation of five Seventh-day Adventist-sponsored health care systems in 16 states and the District of Columbia. AHPA health systems operate 95 hospitals and over 600 affiliated entities. True to its Adventist tradition of health and well-being, AHPA hospitals spent over $2.5 billion supporting programs for housing, food and education in communities across the country.

EXECUTIVE SUMMARY

Five Steps to Health and Well-Being in America

2ND EDITION

A HEALTH AND WELL-BEING POLICY BLUEPRINT FOR THE PRESIDENT AND CONGRESS OF THE UNITED STATES

Has the time finally come? Is America ready–now, after decades of skyrocketing costs, uneven results, and negative trends in measures of individual and societal well-being–to address the key factors that make health care so unaffordable and ineffective at helping people and communities flourish?

We shall soon find out. Regardless of which party wields power in the coming decade, the people in power, be they Republican or Democrats, will face many choices. In each small choice, they will decide whether to double-down on a system geared to manage sickness or to invest in a system designed to improve and sustain individual and community health and well-being.

This is a call to action, and a detailed prescription, for the latter approach. It comes from what may seem, at first, like an unlikely source – a group of systems paid to care for the sick.

The Adventist Health Policy Association is a coalition of Adventist health care systems that together are the equivalent of the eighth-largest health care system in the country. There is much that unites us, including our faith and commitment to care for the body, mind and spirit of every person. But we also share a philosophy that health and well-being are inextricably connected. We recognize that the environments and social factors of the communities we live in impact our health in ways we are just beginning to understand, and we stand united in our dedication to innovation, investment and policy change to see a time when all Americans have the opportunity to live full and flourishing lives.

That is the foundation for these recommendations – these Five Steps to Health and Well-Being in America – which we hope emerging leaders will mine for ideas and inspiration in the years to come. We stand ready to help because the big picture changes, as well as the details, are what matter for those of us committed to a better way.

Problem: Our Nation Spends Too Much on "Sick" Care

There is no doubt that the United States has the most advanced technology for treating illnesses, and the greatest majority of medical advances and innovations come from our country. The challenge is that our culture and payment systems have focused on acute episodes of illness – and not on chronic disease, lifestyle and prevention.

The federal public health investment of $1.5 federal dollars for every $8.5 state dollars means that the challenge to keep Americans free from disease is left to the states. Subsequently, disease rates and health care costs vary widely by state. Death rates for heart disease are highest in the South and lowest in the West.

The prevalence of chronic illness and the poor health that follows explains in part why our nation spends so much on health care. In 2017, health care costs on average $10.206 per person – the most of any nation in the world (The Organisation for Economic Co-operation and Development cites its average per-person cost at $3.857 across member nations). In 2018, the United States spent $3.6 trillion on health care but less than 3 percent of that spending went to public health and prevention keep Americans healthy in the first place. At the same time, funding for emergency preparedness has been cut repeatedly: for example, the Hospital Preparedness Program is the only source of federal funding to help regional healthcare systems prepare for emergencies yet its budget was cut from $515 million in fiscal year (FY) 2004 to $275 million in FY 2020.[4]

The high cost of medical care an unhealthy workforce also cripple the U.S. economy and its ability to compete in the global market. Each year, Americans miss 2.5 billion days of work due to chronic conditions resulting in lost productivity totaling more than $1 trillion. Health care is the most expensive benefit for businesses and employers spent an average of over $14,000 per employee in 2018.

The federal government's approach to disease prevention and wellness is limited and fragmented. Multiple agencies – including the Centers for Medicare & Medicaid Services, the Centers for Disease Control & Prevention, the Administration on Aging, the Office of Minority Health, Indian Health Services, and the National Institutes of Health – oversee the nation's health policies. But no single office coordinates federal prevention and well-being improvement efforts.

Adventist Health Policy Association believes that every person who needs health care, regardless of social or economic status, should have access to it. We believe that each person and every community has the potential to flourish and that together, with our Nation's leaders, we can invest in measurable and sustainable well-being transformation.

Solution: Five Steps to Health and Well-Being in America

More money is not the only answer. Our current system focuses heavily on medical services rather than upstream investments in well-being creation and disease prevention. Our flawed priorities have generated an increasing financial burden on the federal budget, meaning that health care costs have emerged as an increasingly important policy priority.

By switching our focus from, "what causes disease?" to one that asks, "what creates well-being?", we can rein in and reverse the trend of rising health care costs and the diminishing well-being of our nation. We can strengthen our economy by improving the health and well-being of our workforce, boosting productivity, and ultimately advancing health, well-being and quality of life.

It is time to shift our "downstream" health spending into an "upstream" focus that will make a profound and meaningful impact on the health and well-being of all Americans. Reshaping our health spending priorities will help our country build a stronger, healthier America.

This is how the White House and Congress can make that happen:

1. Create a National Well-Being Policy

- In order to construct a National Well-Being Policy, the President can establish a National Well-Being Council by reconvening the historic National Prevention Council. That would immediately bring together a cross-section of 20 federal agencies under the leadership of the surgeon general and encourage them to consider the ramifications all federal policies have on the well-being of Americans. Additional members can be identified with expertise in the determinants of health and the creation of well-being to ensure a focus on upstream investments and policies.
- In addition, Congress can ensure that health and well-being considerations are included in policies that involve education, transportation, criminal justice, built environment and other determinant factors not directly related to health care, because we know that health and well-being aren't found at the hospital or doctor's office but instead begin in our homes, in our schools and workplaces, in our playgrounds and parks, and in the air we breathe and the water we drink.
- Congressional budget committees can commit more money to promote well-being and prevent diseases. The federal government currently spends less than $3 for each American on prevention.

Increasing that amount to just $10 per person could improve the nation's health and well-being and save billions of dollars in health care costs over the long term.

- The President can issue an executive order creating a White House Office of Well-Being and Prevention to coordinate policies aimed at improving our nation's levels of well-being and disease prevention. The office can coordinate well-being policies, created by the Administration and Congress, that encourage and facilitate data sharing and cross-sector collaboration to improve systems and measurably and sustainably improve well-being.

2. Connect Health Care to Well-Being

- The federal government currently provides little incentive for health care providers and insurers to invest in behavior that promotes well-being and prevents diseases. Medicare and Medicaid must help shift the emphasis of health care in America to the creation of well-being and disease prevention. Their payment systems currently are set up to reimburse treatments for chronic diseases, so preventive measures aren't emphasized. Reimbursement is based on volume rather than the overall cost and quality of care. Congress has the ability and responsibility to change that dynamic.
- Training enough primary care physicians is essential to providing care and preventative treatments to more patients. Congress can look for innovative approaches to incentivizing medical schools to train more primary care physicians, and expand medical school curriculum requirements to provide more comprehensive training and education on well-being creation and disease prevention.
- The White House and Congress must ensure that IRS-required Community Health Needs Assessments and associated Community Health Improvement Strategies are used to strategically invest in measurably and sustainably improving community well-being.

3. Strengthen the Backbone of Public Health

- The White House and Congress must ensure continued federal funding for public health training programs. Federal money for that training flows through four existing grant programs, but it is not guaranteed. So, the President and Congressional Appropriations Committee members must make that funding a priority.

- The COVID-19 pandemic revealed vast health disparities in our nation. The President and Congress must work to strengthen crucial public health infrastructure to be able to handle future pandemics or health outbreaks.
- There are efforts by health care associations to improve public health education, but the work would be more effective if Congress or the President created a national task force charged with finding ways to increase the ranks of public health workers and improve their training.
- It is essential for Congress to provide more money for training doctors to provide preventative medicine. Currently, none of the graduate medical education funding from Medicare or Medicaid are going to these programs. The Health Resources and Services Administration now provides only $4.5 million to 10 primary care residency training programs. Congress should increase that fund and find other sources of funding to allow all 73 training programs across the nation to reach their capacity.
- Beyond physicians, there are shortages across the health care workforce spectrum, particularly in rural areas. To recruit those allied health workers, the federal government could provide important financial incentives and/or loan forgiveness for students willing to work in rural communities.
- Congress also should consider adopting a federal rather than state system for licensing allied health workers. That would make it easier for those health workers to move across state lines for jobs and would ensure skills are standardized.

4. Invest in and Prioritize Well-Being Improvement

- To respond to the national mental health crisis and make mental health care more available, especially in rural areas, Congress can remove technological and administrative barriers to tele-psychiatry. Any person needing mental health services should have access.
- Congress can provide increased federal funding for community-based resources and outpatient treatment for people in need of mental health services. Funding for crisis intervention training for law enforcement and other community services personnel must be increased.
- Dental care is an essential component of health. Diabetes and dozens of other diseases can be identified through dental checkups. Yet, Medicare excludes most dental care coverage from policies for seniors, and the

Affordable Care Act classified dental coverage as an optional benefit. Congress can close this gap in preventative care.

- The President and Congress can enhance federal programs and policies that promote community designs and build environment investments that make healthy choices easier, such as walking and bicycling.
- Congress must sustainably fund school-based health centers, which provide holistic services to students and their families.

5. Prioritize Determinants of Health Infrastructure and Investment

- Income, education and the strength of social networks all effect a person's ability to access health care and achieve their highest levels of health and well-being, which impacts their longevity. Food security and stable, safe, affordable housing also are among the most vital determinants of health, but too many people lack these essentials. To close the gaps, Congress and the President can ensure opportunities for livable wages and expand training opportunities for Americans who are struggling.
- It is vital for Congress to help expand access to high-quality early childhood education programs, which are especially needed for children from lower socioeconomic conditions.
- Increasing the minimum wage and expanding the Earned Income Tax Credit for low-income families also could ease broad societal inequities that have a negative impact on health and well-being. The new Congress should push for those changes.
- The challenges facing our society today are only solvable through collaboration and an eco-system of alignment across agencies and sectors. The President and Congress can incentivize and influence effective multi-sector collaboration by reducing bureaucratic barriers to data sharing and requiring effective collaboration for access to federal funding.

Our nation's health care is unaffordable, difficult to access, and doesn't meet Americans' needs. That can – and must – change. The President and Congress can make that happen.

The Adventist Health Policy Association proposes a Five-point health policy plan with 40 detailed strategies that focus on lifestyle choices, disease prevention and health promotion.

1. Create a National Well-Being Policy
2. Connect Health Care to Well-Being
3. Strengthen the Backbone of Public Health
4. Invest in and Prioritize Well-Being Improvement
5. Prioritize Determinants of Health Infrastructure and Investment

ACTION STEP ONE
CREATE A NATIONAL WELL-BEING POLICY

STRATEGY

1 Provide stable sufficient funding for disease prevention and well-being promotion.

2 Coordinate "health in all policies" within non-health federal agencies to promote well-being.

3 Establish the White House Office of Well-Being and Prevention.

4 Commission a new White House Conference on well-being promotion and disease prevention.

ACTION STEP TWO
CONNECT HEALTH CARE TO WELL-BEING

STRATEGY

5. Clearly define the emerging role of hospitals in well-being promotion and population health.

6 Encourage multi-sector collaboration with traditional and nontraditional partners to improve well-being.

7 Modernize provider reimbursement by moving away from volume and intensity and toward quality, value of services and well-being improvement.

8 Expand health care coverage and reduce cost-sharing for patients who seek primary care and preventative services.

9 Support the training of more primary care physicians, and expand curriculum and course work to deepen education and training associated with well-being improvement and prevention.

10 Establish policies that incentivize hospitals that invest in and deliver measurable and sustainable community well-being improvement.

ACTION STEP THREE
STRENGTHEN THE BACKBONE OF PUBLIC HEALTH

STRATEGY

11 Repurpose the role of public health to allow health systems to more effectively connect their Community Health Improvement Strategies and demonstrate measurable and sustainable well-being improvement in their local communities.

12 Support alternative funding structures and financial investments for prevention and well-being improvement.

13 Integrate clinical and community health data to drive action for better disease prevention and well-being improvement.

14 Incentivize multi-sector partnerships to improve overall health and well-being.

15 Increase federal funding to expand and improve public health training programs.

16 Create a national task force to implement an action plan to increase and improve the quality of the public health workforce.

17 Create a system for accurate and standardized collection of data on the public health workforce with projection analysis to estimate future need.

18 Increase federal funding for preventative medicine residency (PMR) programs.

19 Implement an action plan to improve recruitment and retention of allied health providers in rural America.

20 Define clear roles for allied health providers.

21 Standardize the education training and licensing requirements for allied health providers.

ACTION STEP FOUR
INVEST IN AND PRIORITIZE WELL-BEING IMPROVEMENT

STRATEGY

22 Remove clinical, technological and administrative barriers to mental health.

23 Create alternatives to institutionalization for mental health issues.

24 Support policies that promote early intervention of mental health conditions, especially in children.

25 Develop infrastructure that is interoperable, accessible across clinical settings, and enhances the adoption of the oral health care clinical competencies.

26 Expand oral health coverage by public and private payors.

27 Improve access to oral health care for vulnerable and underserved populations.

28 Design communities to encourage walking, biking and other methods of active transportation.

29 Support multidisciplinary initiatives that include health design principles.

30 Make effective incentives part of an overall employee health strategy, not the whole strategy.

31 Offer well-designed, measurable initiatives that measurably and sustainably improve employee well-being.

32 Establish school-based healthy eating and physical activity policies and practices for students.

33 Improve funding to support school-based health centers to promote well-being and prevent disease.

34 Empower faith communities to own and promote healthy lifestyles that lead to measurable and sustainable well-being improvement.

ACTION STEP FIVE
PRIORITIZE DETERMINANTS OF HEALTH INFRASTRUCTURE AND INVESTMENTS

STRATEGY

35 Develop new strategies to reduce inequalities of school resources.

36 Address food insecurity and lack of affordable housing as health issues.

37 Identify health literacy issues in under-resourced communities and implement a targeted response.

38 Create safe communities, free of crime and violence.

39 Establish equity-promoting policies that reduce social disparities, improve well-being, and result in better health for all.

40 Create opportunities for social and civic engagement.

FOREWORD

Preparation of this book on the future of America's health was nearing completion at the very height of a historic pandemic. A novel virus and the disease it causes – COVID-19 – have provided a defining moment for the way our society thinks about health and illness. Every one of the nation's states officially declared a public health emergency. The onerous measures needed to curb the spread of the virus provided vivid reminders of how precious health is, and how much we are willing to sacrifice in order to protect human life and well-being.

In such a difficult time, faith-inspired health systems have a distinctive responsibility to renew their commitment to the mission of preventing illness, restoring health, and collaborating in the development of healthy communities.

The Seventh-day Adventist dedication to fostering human health was born more than 150 years ago. Adventists began to teach the value of a healthy lifestyle and a preference for natural remedies including fresh air, regular exercise and pure water. Within a few years, Adventists expanded their health ministry by establishing innovative health care institutions, where people not only received treatment for diseases but were also taught how to prevent them. Since these early beginnings, Adventists have continued to build hundreds of hospitals, nursing homes, clinics, and health-sciences schools around the world.

The Adventist work for human health and well-being is founded on the belief that every person is a beloved child of the Creator and deserving of compassionate, whole-person care. Adventists believe that caring for physical well-being is spiritually significant. One of the practical implications of such faith is a willingness to take responsibility for one's own health and that of one's community. The hope is that all may experience the abundance of life intended by the Creator.

In recent years, the Adventist Health systems in the United States have recognized more fully the opportunity to influence health policy in order to preserve the vitality of charitable, mission-focused health systems and to deploy effective resources to measurably and sustainably improve community health and well-being. In 2010, the Adventist Health Policy Association (AHPA) was created as a united voice for health policy priorities. During the decade since its birth, AHPA has become a trusted advocate for health and well-being policies that make good sense for the nation.

People who are motivated by Christian faith understand that they must address the socially complex circumstances that frequently result in poor individual and community health and well-being. We are committed to responding to the often-inconvenient pleas for mercy and fairness. We know that such work can never be reduced to mere business exchanges. Many of the persons who most need care may have little to offer in exchange.

The experience of the COVID-19 pandemic revealed the health disparities that persist in our nation. Adventists believe that all persons in need of health care, regardless of their social or economic status, are deserving of care. This dedication to prioritize and invest in well-being provides the moral energy necessary to pursue the goals set forth in this plan.

We welcome the President and Congress of the United States to join with us and like-minded policy makers in building a future that is healthier and more equitable for all.

Dr. Gerald Winslow,
Founding Director

Adventist Health Policy Association

Promoting Wholeness to Live God's Healing Love

The Adventist Health Policy Association (AHPA) is an affiliation of Seventh-day Adventist-sponsored health care systems across the United States. Since the mid-1800s, Adventist hospitals have provided quality, faith-based health care dedicated to helping people achieve mind, body and spiritual wholeness.

The five health systems that comprise the Adventist Health Policy Association operate 95 hospitals and more than 600 affiliated entities – home health agencies, nursing centers, outpatient centers, physician practices and related health care services – in 16 states and the District of Columbia. Our 149,000-plus team members serve hundreds of thousands of hospital patients each year, and millions more in our outpatient centers.

AHPA's goal is to help ensure sound public policies and regulations that encourage and allow member hospitals to provide high quality, accessible health care to the communities we serve.

The AHPA board is comprised of the CEOs from the five systems:

AdventHealth

CEO: Terry Shaw

- 52 hospitals: 9,000+ beds and 80,000+ employees
- Serving: CO, FL, GA, IL, KS, KY, MO, NC, TX, and WI
- Includes AdventHealth Orlando, the nation's largest Medicare provider
- AdventHealth University (FL)

Adventist Health

CEO: Scott Reiner

- 23 hospitals: 3,200 beds and 30,000 employees
- Serving: CA, HI, OR, and WA

Adventist HealthCare

CEO: Terry Forde (board chair)

- 5 hospitals: 1,321 beds and 8,268 employees
- Serving: DC & MD

Kettering Health

CEO: Fred Manchur

- 9 hospitals: 1,464 beds and 14,697 employees
- Serving: Ohio
- Kettering College

Loma Linda University Health

CEO: Dr. Richard Hart

- 6 hospitals: 1,003 beds and 16,500 employees
- Serving: California
- Loma Linda University

ACTION STEP ONE

Create a National Well-Being Policy

Chronic diseases – such as heart disease, cancer, stroke, chronic obstructive pulmonary disease (COPD), type 2 diabetes, depression and arthritis – are long-term health conditions that may not have a cure. According to the Centers for Disease Control and Prevention (CDC), chronic diseases last one year or more, require ongoing medical attention and/or limit a person's daily activities.[7]

Chronic diseases place considerable physical, emotional and financial burden on the American people. Chronic diseases tax our health care system as well as our economy. Paying for health care dominates political debates and is a top policy issue for voters and candidates alike. However, health care discussions often center on the high costs of treating diseases, neglecting the potential economic benefits of preventing them – to keep Americans, and the communities we live in, healthy in the first place.

As they chart the course for the years, we urge that the President and Congress bring well-being improvement and chronic disease prevention into national focus and make individual and community well-being an esteemed social value in America.

Strategy 1

Provide stable and sufficient funding for disease prevention and well-being promotion

Benjamin Franklin famously noted, "An ounce of prevention is worth a pound of cure." Although no one disputes such wisdom, the Partnership for Prevention outlines why disease prevention and well-being promotion have not been prioritized in the United States[8]:

- The natural tendency to focus on the current crisis rather than future opportunities and issues
- A lack of enabling and supporting public health infrastructure
- Fragmented efforts when multiple individuals and groups work separately or on parts of an issue
- Unrealistic expectations of new technology's ability to replace current resources

The first reason is particularly challenging for disease prevention. The costs of prevention are incurred immediately while most of the benefits of reduced disease burden and medical care are realized in the future, sometimes over several years or decades.

The high cost of medical care and a workforce with low levels of well-being hurts the U.S. economy and its ability to compete in the global market.

- Missed days of work connected to high blood pressure, diabetes, smoking, physical inactivity, and obesity cost employers $36.4 billion a year.[5]
- Health care is the most expensive benefit for businesses and employers spent an average of over $14,000 per employee in 2018.[6]
- Health care spending threatens the solvency of Medicare and Medicaid, and is outpacing education as the largest state budget item.[20]

In our traditional system that emphasizes "sick" care rather than "health" care, we spend about $6,032 per person per year for chronic disease treatment,[9] while the entire CDC budget for all chronic disease prevention activities for fiscal year (FY) 2018 was decreased by $222 million from FY 2017, making it just below $3 per person per year.[10] Investing $10 per person in proven, community-based public health efforts could result in savings of more than $16 billion in just five years, a $5.60 return for every $1 invested.[11]

Our lack of federal investment in prevention and public health (vs. acute care spending) demonstrates a minimal commitment to assuring the health of individuals. Without a stable and reliable funding source to alleviate inadequate funding of prevention programs, our efforts to improve health outcomes and reduce health care spending will not be sustainable. Continuing investment in prevention and well-being must be protected for the physical, mental, emotional and fiscal health of our nation.

Chronic Diseases are Deadly

Chronic diseases are leading causes of premature death and long-term disability in the United States. They are responsible for seven out of 10 deaths, killing more than 1.7 million Americans each year.[12]

Chronic Diseases are Common

The pervasiveness of chronic disease makes it a national crisis. Six in 10 American adults have at least one chronic illness and four in 10 have two or more.[13] The likelihood of having multiple chronic diseases goes up as we age, with almost 70 percent of older Americans having two or more chronic conditions at the same time.[14] Given the "gray tsunami" of 10,000 Baby Boomers turning 65 each day until 2030,[15] the number of individuals suffering from chronic diseases is expected to rise for the next 10 years.

Chronic Diseases are Costly

Chronic conditions drive 90 percent of the nation's $3.5 trillion in annual health care costs.[16] In 2016, the total costs of direct health care treatment for chronic health conditions totaled $1.1 trillion.[17] This is nearly six percent of the nation's Gross Domestic Product (GDP). For every Medicare dollar, 96 cents go to treating chronic disease; for Medicaid, the cost is 83 cents per dollar.[18]

Chronic Diseases are Preventable

Approximately 70 percent of chronic illnesses are costly to treat but largely preventable.[19] Addressing four risky behaviors (tobacco use, physical inactivity, poor nutrition, and excessive alcohol use) could prevent almost 40 percent of all deaths including those from chronic disease.[17]

Strategy 2

Coordinate "health in all policies" within non-health federal agencies to promote well-being

To achieve a healthier America, political and fiscal contexts should be conducive to interagency collaboration and partnerships.

Through an Executive Order, the President could establish a National Well-Being Council to organize nationwide well-being and prevention efforts. Chaired by the U.S. Surgeon General, the Council can continue to provide coordination and leadership to 20 federal entities historically participating in the National Prevention Council and listed below:

- Surgeon General (Council Chair)
- Department of Health and Human Services
- Department of Agriculture
- Department of Education
- Federal Trade Commission
- Department of Transportation
- Department of Labor
- Department of Homeland Security
- Environmental Protection Agency
- Office of National Drug Control Policy
- Domestic Policy Council
- Bureau of Indian Affairs
- Department of Justice
- Corporation for National and Community Services
- Department of Defense
- Department of Veteran Affairs
- Department of Housing and Urban Development
- Office of Management and Budget
- Department of the Interior
- General Services Administration
- Office of Personnel Management

The efforts of this multi-sectoral Council underscore the paradigm of "health in all policies." In this model, nontraditional partnerships are forged to create policies and practices that promote well-being. Working together also may contribute to a cultural shift in non-health agencies to consider health when making policy decisions,[21] and models the importance of effective multi-sector collaboration at the community level.

We also urge the President and Congress to embed health and well-being considerations into the policy-making processes across a wide array of sectors beyond the direct control of medicine, as well as hold policymakers responsible for the health and well-being of our communities. Much like economic impacts are considered in non-finance decision-making, health and well-being impacts must be analyzed when shaping policies in education, transportation, or housing.

Strategy 3

Establish the White House Office of Well-Being & Prevention

Through an Executive Order, the President could establish a White House Office of Well-Being and Prevention. Such an office would provide leadership to the Executive Branch in setting priorities, policies and objectives for a comprehensive effort to improve the health and well-being of this nation. The functions of the White House Office of Well-Being and Prevention could include:

- Identifying federal barriers to prioritizing well-being as a key domestic policy
- Coordinating the development and implementation of the Administration and Congress' well-being policy agenda across executive departments and agencies
- Overseeing improvements in coordinating well-being related data and information technology
- Promoting policies that foster environments conducive to adopting and maintaining healthy behaviors and obtaining preventative services
- Developing and disseminating measurable, sustainable, and scalable well-being frameworks informed by best practice and sound scientific evidence

Similarly, the existing White House Faith and Opportunity Initiative is leading efforts to support faith-based community organizations to better serve individuals, families and communities in need. Since faith groups are well situated to meet the needs of local people, the new Office of Well-Being and Prevention and the Faith and Opportunity initiative can play key roles in supporting the collaboration of both health and social services.

Strategy 4

Commission a new White House Conference on well-being promotion and disease prevention

First held in 1909, White House conferences discuss topics important to the American public and conclude by issuing summary reports to the President and making recommendations for executive or legislative action on the issue. Past conference topics include:

- White House Conference on Children and Youth; seven conferences held from 1909 to 1971
- White House Conference on Education in 1956
- White House Conference on Civil Rights in 1966
- White House Conference on Food and Nutrition in 1969
- White House Conference for a Drug Free America in 1987
- White House Conference on Bullying Prevention in 2011
- White House Conference on Aging, held since 1950 with last one held in 2015

A White House conference on Well-Being would create an overarching national policy; survey the current challenges in measurably and sustainably improving well-being; and outline potential policy solutions, including actions for the public health system, hospitals, health care professionals, all levels of government, business, communities, citizens and other stakeholders.

ACTION STEP TWO

Connect Health Care to Well-Being

The American health care system faces unprecedented pressures from multiple, intersecting forces. These environmental factors include[22]:

- Health reform efforts and associated uncertainties
- Legal and regulatory changes
- Market condition changes
- Projected health care workforce shortages
- Population and demographic changes
- Variations in health care access, cost and quality by location
- Shifts in values and accountability
- Organizational and system performance challenges
- Rising health care expenditures or costs
- Negative individual and community well-being impacts resulting from determinants of health challenges outside of the acute clinical settings

To adapt to these external challenges, hospitals must move beyond their traditional role of acute care by expanding their focus to help improve the health and well-being of the communities they serve.

PROJECT RESTORATION

Lake County is one of the poorest counties in California, with health rankings in the lowest decile of the state. Devastation from recent wildfires, lack of affordable housing, modest employment opportunities, and widespread substance addiction stretch this rural community's limited resources.

Adventist Health Clear Lake is a 25-bed, critical access hospital serving Lake County and surrounding areas. The hospital has more than 20,000 emergency room visits and 1,500 inpatient admissions every year. Adventist Health's integrated clinic, Live Well, provides health coaching, nutrition counseling, diabetes education, chiropractic treatment, sleep assessment, quality of life improvements, counseling and psychiatry, care management, addiction treatment, orthotic evaluation, and pain management support groups to complex populations. However, the region's social challenges that routinely manifest in the clinical setting impede Live Well clinic's ability to create long-term stability for some patients.

Adventist Health's Community Integration team sought creative solutions to address community issues that impact health. The team hypothesized that treatment, coupled with a more comprehensive, cross-sector approach to treating complex patients - could yield strategies that better serve patients and communities.

Developing Project Restoration

In 2017, the Adventist Health team began meeting with community leaders to understand issues of mutual concern. They hoped this deep listening exercise would generate the buy-in critical to the program's success, as well as narrow the scope of the project to a single topic they could collectively address with concrete, measurable outcomes. This differed from the conventional community coalition's approach of focusing on broad impact initiatives such as promoting safer neighborhoods.

The mayor of Clearlake and some key community members identified homelessness as a core challenge upon which many other problems arose. Local community groups hesitated to tackle homelessness exclusively. However, building on interest expressed by the fire chief and Emergency Medical Services director, the Adventist Health team and community stakeholders proposed "Project Restoration." This project would serve the highest utilizers of local community services, hoping that homeless populations would be tangentially, if not directly, impacted by those interventions.

Establishing Project Restoration

Project Restoration is a multi-stakeholder, cross-sector model of intervention that involves various community partners in addressing an individual's whole needs, instead of each agency focusing on one particular issue. All participating agencies and community groups in Project Restoration are rural service providers in Lake County, including Clearlake city government, local law enforcement, fire district/EMS leaders, county behavioral health plus public and private community agencies. Patients served by Project Restoration regularly receive care at Adventist Health Clear Lake and are high utilizers of police or Emergency Medical Systems

(EMS). In fact, entry into the program is determined based on high utilization of two or more community systems, including hospital, police, and EMS.

The Project Restoration Collaborative began its work by analyzing data from a range of service providers to understand the population. From that data, they identified shared metrics across sectors to measure success, created an intervention model with community agencies, and developed a centralized infrastructure to translate lessons learned from individual patients into process improvements for the community.

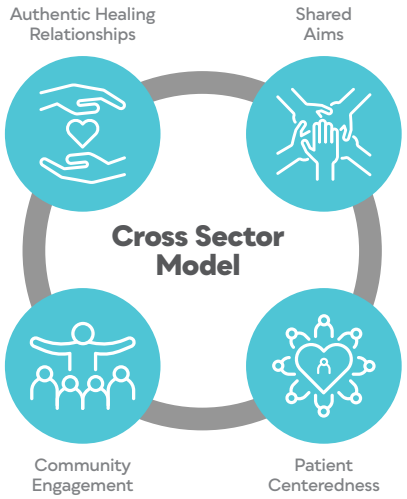


Figure 3. Project Restoration Cross-Sector Intervention Model

To inspire community investment in Project Restoration, with a sense of urgency, the Collaborative integrated Adventist Health's senior leadership in the earliest stages of the project, interviewed community members to identify areas of concern, brought together the broader community to explore best practices in serving vulnerable populations.

Goals for the collaboration include:

- **Authentic Healing Relationships**
  - » Demonstrate unconditional positive regard for patients and community members/agencies
  - » Focus on what matters most to patients
- **Shared Aims**
  - » Execute Memorandum of Understanding (MOU)/Business Associate Agreements (BAA)
  - » Co-create charter, metrics, and structure
- **Patient-Centeredness**
  - » Identify high utilizers across agencies
  - » Analyze root causes
- **Community Engagement**
  - » Lead collaborative conferences for patients and providers
  - » Translate patient stories into process improvements

Improving Well-Being

Project Restoration focuses on high utilizer identification; readmission prevention; streamlined access to services for vulnerable populations; homelessness alternatives; intensive case management; mental health options; and substance abuse support.

Restoration House, a seven-bed transitional housing and respite facility, opened in September 2017. Restoration House provides an additional link to housing and healing for Lake County's most vulnerable individuals. Patients ready for hospital discharge without proper housing or without home care can continue their medical healing at Restoration House. Restoration House clients are enrolled in the Project Restoration Collaboration.

Outcomes of [18] Project Restoration customers were analyzed, and the collaborative approach is associated with a 44 percent reduction in hospital utilization, an 83 percent reduction in community response system usage, and a 71 percent reduction in costs for the population.[23]

NONPROFIT HOSPITALS AS ANCHOR INSTITUTIONS

Anchor institutions are large, nonprofit organizations rooted deeply in their local communities through mission and invested capital. They are often the largest employers in struggling neighborhoods and surpass manufacturing corporations as leading regional employers.[24] Increasingly, these anchor institutions are expanding their public or nonprofit mission to incorporate an "anchor mission": Strategically leveraging their economic power and human capital to improve the long-term welfare of their local communities.[25] Anchor institutions tend to be universities and nonprofit hospitals, but may also include faith-based institutions, museums, and community foundations.

As anchor institutions, nonprofit hospitals share accountability for improved community health. Hospitals need not always take the leading role or be the only funders, but can link stakeholder groups, engage communities and provide strategic support to a web of partners aligned toward measurable and sustainable well-being improvement.

Strategy 5

Clearly define the emerging role of hospitals in well-being promotion and population health

More than two decades ago, health providers and policy researchers discussed the reinvention of the American hospital to a new or emerging model that focused on "disease prevention, health promotion and primary care."[27] That is, a hospital that not only treats the sick but both creates and sustains health.

What is population health?

Population health was initially defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group."[26] These groups can be groups within a geographic location, ethnic groups, age groups, or any other defined group. The definition was later expanded to include two other important components[3]:

1. Why some populations are healthier than others, as well as the policy development, research agenda, and resource allocation that flow from it"

2. The health of a population as measured by health status indicators and as influenced by social, economic, and physical environments; personal health practices; individual capacity and coping skills; human biology; early childhood development; and health services."

This broader definition provides a wide rationale for the term's use, expanding the concept from public health only and helping foster more agreement on the term.

The Robert Wood Johnson Foundation (RWJF) and the Health Research & Educational Trust (HRET) of the American Hospital Association conducted a study on ways that hospitals and health systems might operate in this new role. RWJF believes that hospitals are uniquely positioned to help create a "culture of health." The vision for building a culture of health is eloquently presented by RWJF[28,29]:

- Good health flourishes across geographic, demographic and social sectors
- Being healthy and staying healthy is valued by the entire society
- Individuals and families have the means and opportunity to make choices that lead to healthy lifestyles and optimal well-being and functioning
- Businesses, government, organizations and individuals work together to foster healthy communities and lifestyles
- Everyone has access to affordable, quality health care
- No one is excluded
- Health care is efficient and equitable
- The economy is less burdened by excessive and unwarranted health care spending
- The health of the population guides public and private decision-making
- Americans understand that we are all in this together

The RWJF and HRET study30 provides a range of strategic considerations for the hospital/health system, community, and stakeholders/partners. Based on the degree of collaboration and intervention that aligns with the organization's capacity and the community's needs, hospitals can select from one of four key roles - Anchor, Convener, Promoter, and Specialist. A number of similar roadmaps and briefings address hospitals' potential roles in population health, including provider perspectives.[31,32,33]

Anchor Hospitals have strong, active partnerships with a wide range of diverse community organizations to address a comprehensive scope of interventions that encompass both socioeconomic and medical concerns in the community. Anchor hospitals serve as a leader, and their activities can include those of the specialist, promoter and convener. Population health improvement is a fully integrated part of their mission, with leadership engagement and significant resources allocated to support a broad range of issues that affect health.

Convener Hospitals target specific issues to address significant community health needs. Conveners may provide funding, facilities, staff expertise or in-kind services to support broader community health programs, but they also empower community stakeholders to take the lead.

Promoter Hospitals support other organization's initiatives through funding or contributing resources such as employees and facility space. Promoter hospitals have a broad intervention scope but limited community partnerships. They may use their influence in the community and with the government to help shape policy or provide community education.

Specialist Hospitals concentrate on a few specific issues for which the hospital is a subject matter or programmatic expert. Specialist hospitals may have limited support and resources for broader initiatives or choose to address issues where it can have the greatest impact given its expertise and resources.

Strategy 6

Encourage multi-sector collaboration with traditional and nontraditional partners to improve well-being

Our nation's health challenges cannot be solved by one entity. It is not the role of the health care system to be the sole expert on nonmedical factors that have significant impacts on health such as employment, education and housing.

Since it would be quite daunting for hospitals to shoulder these issues alone, harnessing the power of community champions - such as schools and faith-based organizations — to promote health and well-being will be crucial. The Administration and Congress must encourage and incentivize multi-sector collaboration and partnership in developing mutually reinforcing interventions that measurably and sustainably improve individual and community well-being.

Public Health Departments

The Internal Revenue Service (IRS) mandates nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years to retain their tax-exempt status. County health departments must conduct their community health assessments and develop a regional health improvement plan to retain their accreditation.

Because the work and interest of health systems and public health departments overlap, collaboration between these two natural partners is essential. Collaborative and collective processes can help maximize programming specific to each partner's area of proficiency and minimize service duplication.

Community Based Organizations (CBOs)

If health systems and public health are to create sustainable and engaging initiatives, they must also find ways to work with CBOs like United Way, food banks and others. By addressing issues in partnership with CBOs, health systems can empower entities that already have built trust and connections within communities.

Community Members

Community voices must be integrated in designing and implementing any community-based health improvement effort. Support from residents and other stakeholders ensure that these efforts receive broader community support. Such input also will provide communities with a sense of ownership and oversight over projects. By empowering community members to get involved in programming, programs are more likely to be sustained and to function in a manner that reflects the cultural norms of that community.

Faith Communities

Many U.S. health systems have origins in, and strong ties to, communities of faith. Faith communities remain trusted community partners, and have effectively reached people through the strong infrastructure of congregations and community leaders. Faith communities can promote messages about healthy living, well-being, preventative care and chronic conditions that diminish the quality of people's lives.

School Districts

In addition to faith communities, health systems need to align their success metrics with local schools. Health and education are strongly linked, yet both systems struggle to define effective collaborations and partnerships. Incorporating health and well-being into the school culture is a crucial step in reversing the decreased life expectancy of the current generation.

COMMUNITY CARE PROGRAM

Originally designed to target high risk, high utilizers of the AdventHealth hospitals in Central Florida, the Community Care Program, was launched as a pilot program in 2014. The program started with the top five percent of the population that utilizes about 50 percent of the overall health care dollars. Within that five percent, Community Care started with a focus on the uninsured or underinsured population as a starting point, with the intention to build to other populations as the need was identified.

Community Care Program supports AdventHealth's vision of delivering whole person care to every patient, every time. The program uses a medically driven, patient-centered, home-based, community model, delivered by an interdisciplinary team comprised of:

- Registered nurses
- Licensed clinical social workers or mental health counselors
- Medical director
- Divisional director
- Health coach students
- Social work students at both the bachelor's and master's level

This collaborative care team assesses and addresses the medical (access to care, health insurance status, medication reconciliation), psychosocial (transportation barriers, inadequate housing, food insecurity, financial issues, mental health treatment) and spiritual needs of the patient to better manage their chronic health conditions. The goal of the Community Care Program is to help patients become self-sufficient in managing their chronic illnesses.

The care team partners with local stakeholders including a local homeless shelter, food banks, mental health treatment centers, free clinics, federally qualified health centers as well as many pharmacies and volunteers. As an example, the Community Care Program works with the Second Harvest Food Bank to provide and deliver healthy food boxes to program participants.

A year after patients have been enrolled in the Community Care program, there is an average of a 30 percent reduction in emergency room visits, 30 percent reduction in observation stays, and a 45 percent reduction in inpatient stays.

Other Large Organizations

While hospitals or public health departments will most likely be the largest health institution in a community, banks and other large businesses also can lead community-based health initiatives.

The Community Reinvestment Act (CRA) of 1977 requires federal regulators to assess how well each bank fulfills its obligations to its communities. Under CRA, financial institutions are taking steps to promote housing and economic opportunity for underserved groups by providing affordable mortgage programs, small business loans, community development financing, funding for nonprofit housing, economic development programs and the like. Such laws encourage businesses to develop and implement community-centered plans for the people they serve.

The Right Incentive Structures

The financing and delivery structure of health care in the United States still provides minimal incentive for insurers or providers to invest in lifestyle changes that prevent disease and promote health. In our fragmented system, an individual's health insurance coverage changes routinely, depending on age, work status, marital status, or income. Insurers have little incentive to invest significantly in health promoting services today that will benefit other insurers tomorrow.

Strategy 7

Modernize provider reimbursement by moving away from volume and intensity and toward quality, value of services and well-being improvement

Our current national health investment focuses heavily on medical interventions rather than on strategies that address disease prevention or social and environmental conditions that affect the health and well-being of a population. The traditional "fee-for-service" reimbursement system pays physicians and hospitals for each procedure performed on a sick patient, financially rewarding quantity over quality of the care provided.

In a 2018 stakeholder interview conducted with industry experts, researchers found that underutilization of preventive services is not the result of an information gap but rather that of an implementation gap. That is, most providers in the health care system understand the benefit of preventing chronic diseases, but do not prioritize them because financial incentives do not align with a focus on preventing chronic diseases. According to the researchers, "currently, most providers, including hospitals and physicians, are paid to treat rather than to prevent disease."[34] As risk-bearing entities that provide payment models and incentives, health care payers (commercial health plans, Medicaid, and particularly Medicare) have the influence that can affect the uptake of chronic disease preventive services.

It is essential that we change provider reimbursement from one focused on volume toward one focused on accountability for overall cost and quality. Many valuable services - such as patient education, effective preventive care and coordinated post-hospital care - are generally underprovided because doctors and hospitals do not have adequate financial or other support to provide them. A reformed system should support providers who provide primary care and reward value, quality and organized delivery of care.

Strategy 8

Expand health care coverage and reduce cost-sharing for patients who seek primary care and preventative services

Individuals with a regular source of primary care receive more preventive services, also are likely to comply with their prescribed treatments, and have lower rates of illness and premature death.[35] People who lack health insurance are less likely to have a regular source of primary care and less likely to receive not only preventive care, but also treatment for major health conditions and chronic diseases.[36] "Underinsured" people with significant out-of-pocket costs also are likely to forgo both necessary and elective care. They often use hospital emergency departments for conditions that could and should have been treated in a primary care setting, driving up costs for businesses and other patients.

We urge consideration of health benefit designs that encourage patients to access and use cost-effective primary care, especially health services shown to delay or prevent the onset of chronic conditions.

Strategy 9

Support the training of more primary care physicians, and expand curriculum and course work to deepen education and training associated with well-being improvement and prevention

Access to optimal disease prevention and well-being improvement interventions hinge on the availability of an adequate workforce to meet those demands… We need to incentivize medical schools to train more primary care physicians, and expand curriculum and course work to deepen education and training associated with well-being improvement and prevention. It is also important to reevaluate physician compensation to encourage medical students to pursue a primary care specialty such as family medicine, internal medicine, pediatric medicine, geriatric medicine, general surgery, and obstetrics and gynecology.

Strategy 10

Establish policies that incentivize hospitals that invest in and deliver measurable and sustainable community well-being improvement

As previously noted, the IRS-mandated Community Health Needs Assessment (CHNA) allows nonprofit hospitals to play a greater role in building a "culture of health." By providing critical information not typically captured in corporate planning sessions, CHNAs enable these hospitals to address the health and social needs of the communities they serve, including the vulnerable and underserved populations.

CHNAs shift the focus of hospital community health programming from isolated events such as health fairs to more structurally oriented programs. While health fairs may present the opportunity to show individuals that their Body Mass Index (BMI) is at risk or that their blood pressure is abnormally high, they typically fail to provide opportunities for individuals to act on that information. Additionally, health fairs typically lack the ability to provide continuity of care once a patient is aware of a health risk factor.

Initiatives that look at health determinants (as described in Action Step 5) have greater capacity to affect communities on a structural level. Challenging traditional methods of community health engagement by making factors like transportation or leisure-time physical activity more accessible can generate both immediate and generational effects on health status and risk.

Evidence-based Tools for Behavior and Lifestyle

Interventions in the Communities

Hospitals and health systems rely on evidence-based tools to be effective in their population health management strategies. Below are tools that help health systems invest in community-based strategies that prompt behavior change, lifestyle modification, and health engagement:

1. **Community Health Needs Assessment (CHNA).** Nonprofit, tax-exempt hospitals are required to assess the health needs of the community to provide benefits that meet the needs of the communities they serve. CHNA provides hospitals with the unique opportunity to work beside community members and other stakeholders to identify and prioritize challenges specific to the community. Once issues are prioritized, hospitals are responsible for investing in interventions that address those issues.

2. **The Community Preventative Services Task Force Guide (Community Guide)** was created to aggregate and evaluate the efficacy of population health interventions. The Task Force is appointed by the Centers for Disease Control and Prevention (CDC) and composed of 15 experts from various public and private national institutions. This Task Force reviews programs proven to save lives, improve quality of life, improve life spans, and designates them as "recommended," "recommended against," or "lacking significant evidence to make a determination." By stratifying effective programming, the Community Guide ensures that health systems invest in effective, evidence-based interventions with a proven record.

3. **The Community Health Improvement Navigator** functions as a database that categorizes interventions according to their ability to influence socioeconomic factors, the physical environment, health behaviors, and clinical care. This tool enables health systems to select interventions according to their desired outcome.

Hospital community benefit activities must function collaboratively with regional public health entities if evidence-based practices are to be implemented effectively. In order for the CHNAs to be effective vehicles for contextualizing community challenges, they must do more than view underserved communities through a collective lens. They must describe how specific communities are disproportionately affected by the current health state of a region. Health systems must take a deeper look at specific health disparities through a lens that highlights gender, sex, ethnicity, geography, income, race and other related factors.

ACTION STEP THREE

Strengthen the Backbone of Public Health

The term "health system" encompasses the full continuum between medical care (delivered to individual patients) and public health (population-based services).[37] Health is not confined to either end of the spectrum. To ensure optimal health for all Americans, high-quality medical care must be provided within a strong public health system.

America's response to the recent COVID-19 pandemic demonstrates to the President and Congress their vital role in strengthening our nation's crucial public health infrastructure. In this chapter, we present strategies to bolster existing public health infrastructures to ensure the health and well-being of all Americans.

Strategy 11

Repurpose the role of public health to allow health systems to more effectively connect their Community Health Improvement Strategies and demonstrate measurable and sustainable well-being improvement in their local communities

Just as we are asking health care providers to practice to the full extent of their education and training, we need to ask the same of our public health professionals. The role of local public health directors and health officers should be redefined as Community Health Strategists whose duties include:

- Promoting collaboration among all sectors, especially with hospitals
- Improving communities' understanding of future possibilities including risks, challenges and opportunities
- Articulating evidence-based strategies with the greatest potential for public health advancement

What is Public Health?

Public health agencies, health systems, health plans, health professionals, governmental agencies, employers and community groups are stakeholders in overall health improvement. Of these stakeholders, public health is the only entity specifically mandated to do the following:

- Prevent injuries, epidemics and the spread of disease
- Prepare and respond to disasters and emergencies
- Protect against environmental hazards
- Promote healthy behaviors
- Assure the quality and accessibility of health services
- Affect social, economic and environmental factors fundamental to excellent health
- Train its workforce to gain insight about health improvement, health determinants and prevention

Public health saves money, improves our quality of life, helps children thrive and reduces human suffering.[41]

Public health benefits everyone. The public health system promotes healthy lifestyles, researches disease prevention, and responds to infectious disease outbreaks. While critical to ensuring the health of all Americans, this system is also chronically underfunded. In 2017, public health represented 2.5 percent, or $274 per person, of all health spending in the U.S.[9]

Public health programs are primarily funded by taxpayer dollars and enjoy broad public support. According to a September 2018 poll of U.S. voters, 89 percent of respondents believed that public health plays an important role in the health of their communities and 57 percent were willing to pay higher taxes to ensure that everyone has access to basic public health protections.[40]

The Centers for Disease Control and Prevention (CDC) supports voluntary accreditation of state, tribal, local, and territorial health departments by the Public Health Accreditation Board.[38] Such accreditation can facilitate and incentivize alignment of community assessments with health systems (and vice-versa), aiding in the transformation of public health practice.[39]

Strategy 12

Support alternative funding structures and financial investments for prevention and well-being improvement

Four promising funding approaches can support alternative funding structures for prevention and well-being improvement. These include Wellness Trusts; Social Impact and Health Impact bonds; the IRS inclusion of community building as allowable community benefit on Form 990; and supporting the development of Accountable Care Communities within Accountable Care Organizations.[42]

Successful investment opportunities include:

- Targeted outcomes that are measurable and sustainable
- Interventions that are informed by best practices
- Measured outcomes that are independently validated
- Defined savings or return on value that are established
- Public agencies, nonprofits, investors, and community stakeholders who are incentivized to work together

Strategy 13

Integrate clinical and community health data to drive action for better disease prevention and well-being improvement

Traditionally, clinical data is thought to be of specific, necessary, and immediate value to patients, while population health and well-being data is viewed as general, nice to know, and long range. These competing or contrasting perspectives can no longer suffice in delivering the type of timely information required to run a large health system across a socially and culturally diverse, widely distributed "community." Similarly, public health can leverage health system data to improve public health surveillance as well as outcomes for various health conditions.

In order to measurably and sustainably transform the health and well-being of individuals and communities, new data models must:

- Support a new analytical framework to incorporate both clinical and community data
- Incentivize health systems to incorporate findings and priorities from their community health needs assessments (CHNA) into hospital strategy, as well as, aligning the community health process outcomes to outcome measures
- Incorporate geographically enabled clinical data and societal factors that impact health into the electronic medical record (EMR) for improved coordination and integration of care
- Create a new data voice that speaks of impact, results, and return on investment, not just process. Improving the processes that create, deliver and interpret data within the context of accountable care will require thoughtful and proactive modernization of the information systems and workflows that underpin the organization.

Strategy 14

Incentivize multi-sector partnerships to improve overall health and well-being

New population health strategies must incorporate government sectors often found outside of the traditional health system such as education, transportation, community development, business, housing, and law enforcement and, use metrics that reflect the shared priorities and values of the community. The good news is that multi-sectoral partnerships for health and well-being have been steadily increasing since 2010.[43]

Since businesses are proven powerful allies of local governments in improving public health, the right incentives from local public health departments can encourage business owners to invest not only in their own growth, but also in new opportunities for physical activity and access to healthy, affordable food. Examples include the New York City FRESH Program, Orlando Magic community projects, and AdventHealth's Lift Orlando.[44]

Public Health Workforce Development:
Public Health Professionals

An essential element of public health is the assurance of a competent workforce. In order to strengthen the prevention and well-being improvement infrastructure, effective and sufficient workforce development in the fields of public health, medicine and allied health needs to take place to meet future health challenges.

However, almost 19 percent of the public health workforce (roughly 51,000 jobs) at government health agencies were lost during the 2008 recession and never replaced.[45] Many reductions affected health promotion programs as well as core public health programs such as those that prevent the spread of infectious disease.

Strategy 15

Increase federal funding to expand and improve public health training programs

In terms of training, the Council on Education for Public Health (CEPH), an independent agency recognized by the U.S. Department of Education to accredit schools of public health and public health programs, currently accredits 62 schools and 122 programs nationwide.[46] Although there is little research on the effect of public health workforce shortages and reduced services on health outcomes, having fewer services and service providers is likely to have negative effects on the health of communities.

Current federal funding for the public health workforce comes from Title VII of the Public Health Service Act, which is administered by the Health Resources & Services Administration (HRSA) of the U.S. Department of Health and Human Services. Title VII supports the following grant programs:

1. Public Health Training Centers (PHTC) Program, which funds schools of public health and other programs that provide graduate-level training in public health
2. Public Health Traineeship (PHT) Program, which provides grants to accredited institutions for graduate-level training in public health through traineeships
3. Preventive Medicine Residency (PMR) Program, which supports residency-level training for some preventive medicine physicians
4. Integrative Medicine Program (IMP), which supports a national center of excellence for integrative primary care

Because authorization does not ensure funding, the President and Appropriations Committees must embrace the importance of continued public health workforce funding to promote our nation's well-being.

Strategy 16

Create a national task force to implement an action plan to increase and improve the quality of the public health workforce

The Council on Linkages Between Academia and Public Health Practice, a collaborative of 23 national organizations focused on improving public health education and training, practice, and research, launched the Public Health Training Impact initiative. The de Beaumont Foundation's Public Health Workforce Interests and Needs Survey (PH WINS) seeks to understand the public health workforce's strengths, gaps, and opportunities to improve skills, training, and employee engagement. It would be beneficial to bring such organizations charged with developing recommendations to grow the public health workforce and improve the quality of training opportunities.

Title VII supports health professions education and training through grants to institutions and direct assistance to individuals.

TITLE VII TYPES OF ASSISTANCE PROVIDED[47]	
Institutional	Individual
Residency programs and medical and dental schools	Scholarships
Recruitment and retention initiatives in community-based educational settings	Loans or loan repayments
Health workforce data collection and analysis within state health departments	Fellowships

The Health Resources and Services Administration (HRSA), within the Department of Health and Human Services (HHS), oversees programs authorized in Title VII.

Strategy 17

Create a system for accurate and standardized collection of data on the public health workforce with projection analysis to estimate future need

An accurate enumeration of the public health workforce is challenging. Systematic collection of data on

the current public health workforce as well as others, along with reliable projection analysis, is needed to know how many public health professionals to train.

Public Health Workforce Development:
Preventive Medicine Physicians

Access to primary care can help Americans live longer and healthier lives. The U.S. health care system would greatly benefit if primary care were more readily available to patients. Improving access to preventive care, which is an important component of primary care medicine, can shift care away from more expensive and intensive services provided in emergency departments. This in turn can reduce health care cost and lower preventable hospitalizations.[48]

Strategy 18

Increase federal funding for preventive medicine residency (PMR) programs

A shortage of physicians specialized in preventive medicine is a significant barrier to preventive care.

Preventive medicine is one of the more than 150 specialties and subspecialties recognized by the American Board of Medical Specialties (ABMS). Physicians specialized in preventive medicine train in both clinical care and public health, placing them in a unique position to "promote and maintain health and well-being and reduce the risks of disease, disability, and death in individuals and populations.[49,50]

Medicare, Medicaid or other third-party payers fund most graduate medical education (GME) programs. However, preventive medicine programs do not receive GME dollars because the training tends to occur in non-hospital settings. Their only federal funding comes through Title VII. After reaching almost $10 million for preventive medicine residency training programs in 2010, HRSA provides just $4.5 million to 10 programs across the country.[51,52] As a result, many PMR program directors have to seek creative ways to fund residency positions.

An increase in federal funding will ensure that the 73 PMR programs are able to run at full capacity for training preventive medicine physicians. We recommend that Title VII appropriations for the PMR program be increased to support at least half of the accredited positions and that the government consider other ways to provide funding support for PMR programs.

Public Health Workforce Development:
Allied Health

In addition to the physician shortage, there is a workforce shortage across all areas of health care including nursing, mental health, pharmacy, dentistry, occupational and physical therapy, radiation therapy, respiratory therapy, speech pathology, and laboratory technology.[53]

These workforce shortages exacerbate the issues of availability and accessibility to primary health care critical to the maintenance of wellness and improvement of health.

Continued innovation and efficiency are needed to address gaps in the way primary health services are delivered.

Strategy 19

Implement an action plan to improve recruitment and retention of allied health providers in rural America

By 2025, the U.S. population is projected to increase by 30.8 million and the number of Americans over age 65 is projected to increase by 46 percent.[54] With this growing and aging population, the demand for physicians in both primary and specialty care has intensified.[55] This is especially the case in rural America where 20 percent of the U.S. population live but only about 11 percent of the nation's physicians practice.[56]

The health care workforce shortage in rural areas applies to allied health professionals, as well. Most health care professionals come from and are trained in urban areas and remain in these familiar surroundings to practice their profession. "Grow Your Own Health Professionals" demonstration projects recruit students from rural areas as they have a deeper desire to go back to their rural communities and practice there. Policymakers should consider supporting these projects in rural communities, including funding for the following:

- Early identification and mentoring of highly prospective candidates to serve in rural areas
- Financial support and/or loan forgiveness for living expenses, education and training beyond high school for selected candidates
- Ongoing community support as the candidate transitions to an urban setting for undergraduate and graduate education
- Continued support as the student transitions back to the rural community following education in the urban setting

Strategy 20

Define clear roles for allied health providers

Our nation's approach to meeting the health care workforce shortage while assuring the quality of care is to examine the role of the non-physician providers - what care is delivered, by whom, in what setting, and with what supervision. It is time to consider a redefinition and possible expansion of the scope and standards of practice based on education, training and experience. At the same time, new reimbursement structures should be created for allied health providers practicing in expanded roles to help with workforce shortages.

Standardized role descriptions and definitions including scope of practice for each allied health discipline would assure consistency and quality regardless of geographic (state, urban, suburban, and rural) location. Further, scope of practice laws should be regularly evaluated to assure consistency of skills and competencies for allied health. These skills would include diagnosis and treatment for low-acuity illnesses and chronic diseases, basic health needs, health maintenance and disease prevention. It also would include the ability to request consulting services as needed.

Strategy 21

Standardize the educational training and licensing requirements for allied health providers

The adoption of a federal rather than state allied health licensure and registration system could ease mobility across state lines as well as urban and rural locations, while assuring standardized competencies and quality of care. Also, regulations that elevate and standardize the educational and licensing requirements for allied health providers should be considered. For example, pharmacists could serve as an invaluable resource to patients and families. The medication reconciliation process can be an overwhelming or impossible task for patients, but pharmacists could fill that role. They could bridge knowledge gaps created by multiple providers and multiple medications often prescribed in a vacuum.

COMMUNITY HEALTH WORKER WORKFORCE INTEGRATION

Loma Linda University Health (LLUH) is in San Bernardino County. Located about 90 minutes east of Los Angeles, San Bernardino is the largest county in the United States. LLUH is also bordered on the north by the city of San Bernardino - voted an All-American City in 1977 but now ranked as the third-most dangerous city in the United States.[57]

The Institute for Community Partnerships (ICP) coordinates LLUH's investments to promote resiliency and hope in LLUH-served communities. ICP ensures that LLUH remains relevant and responsive to the needs of the community and focuses its impact on the community towards:

- Social determinants, especially workforce development and education
- Health priorities, to increase access to care for vulnerable populations

Through ICP, LLUH hospitals invest in the development of regional community health workers (CHW). CHWs are an emerging community-based workforce, and LLUH provides technical assistance and expertise to integrate them into traditional systems and infrastructures. The implementation plan for this effort includes initiatives in local school districts, in clinical settings, and with community-based service organizations in the region to ensure workforce development for CHWs.

Community Health Education Workers in Schools

Community Health Education Workers (CHEWs) are lay community members trained to work in the education system. They extend outreach to at-risk students who are chronically absent, face undue health challenges, or are experiencing mental or behavioral health crisis. Outreach efforts include relationship building, home visits, social supports, linkages and accompaniments to families, resource support, informal peer counseling, and referral to intensive supportive resources.

Two local school districts currently participate in the program. This school-based initiative employs eight CHEWs working in the community and a manager of integration who oversees the project. At one school district, CHEWs conduct interventions with children who are chronically absent. At another school district, CHEWs work with students to prevent suicidal ideation or action.

Community Health Workers in the Health System

In 2019, LLUH conducted a pilot program to have CHWs aid at-risk infants and mothers in its Neonatal Intensive Care Unit (NICU) and at-risk diabetic adults in its outpatient Diabetes Treatment Center. CHWs provided home visits, community outreach classes, and peer support groups to community members who lack access to services and face poverty.

Due to its initial success, LLUH is formally creating a CHW Integration and Intervention Program. These LLUH CHWs will be stationed in critical access areas of the health system to connect to community members experiencing the highest levels of need. The CHW program will help at-risk infants and mothers, adults with diabetes, children and youth with diabetes, homeless individuals in the emergency department, individuals experiencing escalation of symptoms related to sickle cell diseases, individuals experiencing lack of access to mental or behavioral health services and resources, and "high utilizers" of multiple systems who experience undue social burdens and require extensive, supportive accompaniment and linkage to health and social services upon discharge from LLUH.

Its Success is Attributed to the Following:

- **Time is Medicine**. Unlike health care providers and clinical staff, CHWs are able to do time-intensive interventions outside the hospital. Expertly trained in recognizing social needs and navigating appropriate resources, CHWs quickly establish themselves as community peers and engage with vulnerable individuals even after they are no longer "patients."

- **Intervention and Accompaniment.** CHWs are able to provide supportive coaching and mentoring to help at-risk individuals navigate complex social services and benefits including Veterans Affairs, Social Security, Department of Motor Vehicles (DMV), and others. CHWs accompany individuals to appointments in both outpatient and inpatient settings at LLUH and non-LLUH hospitals. CHWs also support individuals in accessing resources for survival such as food banks, housing, rental assistance, and others in the community offered by nonprofit community organizations.

Developing Community Health Workers with Community-based Partners

LLUH invests in nonprofit, community-based organizational partners who want to expand outreach to their populations through seed funding for CHW positions or through technical assistance with grant activities to help increase partner potential to acquire dollars to hire CHWs. For example, LLUH invested in the CHW integration program in the Coachella Valley where FIND Food Bank added a CHW to their outreach team. The position will be sustained by Cal Fresh (California's Supplemental Nutrition Assistance Program, widely known as food stamps) enrollment dollars and the CHW will work on intensive outreach visits to at-risk families.

Training CHWs and giving them jobs is an act of economic development for the community. As priority is given to CHWs who have special knowledge of the community or have experience living in poverty and navigating resources, CHWs often need the same access to employment as those they are tirelessly serving. CHWs are also traditionally not part of the systems they support nor have access to workplace benefits in those systems. LLUH is committed to advocating for CHWs to be full-time, with benefits, and making above minimum wage as an equity strategy. Employment in these systems reduces the reliance on grant-based or project-based employment for CHWs while providing them with benefits and reducing income insecurity.

ACTION STEP FOUR

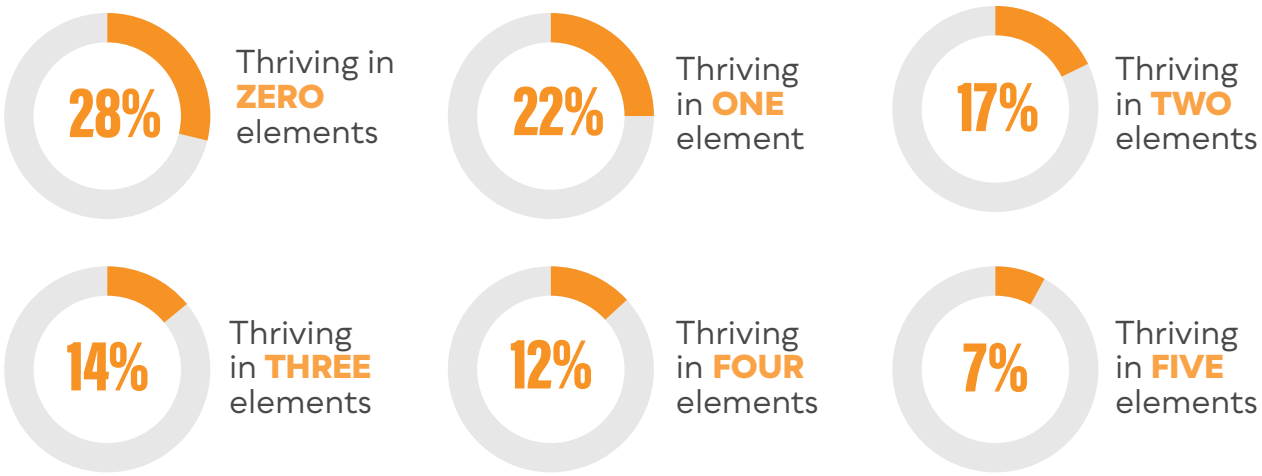
Invest in and Prioritize Well-Being Improvement

"Place gives us a point of entry. It makes visible the concrete and specific social and physical contexts of our patients' lives, pinpoints social work needs and interventions, and helps us begin to identify, assess, and measure the social determinants of their health." [58]

When we limit our understanding of health and well-being to activities within the walls of a hospital, we turn a blind eye to the existing infrastructure within our society that has the potential to create access to health and well-being. These opportunities and resources for health and well-being are found where we live, work, learn, play and worship. The way that we connect individuals to each of these settings, as well as one setting to another, determines our health and well-being and that of the people around us.

The U.S. Well-Being Gap

Gallup and Healthway's definition of well-being encompasses five elements: purpose, social, financial, community, and physical. In the U.S., 28% of adults are not thriving in any element. For every adult who is maximizing his or her potential in well-being, there are 13 who have significant room for improvement in one or more elements.[154]



There is No Health without Mental Health

The health of an individual, family or community and mental health are intricately connected - any attempt to improve one without addressing the other would be futile.

- Mental disorders are on the rise in every country in the world and will cost the global economy $16 trillion by 2030.[59]
- At $201 billion, mental disorders tops the list as the costliest condition in the United States.[60]
- Depressive disorders are the most costly among mental health and substance abuse disorders and we spend $71 billion to treat them.[61]
- One in 25 Americans live with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression.[62]
- More than 10.3 million adults in the U.S. have serious thoughts of suicide.[63]
- Suicide is the 10th leading cause of death in the United States, more than double the number of lives lost to homicide.[64]

Mental illnesses, such as depression, anxiety, bipolar disorder, or schizophrenia, affect a person's thinking, feeling, mood or behavior.[65] These conditions may be occasional or long-lasting and alter one's ability to function each day. In 2018, one in five American adults experienced mental illness.[66] And more than 50 percent of Americans will be diagnosed with a mental illness or disorder at some point in their lifetime.[26]

While the mind and the body are often viewed as separate, mental health plays a critical role in an individual's ability to maintain good physical health. Chronic illness is a risk factor for mental health struggles including depression, suicidal ideation, and suicide attempt.[67] Furthermore, robust evidence shows that there is a strong relationship between mental health symptoms and adverse physical health outcomes.[68]

Individuals with chronic health conditions (e.g., cancer, coronary heart disease, diabetes) are more likely to experience symptoms of depression.[69] Conversely, people experiencing depression symptoms have a higher risk of developing a physical health condition.[68] Given these identified health outcomes, it is critical to incorporate both mental and physical health in addressing overall health and well-being.

Strategy 22

Remove clinical, technological and administrative barriers to mental health

Lack of access to mental health services is well documented. Barriers to mental health services include issues with finding mental health providers who are covered by insurance providers, expensive out-of-pocket costs for patients, heighted rates of insurance denials and problems obtaining medications for psychiatric symptoms.[70] While these issues are present in urban, suburban, and rural areas, rural regions experience an additional barrier: significant shortages of mental health providers and psychiatrists.[70,71,72]

Telehealth is one solution to meeting the mental health needs of people living in underserved geographic locations and rural areas.[70] With the use of telehealth, mental health providers have the ability to conduct consultations alongside other health care providers and deliver mental health services to people while they remain at home.[72] Telehealth is associated with decreased mental health symptoms, improved medication adherence, and reduced length of hospital stays.[72] Removing barriers and expanding the use of telehealth can effectively address the mental health needs of many Americans.

Another solution to minimize and eliminate barriers to mental health is the integration of behavioral and mental health into primary care settings.[73] The integrated care model addresses a number of service access issues including primary care providers' lack of comfort or knowledge regarding referrals for mental health issues, difficulties navigating the mental health system, stigma associated with obtaining mental health services, and lack of follow-through when making appointments.[74] Primary care providers who operate within an integrated care model work alongside mental health providers who are trained to diagnose, manage, and treat mental health symptoms.[74] Successful integration of mental health services into primary care is related to improvements in quality of life and various clinical outcomes.[74]

Strategy 23

Create alternatives to institutionalization for mental health issues

Past deinstitutionalization efforts moved chronically and severely mentally ill patients out of state-run psychiatric hospitals into federally funded community mental health centers. Because sufficient funding for long-term care did not follow these institutionalized patients after discharge, new generations of mentally ill Americans end up in the streets, jails, and emergency rooms.

In the United States, 567,715 individuals are experiencing homelessness; of these, 96,141 are experiencing chronic homelessness.[75] Moreover, 3.4 percent of clients seeking mental health services report that they resided in a homeless shelter in the past year. Roughly 24 percent of homeless individuals are struggling with a severe mental health issue, and approximately two-thirds will experience substance use problems over the course of their lifetime.[76, 77] This figure likely underestimates the extent of the problem, as capturing mental illness among the homeless population is notoriously difficult due to the lack of a clear definition of homelessness, the mobility of the population and the cyclical nature of homelessness for many individuals.[72]

The United States has the highest incarceration rate in the world, incarcerating at a rate five to 10 times higher than other industrialized nations.[79, 80] In such a system, mentally ill individuals are more likely to encounter law enforcement than medical help during a mental health crisis. The Urban Institute estimates 56 percent of state prisoners, 45 percent of federal prisoners and 64 percent of jail inmates suffer from a mental health problem.[81] In fact, jails and prisons are now one of the largest settings for mental health services in the United States.[82]

Hospitals are no different. Psychiatric boarding is a widely recognized phenomenon in the United States where individuals with mental health conditions are kept in emergency departments because no appropriate mental health care is available. This trend is evident among children and adolescents who are increasingly more likely to visit the emergency department for a mental health-related issue.[83] For children and adolescents who visit the emergency department, mental illness is projected to be the most common cause of morbidity and mortality by 2020.[84] The number of mental health and/or substance use patients treated in emergency rooms continues to rise, increasing 44.1 percent from 2006 to 2014.[84] In fact, one in every eight emergency department visits in the U.S. is related to a mental disorder and/or substance use.[68]

By providing more community-based resources and education as well as addressing barriers to outpatient treatment for people with serious mental illness, we can reduce homelessness, imprisonment and hospital emergency department visits. It is also important to expand Crisis Intervention Training for law enforcement so that patients can receive proper care and relieve the burden on the criminal justice system.

THE PAUSE PROGRAM

"Addiction is a Chronic Disease, Not A Moral Failing."

The misuse of prescription opioids is a serious problem in the United States, and the opioid crisis was officially declared a national public health emergency in October 2017. As the number of patients prescribed long-acting narcotics continues to surge, so too have the number of opioid-related deaths.

In Montgomery County, Ohio, the situation has reached epidemic proportions with the highest number of drug overdose deaths per capita in the country. According to the county coroner, almost 400 people in Montgomery County died from an overdose in the first six months of 2017, giving it the unwanted title of the overdose capital of the United States.[78,79]

To stem the spread of the opioid epidemic, Kettering Health Network (KHN), in partnership with Dr. Nancy Pook, created a network-wide initiative: "PAUSE - Not All Pain is the Same."

PAUSE is an opioid-free pathway for physicians and pharmacists to manage chronic or benign pain. The program is about taking a moment to pause and consider alternatives to opioids. It is designed in collaboration with Pain Management and Addiction Medicine, supported by literature, and tested by emergency medicine and hospitalist medicine physicians.

As part of the program, KHN provides a broad-based, community education to prescribers and treatment providers, as well as members of law enforcement and criminal justice. The education focuses on substance use disorders and the changing landscape, particularly to address the increase in methamphetamine in the community. KHN also initiated MAT (medication assisted therapy) in its emergency departments, added case managers, and linked patients to substance abuse treatment programs. To date in 2020, 46 emergency room patients with primary substance use disorder have been linked to treatment.

As the PAUSE program continues to thrive, repetitive emergency department use in the target high utilization population has decreased by more than 50 percent since its implementation.

Strategy 24

Support policies that promote early intervention of mental health conditions, especially in children

While health care's move toward disease prevention and early intervention has been slow, mental health's adoption of these fundamental principles have been even slower.

Mental health research previously focused heavily on mental illness rather than well-being or optimal functioning and psychiatrists are usually not accustomed to mental health promotion and prevention.[85] Emerging research focusing on mental health prevention strategies offers promising outcomes for children and youth.[86] Specifically, these interventions are efficacious in promoting psychological well-being and preventing mental health disorders throughout development.[86] In addition, prevention strategies are shown to alter the trajectories of people who exhibit mental health difficulties earlier in life by delaying the onset of mental illness or by decreasing the severity of mental health symptoms.[86]

Intervening early is important for mental illness as half of mental illness is started by age 14.[87] Toxic stress resulting from strong, frequent and prolonged childhood adversity can disrupt brain development and impair academic performance. Early adverse life experiences are also a factor in increasing risk for mental illness. According to Dr. Robert Block, the former President of the American Academy of Pediatrics, "Adverse Childhood Experiences (ACEs) are the single greatest unaddressed public health threat facing our nation today." ACEs result from[88]:

- Physical, emotional, and sexual abuse
- Household challenges such as persistent poverty, violence against the mother, divorce, and substance abuse
- Physical and emotional neglect

ACEs can go on to have a devastating impact on the child's health, dramatically increasing their risk for seven out of 10 leading causes of death in the United States including high blood pressure, heart disease and cancer.[88]

There are several empirically-supported strategies that can prevent or mitigate the harmful consequences of ACEs on children.[88] These include economic support for children and families, promotion of healthy and positive social norms, development of skills for strong relationships, programs and activities for youth, and early-intervention approaches to lessen and prevent negative outcomes[89].

Dental Health vs. Oral Health

The definition of dental health is often limited to freedom from tooth decay and pain, and quantified as the number of teeth present. Oral health is a more inclusive definition that includes teeth, surrounding bones, and soft tissues of the mouth and face. This definition aligns with the National Institute of Health's expanded definition, incorporating the World Health Organization's view that "health is a state of complete physical, mental and social well-being and not merely the absence of disease."[86,87]

Whole Person Care Includes Oral Health

A healthy smile reflects an individuals' robust physical, mental and social status. Recognizing this, the Surgeon General's first oral health report in 2000 acknowledged a "silent epidemic" of untreated oral disease in the U.S.[84] and recommended that oral health be an "inseparable part of general health."[85]

Evidence links many systemic conditions to manifestations apparent in the mouth, further supporting the intimate connection between the body and its parts. Specifically, diabetes and more than 200 other diseases and deficiencies can be readily identified by signs and symptoms in the mouth or saliva.

Strategy 25

Develop infrastructure that is interoperable, accessible across clinical settings, and enhances adoption of the oral health core clinical competencies

The defined, essential elements of the oral health core clinical competencies should be used to inform decision-making and measure health outcomes. Even though it may appear obvious that the mouth is an integral member of the body, preventive and restorative care has been provided by a group of professionals outside the general medical community. Caring for oral health has been limited to the dental community of dentists, dental specialists (i.e. oral surgeons, orthodontists, pediatric dentists, etc.), hygienists and assistants. Dentists and physicians educated and practicing separately, infrequently co-design comprehensive health promotion strategies and treatment plans.

Strategy 26

Expand oral health coverage by public and private payors

Public and private insurance programs routinely classify oral health as an "independent and optional" benefit. As a result, employers are required to provide health insurance but not dental insurance. Medicare, the national health insurance program for older adults and individuals with disabilities, explicitly excludes most coverage of dental services. The Patient Protection and Affordable Care Act of 2010 deliberately classified dental health coverage as an optional benefit and excluded adult dental care from the 10 Essential Health Benefits.

Strategy 27

Improve access to oral health care for vulnerable and underserved populations

According to the Centers for Disease Control and Prevention (CDC), dental decay, or caries, persists as the most common chronic disease in the U.S.[94] Complications from this preventable disease include pain, reduced function (eating and talking), lost productivity (at school and work), and a

decrease in the overall quality of life.[95] Those suffering most and at highest risk in the U.S. for poor oral health are children, the elderly, certain ethnic minorities and people with a lower socioeconomic status. They face barriers to care that include cost (lack of insurance) and provider shortages, especially in rural communities.

Health Happens in Many Places

WHERE WE LIVE

Home environments (lead exposure, poor ventilation, lack of safety, family support, etc.) affect health. The same is true for the places we work, move through, and play (safe streets, places of employment, access to grocery stores, open spaces, etc.). The healthful design of communities influences activity, economy, connectedness and well-being.

Today, physical inactivity and unhealthy nutrition are leading causes of premature death.[96,97] In 2018, all U.S. states had more than 20 percent of adults suffering from obesity and in 22 states, between 30 and 35 percent of adults were obese.[98]

For children ages 5 to 14,[99, 100] physical activity like walking or riding a bike to school has decreased from 48 percent in 1969 to 13 percent in 2009. Childhood obesity has tripled during the past three decades, and the rise of Type 2 diabetes among children has skyrocketed.[101] Latest research also found that at age 8, many children saw a decrease in their physical activity and an increase in sedentary time.[102] The decrease in physical activity is even steeper when children reached age 11.[64]

Much of this is related to a built environment that promotes or inhibits health and well-being. The built environment includes:

- The design and mix of buildings
- Streets and their networks
- Parks and recreational facilities
- Transportation systems
- Mobility options
- Schools and open spaces (Including natural space preservation)
- Food access

The built environment is a reflection of community and national values; it is health policy in concrete.

Strategic and quality design of the built environment incorporates a Health in All Policies approach at its core. It allows communities to foster and sustain healthy behaviors, contribute to and benefit from a prosperous local economy, improve quality of life for all residents and visitors, and preserve the natural environment. Where healthy community design is missing, communities are faced with less access to healthy choices, greater inequities, and lower well-being.

Campuses, neighborhoods, towns and regions that focus on healthy built environment policies do so through intentional and inclusive visioning, planning and implementation.

Strategy 28

Design communities to encourage walking, biking and other methods of active transportation

When we started building around the needs of the automobile use, we engineered physical activity out of daily living.

Transportation planning, policy and practice should focus on moving people rather than vehicles; designing, constructing and maintaining roads to provide safe, convenient and equitable access for all users. Community design should include building frontages that open directly to the activity on the street, broad sidewalks and crosswalks, and walk-sized blocks. This also means the incorporation of protected bike lanes, public transit and in-between connections proven to reduce traffic congestion, create jobs, strengthen the economy, increase access to health care, reduce transportation costs and increase safety and security.[104] Trees, parks, usable greenways, plazas, paths and other means of contact between nature, especially those of memorable character, can stimulate the local economy and support interaction, belonging and well-being.

According to the Center for Disease Control and Prevention (CDC)[103]

- More than one-third of adults - more than 72 million Americans - are obese
- Annual health care costs of obesity-related disabilities are estimated at $44 billion
- Obesity rates are significantly higher among some racial and ethnic groups; African Americans have a 51 percent higher obesity prevalence and Hispanics have a 21 percent higher obesity prevalence than White populations

Strategy 29

Support multidisciplinary initiatives that include healthy design principles

Children living in low-income neighborhoods with built environments conducive to inactivity, social isolation, and safety and security risks - that lack sidewalks, accessible transportation options, parks, and access to healthy foods - are up to 60 percent more likely to be obese than children not facing similar conditions.[105]

Health-promoting design and practice principles are found in Complete Streets, Safe Routes to School and Safer People, Safer Streets initiatives. These initiatives can guide the transportation design efforts of local and state departments of transportation, the Centers for Disease Control and Prevention (CDC) and the Federal Highway Administration. The President and Congress should consider the enhancement of federal programs and funding streams that supplement core local, regional and state commitments to health-promoting community design.

WHERE WE WORK

Almost 50 percent of Americans get health insurance through their employers.[106]

So, for many years, businesses have held an interest in keeping workers healthy, productive, and satisfied - while working simultaneously to decrease health care and insurance costs. More and more businesses have offered incentives (and some, disincentives) to accomplish these goals.

Though tobacco use and obesity have garnered the most awareness and surveillance, efforts to manage blood pressure, high cholesterol, blood glucose, and sedentary lifestyles have received similar emphasis.

Effective workplace wellness programs can include all or some of the following:

- Health screening
- No smoking policies on and off the job
- Cash incentive payments and gift cards
- Reimbursing employees for gym memberships
- Free health coaching
- Insurance-premium discounts to those who meet health standards[107]
- Rewards such as cash, additional paid vacation, gift cards, health savings account contributions, and premium differentials[108]
- Incentives such as verbal or visual recognition, coveted office space, pedometers and others
- Reduced/free parking options for those ride sharing, free public transportation passes
- Flexible work schedules, including the option to work remotely

To engage workers in a long-term behavioral change, employers must create a culture of health and well-being in the workplace. These efforts should include approaches listed above, environmental changes such as walking paths/routes and healthy foods in cafeterias and vending machines, capacity building through education and connection (lunch and learns), and opportunities for community building (cross departmental/management level activities).

Strategy 30

Make effective incentives part of an overall employee health strategy, not the whole strategy

Types of incentives include[109]:

- Participation-based: Cash incentive or premium reduction for completing an annual health risk assessment or biometric screening
- Outcomes-based (most preferred by business): Premium reduction for attaining and sustaining target ranges for BMI, BP, glucose, and cholesterol levels
- Progress-based (rewarded for making meaningful progress toward specific health goals): Employee with BMI of 40 setting realistic weight loss goals of 10% body weight, instead of unrealistically trying to achieve a BMI of 25 in one year

Incentives provided by successful workplace wellness programs can motivate employees to engage in wellness program specifics, start selected behavioral modification, and learn about health and wellness - but are not necessarily the whole answer.

Strategy 31

Offer well-designed, measurable initiatives that measurably and sustainably improve employee well-being

Scientific evidence suggests that some workplace wellness programs have been successful while others have not. Employers should be encouraged to implement key federal regulations like the Health Insurance Portability and Accountability Act (HIPAA) wellness program regulations or the Genetic Information Nondiscrimination Act (GINA) and follow evidence-based guidelines from consumer agencies such as American Cancer Society, Americans for Disability and others.

HIPAA requires the following for outcomes-based incentive programs:

- The total amount of incentives or penalties cannot exceed 30 percent of the total cost of employer-sponsored insurance coverage

- Incentives can only be used as part of a wellness program that is "reasonably designed to promote health and wellness"
- Opportunities to qualify for incentives must be given at least once per year
- Employers must offer a waiver or "alternative standard" if the employee is unable to meet the standards due to a medical condition or doctor's recommendation. Reasonable alternative standards or waivers must be defined in marketing materials that contain incentive qualifications[110]

Comparing data from early 1970s and 2008, the prevalence of obesity for children[113]

Ages 2 to 5 years:	Ages 6 to 11 years:	Ages 12 to 19 years:
DOUBLED	**QUADRUPLED**	**TRIPLED**
2X	4X	3X

The Joint Consensus (American Heart Association, American Diabetes Association, American Cancer Society, Health Enhancement Research Organization, American College of Occupational and Environmental Medicine and American Cancer Society Cancer Action Network) has also made suggestions for reasonably designed programs and reasonable alternative standard wellness programs.[111] Again, ethical considerations must assure transparency, non-discrimination and adherence to evidence-based scientific data.

WHERE WE LEARN

Children spend the majority of their time in school. In 2017, 96.8 percent of American children between 7 and 17 years of age spent about six hours a day, 180 days a year, in school.[112] For this reason, schools are uniquely positioned to help children develop a foundation for healthy decision-making in the future.

Strategy 32

Establish school-based healthy eating and physical activity policies and practices for students

According to the Centers for Disease Control and Prevention's (CDC) "Unfit to Serve: Obesity is Impacting National Security" document, one in four young adults is too heavy to serve in the U.S.

military.[114] In addition, one in four students has one or more chronic conditions, such as asthma or diabetes, which debilitates their ability to learn.[115] Nonetheless, millions of students throughout the United States attend schools in environments that do not adequately support health and well-being.

School policies should incorporate basic health education and encourage children to make healthy choices from the cafeteria to the classroom:[116]

- Establish a school health team and designate a school health coordinator at the school level
- Provide quality school meals that comply with the Dietary Guidelines for Americans and are culturally relevant
- Adopt food choice architecture to promote healthy eating in students; that is, place nutritious products prominently in the cafeteria so healthy choices can become the easier choice
- Remove unhealthy food and beverage options in vending machines, concession stands, school stores and after-school programs
- Implement a comprehensive physical activity program with quality physical education as the cornerstone. Children and teens should participate in at least 60 minutes of physical activity every day

Schools also can increase community access to school facilities such as gymnasiums, tracks, baseball and softball fields, basketball courts, outdoor play areas and indoor fitness centers to help improve the health and well-being of the entire community.

Strategy 33

Improve funding to support school-based health centers to promote well-being and prevent disease

School-based health centers are often operated in partnership between the school and a community health organization, such as a community health center, hospital, or local health department.

More than 2,600 school-based health centers operate nationwide, providing health care access to over 6.3 million students.[117] Based in schools, these health centers provide a full range of services to students and their families, including[118]:

- Primary medical care (treatment for flu, asthma, diabetes, etc.)
- Mental/behavioral health care
- Dental/oral health care
- Hearing screening
- Health education and promotion

- Substance abuse counseling
- Case management
- Nutrition education

According to a study conducted by the U.S. Department of Health and Human Services, adolescents are more comfortable accessing health care services through school-based clinics and like the idea of accessing a range of health and social services in a single location.[119]

Funding to support school-based health centers has traditionally come from a patchwork of revenue streams. Many centers are funded by traditional school financing sources such as local property taxes and formula-driven state revenue allocations to local school districts. Federal funding comes from various federal discretionary grants for school-based care, and from Medicaid payments for certain services provided to students in special education. It is time to redesign the collaboration between education and health and identify more sustainable funding sources.

WHERE WE WORSHIP

"Community and faith-based organizations are incubators for emerging and informal local leaders who are skilled negotiators and gatekeepers with access to the groups and individuals who know the unspoken history and culture of neighborhoods down to the block level." [16]

Strategy 34

Empower faith communities to own and promote healthy lifestyles that lead to measurable and sustainable well-being improvement

Personal spirituality and attending places of worship help people remain healthy longer. Temples, churches, synagogues and mosques build social support, a key factor in personal health. According to Gallup, 52 percent of Americans were members of a church in 2016 to 2018.[120] This gives access to a vast number of people who already feel connected to places that represent hope and spiritual meaning, places that influence their worldview and how they conduct their lives. Tapping into this social and spiritual core affords a powerful opportunity for integrating healthier lifestyles and communities.

Five reasons to engage faith communities in promoting healthier lifestyles:

1. **Congregations are communities united by a worldview that is influenced by a unique theological framework.** Central to the theology of most faith communities is the idea that humans are created in God's image. If channeled appropriately, this level of consciousness and responsibility can link to the importance of personal and communal health - and motivate health improvement among congregants.

2. **Congregations are already structured for gatherings with subgroups that provide internal support.** We find that most congregations gather together in their facilities at least once a week for worship and community support. This means that the infrastructure for mutual support and objective teaching is already in place. Creating a pathway to tap into and integrate access to healthier lifestyles is a logical and productive proposition.

3. **Faith communities pledge commitment, respect and reverence to God or a Higher Power.** They understand their responsibility to their Higher Being for physical, emotional and spiritual health. However, when it comes to personal health, people may not connect the importance of a healthy lifestyle to the way they care for themselves. There is an opportunity to guide congregations to a place of holistic accountability and intrinsic motivation that honors God through the way they care for themselves. Their accountability to God is core to engaging participation, change, perseverance and ultimately, a willingness to adopt healthy lifestyles.

4. **Congregations ascribe to a theologically integrated view of the human as one unit: Body-Mind-Spirit.** "Theological integration" is the key operating statement. Faith communities ascribe to the importance of not separating the care of the spirit from the care of the mind and the body. However, they often struggle to find pragmatic ways to integrate health practices and personal accountabilities. To create change and movement, congregations must reach a conscious level that recognizes their need to meet the needs of congregations and their communities. This creates an integrated theology that helps create access to healthier lifestyles.

5. **There is an untapped source of energy and resources within each faith congregations.** Members of faith communities have a bent toward volunteerism and community service that, if channeled appropriately, can produce active participation in health initiatives. Many health providers and caregivers are active in faith communities and congregation, but may not be invited to bring their skills to their own faith communities. This is a missed opportunity for improving the health and well-being of the congregations and society.

ACTION STEP FIVE

Prioritize Determinants of Health Infrastructure and Investment

Why do some people experience high levels of health and well-being while others do not?

Health and well-being is not only linked to one's ability to obtain quality health care but to other factors as well, ranging from one's income and level of education to their networks of social support. As a result, Americans from different backgrounds experience different levels of health, well-being and longevity. In general, people with lower socioeconomic status – measured by income, educational attainment or occupation – experience worse health and die earlier than their counterparts with better socioeconomic status. While being poor is bad for one's health, inequalities in health are not limited to the poor. Disparities run across all social classes and can be influenced by an individual's zip code, ethnicity, gender and sexual orientation.

According to research,

- Less-educated adults (high school degree or less) in every age, gender, and racial/ethnic group have a lower life expectancy than their college educated counterparts[122]
- People of color face higher rates of diabetes, obesity, stroke, heart disease, and cancer than White people[123]
- The richest 1 percent of Americans live up to 15 years longer than the poorest 1 percent[124]

The health care we receive is responsible for only 20 percent of our health. Our environment, socioeconomic conditions and our habits determine the other 80 percent (figure 1). Quality education, employment opportunities, livable wages, healthy food, affordable housing and safe communities are all factors that can be modified to shape our health. Thus, solving social and economic challenges through policy changes are key to improving health outcomes and controlling medical costs.

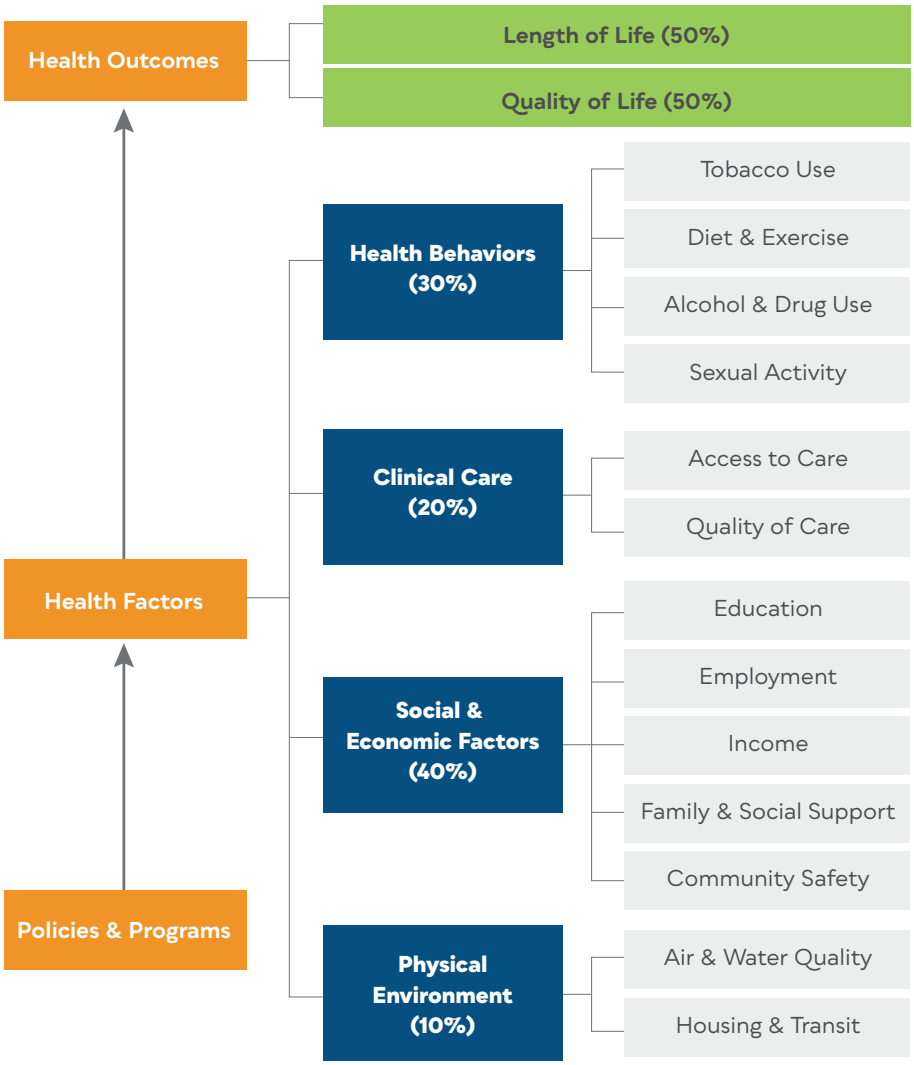


Figure 1. The Determinants of Health[125]

Social and Economic Determinants of Health

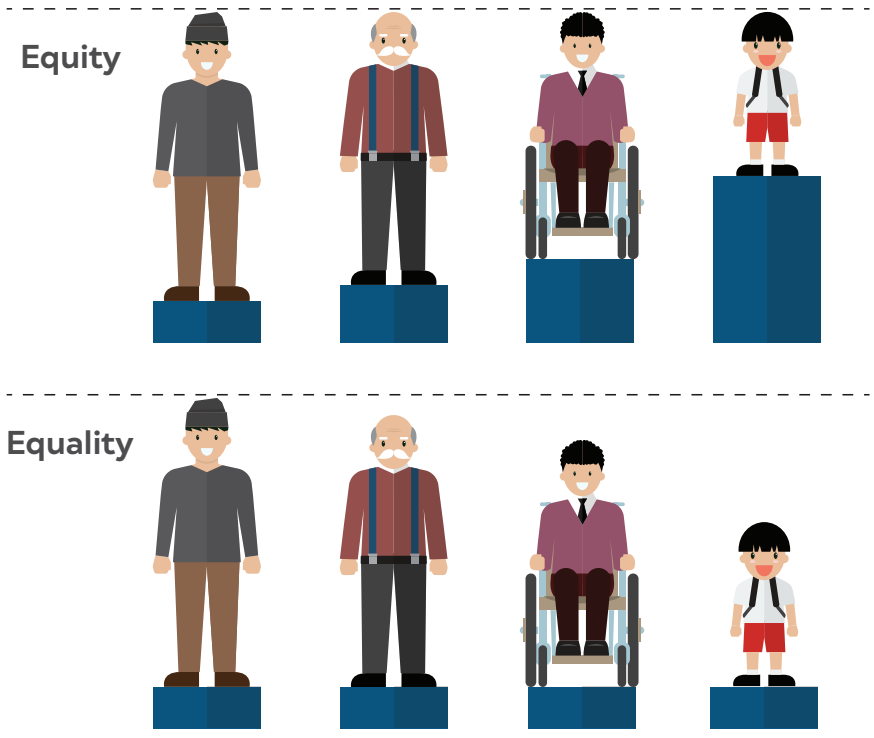
According to the World Health Organization, social determinants of health are "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels."[126] Unequal distribution of money, power and resources are created by social policies and practices and can be based on race, ethnicity, class, gender, place and other factors. To improve the health of our communities, we need to improve the health of our residents, including racial and ethnic minorities, those living in poverty or other vulnerable populations. Special attention needs to be focused on at-risk individuals and communities.

Social Justice: Equality vs. Equity

"There is nothing more unequal than the equal treatment of unequal people."
- Thomas Jefferson

Social justice means that everyone deserves equal rights and opportunities. Equality and equity are key strategies in obtaining social justice. Although they sound similar, equality and equity are not equal.

Equality means treating everyone the same. Equity is giving individuals what they need to be successful. Equal treatment ignores our differences and ends up promoting privilege. Below is an image often used to illustrate this difference.



Health is equitable when all people have the opportunity to "attain their full health potential" and no one is "disadvantaged from achieving this potential because of their social position or other socially determined circumstance."

Figure 2: The Difference Between Equality and Equity

Strategy 35

Develop new strategies to reduce inequalities of school resources

Education is a treasured social value in the United States and considered fundamental in achieving the American dream, opening the door to prosperity and social mobility. According to American educator Horace Mann, "Education then, beyond all other devices of human origin, is a great equalizer of the conditions of men - the balance wheel of the social machinery."[128]

But American schools are profoundly unequal. Schools are not only a vehicle for social success, valuable resources and good health but also an institution that reproduces inequality across generations.[129] Schools in inner city and low-income neighborhoods often do not have the same resources as their suburban counterparts. This includes the school's physical and structural environment (e.g., activity space, air quality and physical safety), health resources (e.g., availability of nurses and mental health professionals), school culture and climate (e.g., violence, bullying and academic values), and school composition (e.g., socioeconomic status and school size).

We know that education is a powerful social determinant that influences health over the course of one's lifetime. In fact, children enrolled in poor quality schools with fewer health resources, more violence and a distressed school climate, are more likely to face worse physical and mental health later in life.[130] Quality education and training opportunities will not only close the nation's opportunity gap but also reinvigorate our economy.

Policies and strategies must invest in expanding access to high-quality early childhood education programs. Every dollar invested in pre-kindergarten education can generate up to $7.30 in return.[131] The impact is even greater for children born into lower socioeconomic conditions.

Strategy 36

Address food insecurity and lack of affordable housing as health issues

For a long time, food insecurity and housing instability were understood and approached largely as a social issue. However, these two factors increase the risk of poor health outcomes and are important determinants of health.

Food insecurity is defined as the disruption of food intake or eating patterns because of lack of money and other resources.[132] Households in principal cities, households with low-income, as well as households with children headed by single parents, are more likely to be food insecure. In 2018, 37.2 million people lived in food insecure households.[133] In the same year, African American households (21.2 percent) and Hispanic households (16.2 percent) were more likely to be food insecure than the national average (11.1 percent).[134] In addition, more than 23 million Americans, including 6.5 million children, live in food deserts and do not have access to stores where they can purchase nutritious foods.[135]

In children, food insecurity is associated with increased risks of birth defects, anemia, low nutrient intakes, cognitive problems, aggression and anxiety, asthma, higher risks of hospitalization, and poorer general health.[136] In adults, food insecurity is associated with increased rates of mental problems and depression, diabetes, hypertension, poor sleep outcomes, hyperlipidemia, and worse outcomes on health exams.[15]

Housing is also one of the best known social determinants of health - housing stability, quality, safety and affordability all affect health outcomes, as do physical and social characteristics of neighborhoods.[137]

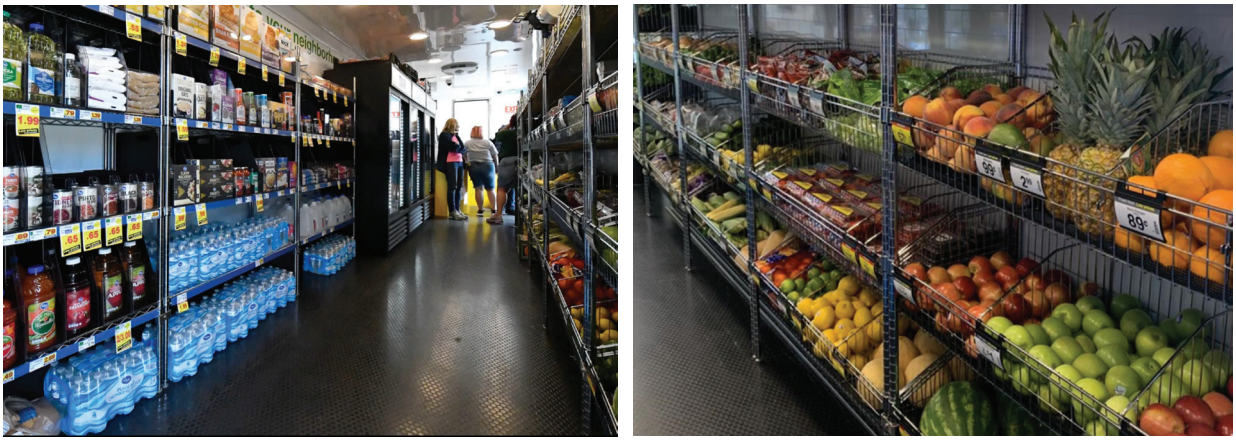
Poverty is the underlying cause of food insecurity and housing instability. Research also tells us that people living in or near poverty have disproportionately worse health outcomes and less access to health care than those who do not. According to the Census Bureau, 38.1 million or 11.8 percent of Americans lived in poverty in 2018.[138]

Not having enough to eat or not having a place to stay are not acceptable in this wealthy nation. It is time to tackle these issues aggressively. AHPA urges the President and Congress to build the political will to create more jobs, ensure livable wages, and expand training opportunities for struggling Americans. As overall participation in the national School Lunch Program has been decreasing over the past six years[139], the federal government also can work with states, counties, cities, and nonprofit agencies to increase participation in federal nutrition programs for children.

GEM CITY MARKET

Dayton, Ohio, is in the bottom quartile of U.S. cities for food hardship for families with children. Kettering Health Network (KHN) partners with many local stakeholders to support the Gem City Market. Located in a low-food access area, Gem City Market is a cooperative-owned, member-controlled facility for the benefit of those same members. In addition to being a full-service grocery store, Gem City offers a teaching kitchen, nutrition classes, wellness programming, a mini-clinic, a café, and a community room with three goals in mind:

- Improving grocery access to low-income neighborhoods
- Providing access to healthy food opportunities to low-income neighborhoods
- Creating a grocery shopping experience that exceeds customer expectations



Teaching Kitchen. KHN first built an integrative culinary medicine program to educate physicians and other health care providers to better understand the role of nutrition in treating and preventing disease. KHN then developed a community-facing program using resident physicians and dieticians to educate consumers about feeding their families nutritious and health foods that are affordable and efficient.

Homefull's Mobile Grocery. A freightliner grocery store on wheels, the mobile grocery will provide locally sourced fresh fruits and vegetables, dairy items, variety of meats, pantry staples, household items and grocery store options to neighborhoods located in food deserts.

Strategy 37

Identify health literacy issues in under-resourced communities and implement a targeted response

Health literacy is an important determinant of health inequities across different groups. Health literacy refers to "the personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health. Health literacy includes the capacity to communicate, assert and enact these decisions."[140]

Social factors, including living in poverty, education, race/ethnicity, age, and disability, influence one's health literacy.[141]

- Adults living below the poverty level have lower health literacy than adults living above the poverty level[142]
- Almost half of adults who did not graduate from high school have low health literacy[21]
- Uninsured individuals and individuals with Medicaid are at higher risk of having low health literacy[21]
- Medicare beneficiaries with low health literacy have higher medical costs, increased ER visits and hospital admissions, and decreased access to health care[20]
- Hispanic adults have the lowest average health literacy scores of all racial/ethnic groups, followed by African Americans and American Indian/Alaska Native adults[21]

Unlike other social determinants of health, health literacy can change through improving patient-provider communication, simplifying health information in educational materials, and efforts to improve underlying health literacy skills.[143]

As health literacy is an important skill in translating health knowledge into healthy behaviors as well as enabling people to overcome barriers to health, health literacy issues in vulnerable communities must be addressed to measurably and sustainably improve overall well-being.

Strategy 38

Create safe communities, free of crime and violence

Unsafe communities are unhealthy as people cannot thrive under constant fear. Chronic fear affects our physical, emotional and spiritual health (Table 1) and exposure to violent crimes damages the health and development of victims and entire communities. Safe and secure environments are essential for health, especially in children.[144]

According to the Department of Housing and Urban Development, violent crimes in neighborhoods are related to poverty, segregation and inequality, disproportionately affecting low-income individuals as well as racial and ethnic minorities.[145]

Table 1. Consequences from Chronic Fear[146]

CONSEQUENCES FROM CHONIC FEAR			
On Overall Health	**On Emotional Health**	**On Environmental Health**	**On Spiritual Health**
Impaired immune system	Unable to have loving feelings	Continued living in fear	Bitterness toward God
Impaired endocrine system	Learned helplessness	Inability to find safe housing	Loss of trust in God and/ or clergy
Eating disorders	Mood swings, anxiety, obsessive-compulsive thoughts	Afraid of leaving the house	Despair related to perceived loss of spirituality

Project SAFE Neighborhoods (PSN), a nationwide crime reduction initiative led by the Justice Department, brings together federal, state, local and tribal law enforcement officials, prosecutors, and community leaders to identify the most pressing violent crimes in the community and develop comprehensive solutions to address them.[147] It offers targeted enforcement along with place-based prevention efforts.

However, PSN's long-term effects in some cities diminish over time due to lack of funding and resources.[148] Looking at factors unique to safer neighborhoods - such as strong social organization, youth job opportunities and housing stability - may help address the cause of the problem rather than its symptoms. A sustained effort at all levels of society will be required to successfully address this complex and deeply rooted problem.

Political Determinants of Health

Health is political for three reasons: 1) health is unevenly distributed, 2) many health determinants are dependent on political action, and 3) health is a basic human need.[149]

Strategy 39

Establish equity-promoting policies that reduce social disparities, improve well-being, and result in better health for all

Income, housing and access to food play integral roles in the health of individuals and communities. For example, people with higher incomes may have more opportunities to live in safe, healthy homes

and near higher quality schools. They are also more likely to have healthier food options, time for physical activity and access to health care services. Conversely, people with low-incomes are more likely to live in substandard housing or unsafe communities. Their communities may lack healthy food options like fresh fruits and vegetables, and they may lack access to outdoor recreational facilities. All these social determinants - income, wealth, education, employment, neighborhood conditions - shape health. And these social determinants are shaped by policies.

According to the Haas Institute, the following six policy solutions can close economic disparities among groups[150]:

1. Increase the minimum wage for the lowest-paid workers
2. Expand the Earned Income Tax to lift children out of poverty and provide economic support for the working poor
3. Encourage higher savings rates and lower the cost of building assets for working and middle class households
4. Invest in early education and school quality
5. Adjust capital gains tax rates so that they are in line with income tax rates
6. End residential segregation by income (particularly the isolation of low-income households) and race

Strategy 40

Create opportunities for social and civic engagement

Civic participation is critical for our democratic society to continue to prosper but has been weakening.

Only 53 percent of Americans view American democracy positively while almost 20 percent of millennials in the United States think a military rule or an authoritarian dictator is a "fairly good" form of government.[151] At the same time, civic participation, and thus political power and influence, is becoming increasingly concentrated among those at the top of the wealth and income distribution.[152]

Social and civic engagement also has secondary health benefits. According to the Office of Disease Prevention and Health Promotion, civic participation improves health by increasing social cohesion and trust, while Americans engaged in civic groups are more likely to be physically active and can help develop a sense of purpose.[153]

Contributors

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