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# *Innovating, Leading & Moving Public Health Forward*

A forum co-hosted by the American Public Health  
Association and the Robert Wood Johnson Foundation

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# Robert Wood Johnson Foundation

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## Introduction

Public health workers in the United States are a long way from the days of confronting singular health threats such as polio, cholera, and tuberculosis. While the field will always have a role in investigating, treating and protecting people from disease, a new era is quickly emerging in which public health workers focus their unique skill sets on the social conditions that help determine who will be healthy and live long and who will struggle with disability and illness.

This complex undertaking is happening against the backdrop of the Affordable Care Act, which offers the public health field a number of opportunities to redefine itself and showcase the power of prevention. For example, many of the nation's public health departments are restructuring and rethinking their role in providing clinical services as more people gain insurance coverage and access to medical care. The health reform law also authorized the landmark Prevention and Public Health Fund and Community Transformation Grants, which support a pointedly population-based approach to problems such as childhood obesity and highlight public health's strength as a cross-sector convener.

Still, this is just the beginning — the journey toward a new public health will be long and ever-evolving and will likely require new skills and flexibility. At the same time, public health enters an era in which efficiency and effectiveness reign, and the field's practitioners must learn how to communicate the social and economic value of a robust public health system. This transitional time invites innovation and creativity and begs the question: What is the role of public health in a community, and how do communities both inform and benefit from the work of a public health department?

This question and many more were at the forefront of discussion on Saturday, Nov. 2, 2013, when the American Public Health Association (APHA), in partnership with the Robert Wood Johnson Foundation (RWJF), hosted a forum titled *"Innovating, Leading and Moving Public Health Forward"*. More than 70 public health leaders, including department directors as well as representatives from government agencies, businesses and community-based organizations, met to swap best practices and discuss opportunities for collaboration.

"Today, public health departments are really rediscovering their unique role in our health system," [Paul Kuehnert](#), a



*Photography Credit: Susan Polan*

senior program officer and team director for public health at RWJF, told forum attendees. “We are in uncharted waters. It’s really an exciting time to be in public health.”

Forum attendees hailed from local, regional and statewide public health departments, from communities small and large, urban and rural, and home to a diversity of public health challenges. They came to the forum, which gathered in Boston just a day before the kick-off of APHA’s 141st Annual Meeting & Exposition, to learn about expanding the reach of public health in their communities; to discuss strategies for building cross-sector partnerships and working at the intersection of public health and services such as transportation, education and affordable housing; to explore new financial models; to overcome health disparities and advance health equity; and, of course, to improve health outcomes.

“No one individual or health department is going to have all the answers, so this meeting was a great opportunity to talk and learn from what others are doing,” said attendee David Fleming, MD, director and health officer for Public Health — Seattle & King County, who spoke about re-thinking funding streams and structures. “Coming together helps

to create a common voice around what the issues are and what the answers are in public health.”

The forum also emphasized the growing importance of promoting equity in communities. The idea that no matter where you live, public health has a role to play in creating healthy, safe and vibrant lives was a common theme throughout the day.

The forum was divided into four panel discussions. Two morning sessions focused on payment and infrastructure of public health and prevention programs. Two afternoon sessions took a closer look at successful community practices in Minnesota and San Bernardino County, Calif., and examined how every community can adapt strategies and practices to their own distinct needs and challenges.

“Things are going to be really different in a state like Massachusetts versus a state like Alabama, especially with the idea of expanding Medicaid (eligibility),” Kuehnert said. “So state health departments are going to have to deal with the particular conditions in their state’s policy. That’s really why we invited representatives from health departments to highlight what they are doing in their own jurisdictions.”

# *What can public health do differently?*

As forum attendees gathered at Boston's Convention Center, they were asked "How did you come into public health?"

**L**ike many of her public health colleagues, forum attendee [Charlotte Parent, RN, MHCM](#), deputy director of health at the [New Orleans Health Department](#), didn't initially set out to be a public health practitioner. Parent used to be a direct care provider, overseeing maternal and child health services at a local hospital. Her entire job was about how fast she could get a patient out the door, but Hurricane Katrina changed her perspective.

"It was a shift in how I thought about not just health, but about people and social issues," Parent said. "That's when I decided that public health may be the way for me to confront that."

Parent's story is a common one. Because the field of public health offers a unique approach to tackling entrenched community health challenges that can't always be solved within the walls of a doctor's office, it attracts passionate people who want to get at the very roots of poor health. But public health needs to run on more than passion to make real change.

Turning that passion into effective public health practice was the topic of the day as Kuehnert and APHA Executive Director [Georges Benjamin](#), kicked off of the forum with

their own thoughts on the future of public health.

"This is an opportunity to figure out where the public is going and then, when the wave comes, be right there to catch it," said APHA Executive Director Georges Benjamin as he opened the forum. To support that same theme, Kuehnert borrowed an analogy from hockey great Wayne Gretzky.

"We need to skate to where the puck will be," he said.

During the forum's discussions, finding new resources, defining priorities and nimbly embracing change emerged as common threads. Indeed, the forum itself — as a way to share what works and collaboratively build knowledge — became part of that transformative process.

"What this meeting is about is a chance to listen to and talk with each other because we are all coming from diverse views and experiences," Kuehnert said. "We have to ask ourselves what we can do to catalyze and solve public health problems. And it seems like today's theme — innovation — is taking form in ways that public health departments and people are trying to create new resources."

For public health to make progress, it must be more than a





*Mildred Thompson, MSW – opening keynote, Credit: EZ Event Photography*

force for prevention, promotion and protection and take an all-encompassing view of how public health contributes to the overall health of a community. Public health must position itself as an indispensable catalyst for action, a cross-sector convener, a community liaison, and a collector of best practices and policies.

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*“Everything about how we do our work should have, at its center, a focus around the populations we are serving.”*

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In short, the role of public health must both expand as well as zero in on the roots of poor health rather than its symptoms, said, [Mildred Thompson, MSW](#), senior director of PolicyLink’s Center for Health Equity and Place in Oakland, Calif., in her plenary discussion.

“If you continue to put a Band-Aid on the problems in public health and send them back out there, how are we going to address any of the real issues at home or at school,” she asked. “How then do we dialogue deeper issues like race and class into these discussions on public health?”

Public health must renew its commitment to serving all people from all walks of life. For example, as the health care law creates access to coverage for millions who were previously uninsured, public health systems should be prepared to address language barriers, cultural appropriateness, and the “hiring people who look like the recipients who are getting the care,” Thompson said.

“Everything about how we do our work should have, at its center, a focus around the populations we are serving. Our work has to be aligned with a variety of cultures and populations and what their needs are,” she said.



*Mia Lufuquisen, DrPH, MPH, RN Credit: EZ Event Photography*



# *Re-thinking how we pay for public health & prevention*

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How did Massachusetts create a \$60 million four-year trust for community health initiatives? How do we “make the actuaries happy” and demonstrate measurable results in public health? What can a local public health department do to better define its mission in the community and attract the support of funders?

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**I**n this first session of the forum, expert panelists shared their unique challenges with public health financing and discussed creative outlets for extending and expanding prevention dollars.

Panelists included [John Auerbach, MBA](#), a professor of practice in the Department of Health Sciences and the director of the Institute on Urban Health Research at Northeastern University; [David W. Fleming, MD](#), the director and health officer for Public Health — Seattle & King County; and [James Hester, PhD](#), a health care consultant and former acting director of the Population Health Models Group at the Innovation Center within the Centers for Medicare & Medicaid Services (CMS), where he helped to develop delivery system transformation and payment reform initiatives.

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*In Massachusetts, a first-of-its-kind trust for community health*

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Since 2006, when Massachusetts passed health care insurance reform, the percentage of the state’s adult population covered by health insurance has risen

to 98 percent. Some of the state’s success stories so far include narrowing health care disparity gaps, especially between white and black patients, and a dramatically reduced smoking rate among Medicaid recipients thanks to new smoking cessation benefits. According to a survey conducted by the Massachusetts Department of Public Health, the reduction of smoking among Medicaid patients has led to a significant decrease in the number of heart attacks as well.

But gaps still exist: Not all residents have health insurance, and not everyone makes the best use of the coverage they have. More than half of the remaining uninsured population of Massachusetts did not see a doctor or a specialist in the past 12 months.

“Simply having health care doesn’t mean you are going to see a doctor,” said Auerbach, who served as Massachusetts commissioner of public health from 2007 to 2012.

To close that gap — and to slow the pace of rising health care costs — [Massachusetts created the Massachusetts Prevention and Wellness Trust Fund](#), a

four-year, \$60 million project to fund collaborative, community-based prevention and health promotion projects in the state. The program, launched in 2012, was the first of its kind.

“We thought it was a real victory to have such strong support, to have prevention as a practical way to reduce costs and, of course, be important for health,” Auerbach said. “[The grants] create conditions to make sure that the residents of the community are healthy.”

Massachusetts officials are also working on a state-wide initiative, [Mass In Motion](#), to promote healthy eating and active lifestyles. Mass In Motion is a collaboration between various government agencies, including the state Department of Transportation and the state Department of Elementary and Secondary Education, and is designed to mobilize communities around improving the quality of life for all residents.

However, the program couldn’t rely solely on public funds, Auerbach said. Private funders — including a local insurance company and other provider groups — also saw the benefit of investing in community-based prevention and contributed \$5 million to the project, which was bolstered with additional funding through the federal [Community Transformation Grants](#) program. Today, Mass in Motion is an \$8 million program through which funding is available to 50 different cities across the state.

Through its innovative funding strategies, Massachusetts serves as a public health laboratory — a test kitchen for ambitious solutions and emerging best practices.

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### *Funding the “trunk” of public health*

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It’s one thing to drum up funding for specific programs and initiatives, but how can public health find sustainable resources for its core functions?

“The financing system for governmental public health in this country is broken — some would say profoundly broken,” said Fleming as he addressed the forum panel and audience.

A fragmented funding scheme, consisting of multiple independent funders of specific programs at

the state, local and federal levels, doesn’t create a cohesive public health system, Fleming argued.

“As a public health community, we’ve never gotten together and asked ourselves realistically, ‘What is that core base of functioning that we need to have in order to do our work and how much does that cost,’” Fleming said.

Last year, the Institute of Medicine published [“For the Public’s Health: Investing in a Healthier Future.”](#) The report makes the case that in order to improve health outcomes, we must transform the way the U.S. invests in health. This means paying more attention to population-based prevention efforts; changing how public health funding is allocated, structured and used; and ensuring stable funding for public health departments.

“But what does all that really mean,” Fleming asked. “If you think of public health as a tree, you can think of the programs and services as the leaves and the branches of that tree. But you cannot have a living tree if you do not have a trunk — something that supports those activities.”

Today, we need to find stable funding for the “trunk,” which represents the core functions and foundations of public health. In his work in the state of Washington, Fleming has tried to address this by establishing a few core principles and questions:

#### **1 Embrace categorical funding:**

“As much as we might not like categorical funding, that is the way the world works,” Fleming said. “We are not going to propose an alternate finance system that magically makes it go away.”

#### **2 What needs to be present everywhere for the system to work anywhere?**

This is a question all public health departments need to ask themselves. “This is not about the 10 essential services, and this is not about everything you want to do in your public health department,” Fleming said. “This is about functioning so that the departments around you will be able to help you get your work done.”

#### **3 Be specific:**

Public health departments are often unable to prioritize their needs, and that can complicate

financing initiatives. Be specific so that at the end of the day, you can create a price tag.

#### 4 What does the individual need?

In a post-health care reform nation, public health needs to focus on what people and communities need, not on who is delivering the care.

Public health must also stake out its unique role in a time in which many more people will have access to medical care. Practitioners must also be able to articulate to policymakers why a robust, well-funded public health infrastructure is a critical partner in the age of health reform.

The Washington State Department of Health is working with RWJF to define these funding principles at a national level. To start, they drafted a list of “foundational services.” These include assessment (surveillance and epidemiology); emergency preparedness; communications; policy development and support; community partnership development; and business competencies. Then they established “foundational programs,” including communicable disease control; chronic disease and injury prevention; environmental public health; maternal, child and family health; access to clinical care; and vital records.

While this approach may not be perfect, Fleming said it created a “system bonding experience” that helped staff across the state’s many public health divisions and programs set common goals.

#### *Finding new ways to invest in population health*

As the country’s health care system moves from payment-focused to quality-focused, how do we ensure that population health has access to newly available funding streams?

“How to pay for population health is a simple question to ask, but remarkably difficult to answer,” said Hester, who helped pioneer Vermont’s enhanced medical home program.

The key building blocks for population health funding models are complex and relatively weak. As a result, Hester said he believes there is a risk that they will not be incorporated into new payment models in a meaningful way.

As in Massachusetts, Vermont’s health care reform policies greatly increased insurance coverage: In 2012, about 7 percent of Vermont adults and about



Ron Bialek, MPP Public Health Foundation  
Credit: EZ Event Photography

2 percent of children were uninsured, compared to a nationwide uninsured adult rate of 17 percent. But the transformation of public health will require new ways of thinking about the health care system, even with low uninsured numbers.

“People were really excited about CMS getting involved in population health,” he said. “But the CMS actuaries have to be satisfied at the end of the day.”

One approach that has shown promise in Vermont is embracing the testing phase of various finance models, from capitation to shared savings. Pilot programs across the country have provided examples of how other states are creating stable finance models for their public health departments, such as leveraging tobacco tax dollars, taking a grassroots approach to fundraising, and creating foundations or trusts to fundraise for public health initiatives.

“We are in a testing phase right now,” Hester told attendees. “I’m encouraged in terms of the possibilities, but sobered by the task.”

The crux will be figuring out the best way to model and measure results, Hester said.



Credit: EZ Event Photography



# Exploring & spanning boundaries

Life spans are increasing, but so are rates of chronic disease. Technology is rapidly advancing, and so is income inequality. Public health, given these changes, must be ready to adapt. In the forum's second session, panelists discussed how their communities came face-to-face with and overcame daunting challenges and embraced new opportunities.

Public health, given these changes, must be ready to adapt. In the forum's second session, panelists discussed how their communities came face-to-face with and overcame daunting challenges and embraced new opportunities.

Panelists included [Charlotte Parent, RN, MHCM](#), deputy director of health for the City of New Orleans; [John Wiesman, DrPH, MPH](#), secretary of health for the Washington State Department of Health; and [Gene Nixon, MPA](#) commissioner of Summit County Public Health in Ohio.

## *“What do you want your health department to look like?”*

Parent began her presentation by showing attendees early photographs of the New Orleans Health Department. Workers in the century-old photo were providing services, such as home visits with new and expectant moms, which are still part of the health department's mission today. It was an example that while communities may face new challenges, core values and needs often remain the same.

However, after Hurricane Katrina, the New Orleans Health Department saw an opportunity to wipe the slate clean. What did they want to look like as a health department? How could they best serve the community? For instance, af-

ter the devastating storm, three neighborhood clinics closed, and so the city's health department stepped up and began operating those clinics. But was this the appropriate role for public health workers?

“We were not doing it well,” Parent said. Other changes after the storm included moving Emergency Services under the wing of Homeland Security, running the Ryan White Program for HIV/AIDS patients from the Mayor's Office, and morphing the Environmental Health branch of the department into Code Enforcement to observe and monitor neighborhood blight.

In 2010, with the election of a new mayor and appointment of a new health commissioner, the health department began to focus on reform. They created three goals to accomplish during this restructure: advance the health department into the 21st century; bring a data-driven approach to strengthening the local health care system; and embed a “health-in-all policies” philosophy within local decision-making. In other words, educate local officials on why every sector, from transportation to education to economic development, has a role in improving the health of residents.

The department also had to make a fundamental decision in regard to providing clinical services, which it began doing more of in the wake of Hurricane Katrina.



*Phil Huang, MD, MPH, Credit: EZ Event Photography*

“Do we do direct services or not?” Parent asked. “Do we put all of our dollars into direct services when we know there is a budding health care system in our community, [which] could probably do this job much better than we could?”

The decision was straightforward, and the department sought alternative ways to provide the community with clinical care. Of vital importance was finding providers who would uphold high standards of quality care and were familiar with and attuned to the community’s specific needs.

After the first nine months of this transition, more than 98 percent of Medicaid patients received care. The transition was a significant shift for the health department too, which lost 35 percent of its full-time employees, most of whom were direct care providers. However, the move allowed the department to redirect almost \$4 million in funds to other areas in need of support — such as internal management, external relationships, strengthening administrative capabilities and creating new program areas — and refocus on population health needs.

Gathering input from the community and asking residents to identify their own needs was also an important part of the transition process.

“The communities spoke really loud and clear when we did that,” Parent said. “Hearing that transportation and public violence were major concerns for the community — it was those kinds of things that we realized the public health department had to help change.”

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### *Leadership in public health departments*

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What kind of leadership does it take to produce real change in a public health department?

Being a strong leader starts with establishing credibility. Wiseman found an opportunity to do this through his department’s budget process. When he first drafted it, he came out about \$1 million over.

“I did not want to do what most people in my position would do at that point, which is go to the board and say ‘We need more money.’” Instead, he told the approving board he was going to figure out how to make his original budget parameters work.

“I never went back to them until I felt like we had a core reason to,” he said.

The department spent years transforming and streamlining

its role in the community and making the case for the value of a strong public health system. For example, the H1N1 flu outbreak of 2009 led to the creation of a single, regional all-hazards incident management team, which elevated public health's role in protecting public safety and helped create new partnerships with police and fire departments. Meanwhile, the department worked to scale down its staff, contracting out to direct medical care providers and reducing from 160 to 80 full-time employees.

In 2010, the approving board took one percentage of the state's property tax and dedicated that solely to the public health department — something most local governments don't do.

As in New Orleans, community input was a vital component of the department's strategy. Wiesman's department opened their meetings to the public for an hour every month. The department also built a strong public health advisory committee that included 21 members of the public. The committee was "essential to the success of this transformation," Wiesman said.

Today, the department is focused on the future, Wiesman says, with a stronger emphasis on improving population health, building connections in the community, and forming relationships with partners.

### *Transformation in Summit County, Ohio*

Summit County, Ohio, is home to one of the first health departments in the country to meet the standards of the Public Health Accreditation Board, and it was the first health department in the state to be awarded five-year accreditation. But in 2010, Nixon, the county's health commissioner, was tasked with consolidating three health departments into one.

It would have been a daunting task for any department leader, but Nixon seized an opportunity to transform the community's public health system.

Consolidating three health districts was intended to enhance efficiencies, create a greater joint capacity, and strengthen collaborative relationships between departments.

"It's easier said than done," Nixon said. "It's one thing to talk about transformational change; it's another thing to talk to managers and get them on board with understanding and conceptualizing this process."

The consolidation saved Summit County \$1.5 million, ac-

ording to a study by Kent State University that assessed the consolidation's impact. But the report also noted a few major strategic challenges created by the consolidation. Chief among them: How could the health department rebuild its relationship with communities?



*Paul Kuehnert, DNR, MS, Credit: EZ Event Photography*

"Our communities were concerned that as we became a big health department, we'd lose our connection with neighborhoods," Nixon said.

In response to these challenges, Summit County Public Health has created several efforts to share experiences and gain feedback from other local, state and national groups. Summit County is using data to track health equity issues in the community and working with other local agencies, such as transportation, to discuss their approach to health equity and economic stability. Summit County was also a key partner in creating an Accountable Care Community in Akron, Ohio, which aligns health care providers with the public sector and philanthropic partners to address chronic and costly health problems, such as diabetes, obesity and asthma.

Nixon acknowledges that there is still much work to be done, particularly in pursuit of five overarching goals developed by the department: address social inequities; improve health; sustain national accreditation; strengthen organizational capacity; and transition from direct services to care coordination.





*Thomas Goetz, MPH, Credit: EZ Event Photography*



# *Building a social movement in support of better health*

How does place impact public health? It was a major theme explored during the second half of the forum. To delve deeper into the concept, two panels explored what it's like to pursue public health in two very different places: Minneapolis, Minn., and San Bernardino County, Calif.

The Minneapolis panel included [Edward Ehlinger, MD, MSPH](#), commissioner at the Minnesota Department of Health; [Gretchen Musicant, RN, MPH](#), commissioner at the Minneapolis Department of Health and Family Support; and [Doran Schrantz](#), the director of [ISA-IAH](#), a faith-based community advocacy organization in Minnesota.

Panelists from San Bernardino included [Dora Barilla, DrPH](#), assistant vice president of Strategy and Innovation at the [Institute for Health Policy and Leadership](#) at Loma Linda University; [Trudy Raymundo](#), director of the San Bernardino County Department of Public Health; and [Evette DeLuca](#), director of [Reach Out](#), a community group focused on helping children and families.

## *Community transformation through community engagement*

The state of Minnesota is already on the public health map — literally. Last year, Minneapolis was among the cities awarded the [RWJF Roadmaps to Health Prize](#). The state was also awarded one of six CMS [innovation grants](#). But for all the progress Minnesota has made, the state is dramatically behind on health equity and disparities measures.

“Minnesota is where health care is strong, public health is

good and all our health statistics are above average,” said Ehlinger. “That is unless you are a person of color or a Native American — then we have some of the greatest disparities in the country.”

The significant health care disparities that many Minnesota communities experience pinpoint the need for quality collaborations between community entities as well as between state and local public health departments, Ehlinger told forum attendees.

San Bernardino County — a California community of more than 2 million residents living across approximately 20,000 square miles — presents its own share of public health challenges. The county is ranked low nationally and considered to be in a public health crisis. However, county officials have created a unique method to improve the county's health status, while incorporating geographic, economic and community-building focal points.

## *Success story: San Bernardino*

Affordable housing brought incredible growth to San Bernardino County in the late 1980s and early 1990s. But that spike in the population didn't come with a corresponding spike in funding and resources for local public health, which would be responsible for protecting and monitoring the health of the rapidly growing region.



*Amaal Tokars, EdD, Kendall County Health Department,  
Credit: EZ Event Photography*

“We didn’t have the realignment dollars, we didn’t have the philanthropy dollars ... we really were challenged, not only with not having the funding and infrastructure, but a community with very poor health outcomes,” said Barilla.

Then in 2006, county officials approved a countywide healthy community initiative to be fueled by general fund dollars and set up similar to a grant system, with seed money allotted to cities that wanted to develop a health initiative. They began with three participating cities. Today, 21 out of 24 cities in the county are home to a healthy city initiative.

To achieve better outcomes with the healthy city initiatives, the communities first needed to go through an envisioning process, said Raymundo, director of public health for San Bernardino County.

“We would ask the community: ‘What do you want this community to look like,’” Raymundo said.

Many residents they spoke with said they wanted a “complete” county. From that conversation, public health officials derived nine core elements that could help create a more complete county, including education, wellness, jobs and the economy, water, the environment, and image and perception.

“All of these things had to work in concert,” Raymundo said. “No one of those single sectors is ever going to sin-

gle-handedly move the county to where it needed to be — what happens to one absolutely affects the other. It really comes down to a paradigm shift.”

The community envisioning process led to a community-driven initiative called Community Vital Signs, which looks at health and wellness through a multitude of metrics rather than just the standard medical lens.

San Bernardino officials also focused on the partnerships needed to bring better health to fruition. Barilla, at the [Institute for Health Policy and Leadership](#) at Loma Linda University, has been working to engage local hospitals in community conversations about health improvement, particularly in the San Bernardino city of Ontario.

“It’s always been interesting to me how health systems and public health never collaborated in a meaningful way,” Barilla said. “There was a lot of collaboration with some folks, but it wasn’t effective collaboration — meaning getting everyone to move forward in the same direction.”

The city of Ontario eventually created a guiding principle to help them stay focused on what they were trying to achieve with their health initiative: “Empower the community of Ontario to take ownership of its health and make Ontario a model city by improving physical, social and economic health and well-being.”

This became a “mental model,” which was eventually adopted by the county at-large.

“That was something we really focused on – that it wasn’t just a program, but a mental model of how we create community,” Barilla said.

To create a sustainable funding stream for this endeavor it was important to take a data-driven approach so that community investors could see how the city and county health initiatives created change. It also helped hospitals and public health departments work further upstream. For example, they could map from which neighborhoods asthmatic patients were coming from when they checked into the emergency room, which could help pinpoint areas where public health workers could focus prevention strategies.

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### *Success story: Minneapolis*

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Community involvement has been core to public health work in Minneapolis, too. Ehlinger identified community engagement as one of the greatest resources in the public health toolbox.

“We need everybody engaged in creating health. We need all parts of the population engaged. They need to be empowered and they need to change the conversation about what creates health,” he told attendees, noting that the very panel he was speaking with provided a great example of quality collaboration. “We are trying to build that in, to get communities engaged and to own the issue, and to change the conversation about what creates health.”

Structurally, Ehlinger said his role in the state public health department is to empower local public health departments and community organizers so that they have a stake in improving the community’s health. The ultimate goal is to create an integrated health care system — including medical care, long-term care, behavioral health and public education — that is embedded in the community and is publicly accountable.

A data-driven approach also helps Minneapolis officials focus on impact.

“We have public data that comes out every week on how we

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*“There’s now a cracking open of practice in the health departments that’s going to allow the alignment of community organizations with health departments in a way that I’m not sure I’ve seen before,” Schrantz said.*

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are doing, how city works is doing, and how the police are doing,” said Minneapolis Health Commissioner Musicant. “All that information is public and collected on a regular basis. It’s really a public accountability to see those results, which I think keeps us on our toes.”

It’s vital to harness dedicated funding streams for public health innovation too. For example, Minnesota lawmakers created an initiative called the State Health Improvement Program (SHIP), which focuses on reducing obesity and tobacco use in the state.

“We’ve had a chance now to braid those strategies together towards a common objective,” Musicant said.

Partnering with community organizations has led to positive outcomes as well, while also addressing the issue of health disparities. Schrantz, who serves as director of ISAIAH, a faith-based organization with more than 100 Minnesota congregations as members, is working to create a social movement for racial and economic equity. For the

last five years, ISAIAH has been involved in health-related issues, in part because the assistant commissioner of the Minnesota Department of Health, [Jeanne Ayers](#), reached out to Schrantz at a local parish and encouraged her to see her work as essentially public health-related.

“Jeanne started bringing analysis and perspective on health to our work, and she did that because as a public health professional she had come to the conclusion that part of the solution to the problem is building a social movement,” Schrantz said. “If we are going to build a social movement, that’s a different kind of work than what’s happening in the public health practices. Not unconnected — deeply connected — but different.”

The relationship between ISAIAH and the public health department led to hundreds of conversations that started to pinpoint the intersections between public health problems and deeply-rooted social issues. (The health equity documentary “[Unnatural Causes](#)” was screened in the basement of many of ISAIAH’s churches.)

“We started linking our issues on transportation and in education and housing to this broader analysis on health. Through that work, we built a lot of relationships in the public health field,” Schrantz said.

Following such success, both state and local public health departments were able to connect with many other community organizations, such as [TakeAction Minnesota](#), [Service Employees International Union](#) and [Jewish Community Action](#).

“There’s now a cracking open of practice in the health departments that’s going to allow the alignment of community organizations with health departments in a way that I’m not sure I’ve seen before,” Schrantz said.

In 2013, the Minnesota state legislature directed the state health department to conduct a health equity report to assess disparities and recommend best practices for promoting health equity. Today, the report is a key rallying point and critical in measuring the state’s progress.

“Now they are using it to reorganize the department and bring in all the circles of stakeholders around the health department to really shape a narrative about what health is,” Schrantz said.

# *Data, innovation and new voices*

Throughout the day-long Boston forum, panelists discussed the need for public health to embrace change, adapt to new ideas and take a data-driven approach. During the closing panel of the forum, these ideas were discussed in even more detail.

Given that the forum coincided with the 141st APHA Annual Meeting, panelist Thomas Goetz, MPH, decided to delve into some public health history. Goetz, former executive editor of *Wired* and now entrepreneur-in-residence at RWJF, noted that around the same time as the first APHA Annual Meeting in the late 1800s, public health pioneer [Hermann Biggs](#), who was working for New York City's department of public health, decided to map areas of the city where patients with tuberculosis were concentrated.

"It was Biggs and his map that were able to turn the tide against TB," said Goetz. "It was not antibiotics — it was an effort on the part of people in public health to help us see disease."

Technology and public health as data-centric disciplines have always made sense together, he said. There's also a direct relationship between what public health professionals and data analysts do.

"Public health folks know that their work is built on an assessment of a community's health through data, and they can interpret that data to inform action. That skill set is what everyone wants to do in their profession," Goetz said.

Goetz stressed the importance of looking at meaningful data that reflect actual outcomes, not just "vanity" metrics that make public health look good. And in a society in which technology has led to more and more transparency, he sug-

gested that it's increasingly important for public health to share and communicate information more openly with the public. He suggested a few different programs — including [Socrata](#), an open data platform, and [Tableau](#) from IBM — that might allow public health professionals to accomplish such a goal.

Goetz spoke alongside Jeannie Hanna, MSN, RN, COHN-S, FAAOHN, director of Integrated Health and Productivity at [The Hershey Company](#); and Massachusetts State House Rep. [Gloria Fox](#), D-Roxbury.

Hanna told attendees that innovation means stepping away from the silos often found in public health and becoming more integrated into the community.

"One of the things we try to do at Hershey is to find ways to partner within the communities in which we operate — where our employees and their families live and where they work," Hanna said.

The company's programs take into account what services are already offered in the community and how Hershey can best supplement those services to meet the community's needs. Hanna oversees deployment of the company's well-being strategy for 13,000 employees worldwide. But she began her career as an occupational nurse and also serves as the president-elect of the [American Association for Occupational Health Nurses](#).





*Cynthia Romero, MD, Credit: EZ Event Photography*

“Occupational health is really a subset of public health. It’s just looking at a different population,” she said.

Hanna called back to something that RWJF’s Kuehnert said during the opening session of the forum — that public health needs to skate to where the puck is going rather than playing a game of catch up. She said that working within the community and as a community will create better partnerships for public health and other sectors of society.

“How do we come up with innovative programs that cut across all of those populations, rather than just looking at our own little buckets of how we address the community as a whole,” she asked.

Rep. Fox closed the forum with a rousing call to action. Not only did she energize the crowd with a warm Boston welcome — riding the high of a recent Red Sox World Series win — but she also pointed out some of the gaps she saw in the day’s discussions.

“There aren’t enough young people here that I know must be in the field,” she told attendees. “They should be incorporated in your conversations. They are going to be the folks that are going to carry these innovative ideas you are coming up with. They also have innovative ideas themselves.”

Fox has been in office since 1985 and has served on a variety of legislative committees. In addition to being appointed to the state’s Joint Committee on Health Care Financing,

she’s also done a lot of work with her district’s health care officials.

“Some of the first health centers were in my district,” she said.

The health care system in Massachusetts is based on strong partnerships with businesses, hospitals and the community, but there are still areas that need improvement, she said.

“Diversity is very important when you are talking about anything that impacts our basic health and well being,” she said. “There are 40,000 people in my district — the majority of the people in my district might be English-speaking, but in the districts around me, they are not. We have to work with our immigrant community, and I don’t see a whole lot of people in here that might be representative of the immigrant community.”

Violence was not a central topic of conversation during the forum either and “when you talk about good health and safety, you have to talk about violence,” Fox said. What could help address this disparity? Fox suggested bringing more outsiders into these conversations.

“We should be thinking creatively and we should be thinking out of the box,” she said. “To do that, we’ve got to bring all the minds to the table. It has to be a cross-section of people because everyone has an idea.”

# Conclusion

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Conversations such as those that took place at the Boston forum offer public health leaders critical opportunities to share success stories, swap best practices and discuss how to move public health forward and embrace change.

For Fleming, health officer at Public Health — Seattle & King County, the conversations at the forum allowed him to see how other public health departments are tackling today's big challenges.

"I see public health fundamentally as a team sport. No one individual or one health department is going to have all the answers, so this is an opportunity to talk and learn from what others are doing," he said. "A lot of public health is really based on effective communication, and coming together helps to create more of a common voice around what the issues are or what the answers are. It's a critical success factor, and conferences like this enable that to happen."

For other participants, the forum helped uncover connections between their individual work and the field at-large.

For example, Gretchen Musicant, RN, MPH, commissioner of the Minneapolis Department of Health and Family Support, was pleased to see that her department's mission was aligned with the goals of the forum. "Healthy lives, health equity and healthy environments are the foundations of a vibrant Minneapolis now and in the future," Musicant said. "Our mission includes creating a city that is a healthy place to live, work and play. This idea of place as a conduit for improved community health is something we want to pay attention to." The forum also gave public health leaders across the country the chance to build relationships with their colleagues.

Hanna, of The Hershey Company, said the forum gave her an opportunity to create lasting relationships with other public health officials. "This is the first time I've been to an APHA meeting because I tend to look at things from my perspective as an employer," Hanna said. "This meeting is about what I can bring back not only to my own job, but also as a leader in another membership organization that is focused on the employer health population."

# *What happens next?*

- 1 Public health faces many changes and challenges, from the Affordable Care Act to the economic downturn. But in this shifting landscape, public health departments are responding in transformative ways, rethinking old paradigms and creating new models for structuring and financing public health activities, for engaging community voices, and for harnessing collective action. This adaptive and creative leadership will be key to improving the public's health and to building a culture of health — one in which health is a key component of public and private decision-making.
- 2 During the next year, RWJF and APHA will continue to showcase how the public health system is transforming; the creative ideas and actions for making communities better places to live, learn, work and play; and the leaders who are making it happen. Check out [rwjf.org](http://rwjf.org) and [apha.org](http://apha.org) or follow [@RWJF\\_PubHealth](https://twitter.com/RWJF_PubHealth) and [@PublicHealth](https://twitter.com/PublicHealth) on Twitter.
- 3 RWJF will also seek to provide platforms for public health leaders to connect and share innovative solutions, such as forming a group on LinkedIn and hosting in-person workshops.



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