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CHRONIC DISEASE DIRECTORS**
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Article/Publication:

Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century

Source:

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Theme(s) and/or STAR Framework Component(s):

- Leadership

Relevant NACDD Chronic Disease Competencies:

1. Develop and support partnerships among public, nonprofit and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the lifespan.
2. Develop skills to expand and transfer knowledge generated by research and evaluation for decision- making about policies, programs, and grant-making related to health disparities and health equity.
3. Demonstrate ability to build capacity at all levels of decision making to promote community solutions for ending health disparities.
4. Demonstrate ability to apply a health equity lens to the development, execution and evaluation of programs
5. Develop and adapt approaches to problems that take into account differences among populations.

Note: Also view [Equity and Chronic Disease Competencies: At-a-Glance Guide](#) at the close of the NACDD Chronic Disease Competencies document.

Introduction/Purpose:

This article elevates an importance for public health leaders, particularly those at the local level, to serve as Chief Health Strategists in a new Public Health 3.0 model focused on to addressing upstream, nonmedical determinants of health (e.g., social services, education, transportation, etc.) in improving health and health equity. Key findings from the US Department of Health and Human Services Public Health 3.0 initiative listening sessions and recommendations are summarized.

Summary:

Public Health 3.0, as presented here, is a call to strengthen and expand public health practice in solving a wide range of factors that affect and challenge population health. It intersects with Centers for Disease Control and Prevention's Three Buckets of Prevention, a framework that shows the integration of health care and public health across three areas of prevention: 1) traditional clinical prevention, 2)



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innovative clinical prevention, and 3) total population or community-wide prevention. Public Health 3.0 focuses on the second and third components above and supports the need to increase engagement in addressing equity and upstream, nonmedical determinants of health. This article describes the evolution from Public Health 1.0 to Public Health 3.0, then describes findings from discussions with local public health leaders in five geographically and demographically diverse communities during listening sessions. Using insights from these listening sessions, dialogue with other leaders, and a review of literature, a set of five broad recommendations to achieve Public Health 3.0 are: 1) Leadership and Workforce, 2) Strategic Partnerships, 3) Infrastructure and Accreditation, 4) Data, Metrics, and Analytics, and 5) Sustainable and Flexible Funding. For each recommendation, there is a full list of supportive actions; for example, a Leadership and Workforce action pertains to the development of best practice models and training for public health leaders' roles as Chief Health Strategists. The article concludes with early uptake of the recommendations, key barriers, and other considerations for implementing Public Health 3.0.

Application to Chronic Disease Leadership and Practice:

Despite the progress in public health at large and with chronic disease initiatives over the past century, there are persistent shortfalls to achieving optimal, equitable levels of health across populations of people that can be addressed through implementation of Public Health 3.0 recommendations and aligned actions. The article provides chronic disease practitioners focused steps to apply to their own work in improving chronic disease health outcomes and population health overall.

Reflection Questions (to consider upon reading the full article):

1. What are the key drivers (e.g., frameworks, plans, policies, including "little p" policies, etc.) that influence your state's Public Health 3.0 approach?
2. What opportunities that reflect Public Health 3.0 recommendations have you leveraged and found to be most useful in your chronic disease work?
3. Which of the five recommendations and aligned actions has your unit or team been focused on the most? What processes and results are you most proud of and why?
4. Conversely, which of the five recommendations and aligned actions does your unit or team wish to be more intentional about? What do you see as the benefits for chronic disease once you take greater steps in this area?
5. How do you envision your unit or team's role in building local public health leaders to serve as Chief Health Strategists? What supports do you need to accelerate this movement and community level uptake across your state?

Additional Notes:

An Editor's Note identifies this article as a joint publication initiative of Preventing Chronic Disease and NAM (National Academy of Medicine) Perspectives.