Plenary Session

Evidence to practice: Using data to see the faces of those we serve

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Dr. Bill Foege, former Director of the CDC and founder of my organization, The Task Force for Global Health, reminds us always to see the faces of those we serve. Living up to his admonition in the Internet Era suggests we have an obligation to use the rich information resources available to us to see the faces and to see them within the context of their lives.

Information and the data from which it is made helps tell the stories of those we serve. Data specific to a community — be that a specific geographic locale or a sub-population of our people — can be used to paint a picture of life in that community or of the lives of the people within a community. Do we not have a duty to seek out the data that can tell us more about those we serve? Do we not have a duty to use data across the spectrum of the social determinants of health to inform community action?

Over the past decade a number of national initiatives have been launched to help community health leaders understand the influence of the many factors that influence population health status. For example, the County Health Rankings (www.countyhealthrankings.org) use an algorithmic approach to rank and prioritize health in every state by county. The variables they use can be debated, yet the impact of ranked health status cannot. The rankings have been shown year after year to provoke community interest, spark debate about the reasons for a county's relative rank and, in some cases, have precipitated legislative action to address health inequities. The 2012 Institute of Medicine (IOM) series For the Public's Health (IOM.2011. *For the Public's Health: The Role of Measurement in Action and Accountability*) also pointed to the need for routine, specific data to assess health (Capturing Social and Behavioral Domains in Electronic Health Records (IOM 2014. Phase 1 and Phase 2 Reports. National Academy Press). In 2014 the Robert Wood Johnson Foundation published the *Data for Health: Learning What Works* report (http://www.rwjf.org/en/library/research/2015/04/data-for-health-initiative.html) describing how five major cities across the U.S. each endorsed a future health vision driven by data. Most recently the National Committee on Vital and Health Statistics (NCVHS) has held hearings to support recommendations to the Secretary of the Department of Health and Human Services aimed at promoting a framework of social determinant domains and associated measures and metrics that public health leaders can use to spark community involvement and action to improve population health.

Painting the picture of a community's health resembles using social determinant data as your paintbrush — that is, using data to portray an accurate picture of the lives of the multiple communities served by public health agencies. We need to use data across the spectrum of social determinants at a sub-county level to inform community-level action. Achieving this goal requires that we understand social determinants and that we provide these data in ways that move community leaders to see inequities and disparities and to see opportunities for actions that prevent disease and promote health.

Data tools are now available and often free. Data sources have multiplied at an astonishing rate. Governments at all levels are beginning to make public data publicly available. And the investment in global health initiatives has sparked rapid innovation around use of data. This innovation can and should be made known to domestic public health audiences to enrich their understanding of what is possible today, even in the poorest parts of the world.

Public health work everywhere is driven by the common desire to prevent disease and to promote and protect health. In the late 1900's the British philosopher and historian of economic thought, Arnold Toynbee, wrote that "the 20th Century will be remembered chiefly, not as an age of political conflicts and technical inventions, but as an age in which human society dared to think of the health of the whole human read as a practical objective."

Toynbee was both right and wrong. Yes, by the end of the last century the nations of the developed world had begun to realize that health for all might be possible. The developed nations also realized that our interests and, ultimately, our health would be threatened by unmonitored and unchecked emerging diseases, by health insecurity, and by growing inequities in health. Dr. Paul Farmer, founder of Partners in Health, put it this way: "The essence of global health equity is the idea that something so precious as health might be viewed as a right." In 2000, speaking to the World Health Assembly, Dr. Bill Foege described the opportunity before us as "having a chance to build a new kind of cathedral, a virtual cathedral of global health. …Every cathedral sits on

a solid foundation. The virtual cathedral of global health will rest on a foundation of information — information that serves the child, that binds community services to improve every child's health, and one that serves providers as they provide care."

Each of these luminaries speaks to this need to use data — the granular facts — to build information that challenges us to act to protect children and to improve the lives of all citizens. Today, we have the opportunity to use data from health care, social services, transportation, criminal justice, environment, housing, education, and public safety to build a community health dashboard that shows in a granular, sub-county dynamic manner where interventions are needed that will lead to better health status.

We know that many factors affect a person's ability to achieve good health. We know that lifestyle impacts health. Where we live and the quality of our housing influences our health. A child born into poverty has an uphill fight to attain optimum health. Access to care and the adequacy of that care influences longevity. The safety of our roads and neighborhoods influences our activity patterns in ways that shape health outcomes. And the quality of one's education further shapes how one perceives choices that change health.

We in the U.S public health community have been about the business of building and supporting the virtuous cycle of health — i.e., improving health leads to improved economic potentials that lead to a better standard of living, which further promotes health improvement. We have, however, reached in many communities a plateau in health improvement brought on by increased chronic illness, obesity among children, deaths and injuries due to intentional violence in many low income communities and unwarranted infant mortality rates associated with inequities in access to care.

We know that optimum health for us as individuals and health at the community level is not only the result of receiving medical care when we're sick. While access to care is critically important and access to sufficient levels of primary care remains a critical priority, creating and sustaining healthy people requires a community context that supports health. Creating healthy communities requires knowing the facts. Our challenge in Georgia, America and across the world is basically a challenge of figuring out how to use social determinants data to paint accurate local pictures that spark action.

Fifty years ago Toynbee was, in effect, arguing that we now have within our reach the power to capture the facts that can change health for the better. Social determinants tell us we need to know facts about a range of issues and factors that influence health outcomes. Our public health discipline tells us that we have an obligation to look at the full picture because it is the picture of the person in the context of his or her community that tells us what can and should be done to open the door for him or her to seek better health.

Data on social determinants provide the colors for the painting we need to paint an accurate picture of Georgia's communities. At its core public health is an information business. We use data to inform our progress on every program we manage, every service we deliver. We use data to monitor progress, track epidemic outbreaks and guide policy formation. We must now use the data that describe the more specific picture of life within the county or city. We can create and promote for every county board of health, legislator, business person and citizen a dashboard of relevant facts and trends showing the local hot spots where health inequities exist, where opportunities for improving the built environment will lead to active lifestyles, and how changes in education, housing and the environment can promote health. The technology to do this exits and is affordable. The data exist but must be mined. We must realize our information imperative to see the faces of those we serve.