



Health in All Policies (HiAP)

*Exploring the Role of Three Federal
Departments in Influencing Health*

AUGUST 2019



BIPARTISAN POLICY CENTER

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ACKNOWLEDGMENTS

The Bipartisan Policy Center would like to thank the Robert Wood Johnson Foundation for its generous support of this work. BPC extends a special thanks to the many dedicated officials at the U.S. Departments of Education, Treasury, and Labor for contributing their time and expertise. BPC would also like to thank Hannah Martin, Alex Mays, and Nick Hart; their work was essential to completing this report.

DISCLAIMER

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Glossary of Acronyms

CDC	Centers for Disease Control and Prevention
CHNA	Community Health Needs Assessment
CMS	Centers for Medicare and Medicaid Services
DOJ	U.S. Department of Justice
DOL	U.S. Department of Labor
DWG	Dislocated Worker Grants
ED	U.S. Department of Education
ESEA	Elementary and Secondary Education Act
ESSA	Every Student Succeeds Act
ETA	Employment and Training Administration
FY	Fiscal Year
HiAP	Health in All Policies
HHS	U.S. Department of Health and Human Services
HUD	U.S. Department of Housing and Urban Development
IRS	Internal Revenue Service
LIHTC	Low-Income Housing Tax Credit
OMB	Office of Management and Budget
OSHA	Occupational Safety and Health Administration
PBIS	Positive Behavioral Interventions & Supports
SCCTG	Strengthening College Training Grants
SIPPRA	Social Impact Partnerships to Pay for Results Act
TAACCCT	Trade Adjustment Assistance Community College and Career Training
Treasury	U.S. Department of the Treasury
WIOA	Workforce Innovation and Opportunity Act
WSCC	Whole School, Whole Community, Whole Child model
WWC	What Works Clearinghouse



Executive Summary

Many factors influence individual health beyond clinical services, including socioeconomic status, education, housing, nutrition, and more. Given this, optimizing the nation's health requires coordinated, shared responsibility across various sectors, and these efforts must be reflected in the programs, activities, and initiatives of the entire executive branch of government. While the U.S. Department of Health and Human Services has a substantial responsibility in advancing the health of the nation, other federal departments and agencies can also have a significant impact on disease prevention and health promotion. Health in All Policies (HiAP) is a strategy that considers the factors that influence health across all levels of policymaking to improve health outcomes.

In this study, the Bipartisan Policy Center explores how three executive branch departments—the U.S. Department of Education (ED), U.S. Department of Treasury (Treasury), and U.S. Department of Labor (DOL)—currently implement a HiAP approach and how these departments can build on these efforts. The report is not meant to be an exhaustive examination, but it does highlight specific examples from these departments, and it offers considerations and recommendations to those departments and to the Executive Office of the President of the United States to expand on this approach.

The ED has begun integrating health into its policymaking through various programs and initiatives, including the Promise Neighborhoods program, which mitigates family and community poverty to improve health and overall school performance. The ED can continue to influence and advance health through the Every Student Succeeds Act, which sets K-12 public-education policy for states and schools across the country.

- The ED should integrate health and wellness within existing guidance on needs assessments and evidence-based interventions to provide support for issues related to student behavioral and mental health needs and chronic absenteeism.
- In consultation with the U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention, the ED should develop better guidance for states that have included chronic absence as a measure of school quality, given that it is strong proxy measure for various health conditions.
- The ED should support efforts to increase access to school health providers such as psychologists and social workers, as these providers help address the needs of the whole child.

The Treasury's activities influence health in many ways, most notably through tax policy. An impactful example is the Low-Income Housing Tax Credit, which provides tax credits to private investors to support the development of affordable housing, contributes to social, economic, and educational benefits for communities and families and also helps reduce homelessness. The department has a similar opportunity to optimize health through community benefit requirements for non-profit hospitals to maintain tax-exempt status. Provisions of the Affordable Care Act now require institutions to complete a community health needs assessment every three years and to develop a community implementation plan.

- Congress should require community benefit implementation plans be made public.
- The Internal Revenue Service should partner with the U.S. Department of Health and Human Services to develop guidance that assists hospitals in connecting the needs assessment with evidence-based implementation strategies.
- The Internal Revenue Service should consider including community building spending activities under the community benefit spending category to maximize opportunities for hospitals to address the broader determinants of health.

The DOL's policies influence American workers' ability to perform at work and at home. A crucial factor in performing at work and at home is health. Past DOL initiatives have been quite successful, including the DOL's Trade Adjustment Assistance Community College and Career Training program, which created a path to economic stability and better health outcomes for nearly 500,000 students in the United States. One way the DOL supports stable employment is by allowing a variety of employment and educational training grants to cover supportive services, such as child care and transportation. However, there is significant variability in the language surrounding supportive services and the guidance therein.

- The DOL should clarify and, where possible, standardize supportive-services opportunities across all of their grants.

- The DOL should consider increasing funding flexibility in grant programs so that grantees can provide additional supportive services based on individual community needs.

All executive branch departments should consider adopting a HiAP approach with respect to policymaking whenever feasible. The current administration could build on the prior administration's National Prevention Strategy, which 17 federal departments developed to prioritize health and quality of life for all Americans. Alternatively, the current administration could support a similar HiAP approach in several different ways.

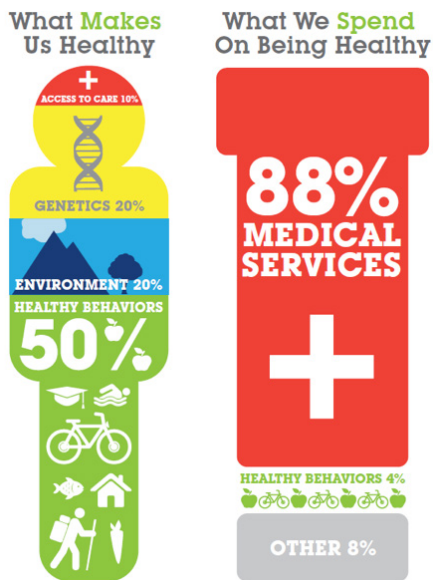
- The Office of Management and Budget could ask that departments integrate a HiAP approach into their quadrennial strategic plans as well as into their annual budget submissions.
- The Office of Information and Regulatory Affairs within the Office of Management and Budget could require departmental regulatory proposals to include health impact assessments, where applicable.
- The White House Domestic Policy Council could convene leaders from select departments to establish a HiAP council. The U.S. Department of Health and Human Services could provide technical assistance to the council regarding the determinants of health and the evidence-based policies that support them.

These options would catalyze a more robust and comprehensive approach to HiAP across the executive branch. Health is impacted by not only health care but also by a plethora of societal factors. The time is ripe for all federal policymakers to appreciate their respective roles in creating a healthier America.



Introduction

There is widespread agreement that improving population health requires effort and leadership beyond the health care sector. Though the United States continues to make advancements in science and medicine, Americans have worse health outcomes when compared with their counterparts in similarly wealthy countries in the Organisation for Economic Co-operation and Development.¹ For example, Americans live shorter lives and have higher rates of infant mortality.² Many drivers of poor health in the United States are preventable; however, these determinants cannot be addressed by any one sector alone or within the four walls of a doctor's office or hospital. Effectively addressing these determinants means forging multisector partnerships that work toward the common goal of improving health.



Source: Bipartisan Policy Center. 2012. "Lots to Lose: How America's Health and Obesity Crisis Threatens Our Economic Future". Derived from data from The Boston Foundation.

Social determinants such as one's environment, education level, and socioeconomic status are the conditions in which people work, learn, live, and age that significantly impact health. Most of these factors are not within the direct control of the health care sector. As such, policymakers across all sectors have the potential and the opportunity to improve health outcomes. Health in All Policies (HiAP) is a strategy that necessitates the inclusion of health considerations, such as mitigating social determinants, across all levels of policymaking to improve health outcomes.

Federal policies have a profound influence on the way people live their lives. Their impact reaches across health outcomes and behaviors. For example, new nutrition standards passed in the Healthy, Hunger-Free Kids Act of 2010 led to healthier breakfast and lunch options, advanced healthier eating habits at schools, and increased participation in school meal programs.³ Under the new requirements, schools are offering meals with more greens, whole fruits, whole wheat and with fewer empty calories. Federal action created stronger nutrition standards that affect the lives of millions of children who rely on receiving breakfast and lunch at school.

This report examines the ways three federal departments that do not directly engage in public health can influence positive health outcomes. In particular, the Department of Education (ED) fosters healthy, safe, and supportive schools, a critical role given that healthy students are better learners. Through their influence on tax policy, the U.S. Department of Treasury (Treasury)

incentivizes investments that support key determinants of health. Finally, the Department of Labor (DOL) supports the well-being of workers and job seekers to maximize economic productivity. By exploring the ways in which the Departments of Education, Treasury, and Labor affect health outcomes, BPC can spotlight their roles and identify opportunities for these departments to enhance their efforts.

METHODOLOGY

This report was developed with critical insight from several dozen policy experts, health stakeholders, practitioners, and staff from the selected federal departments. Department career staff, senior government officials, and political appointees provided important guidance in understanding the role each department could play in advancing health outcomes. To further inform this work, the Bipartisan Policy Center reviewed existing departmental strategic plans and publicly available information to identify how the federal departments currently shape health behaviors and outcomes at the national, regional, and local levels.

BPC also recognizes the significance of congressional action in federal policymaking. Congressional action is often the vehicle that drives policymaking due to its funding and authorization power. While this report focuses on efforts at the Departments of Education, Treasury, and Labor, several suggested actions require cooperation from Congress to encourage the integration of health in all policymaking.



The U.S. Department of Education

STRATEGIC PLAN

In recent years, educational institutions and providers have increasingly recognized the need to support the health and well-being of the whole child, including mental health, school safety, and quality nutrition. The ED's 2018-2022 strategic plan aligns with this trend specifically in strategic goal number one, which prioritizes access to high-quality education opportunities and support for evidence-based strategies to improve academic performance. However, the ED cannot achieve these goals without understanding the critical connection between health and learning. Many factors that affect children's academic performance are health-related. Students need safe and supportive educational environments to ensure healthy development.⁴

DEPARTMENT OF EDUCATION 2018-2022 STRATEGIC GOALS	
1	Support state and local efforts to improve learning outcomes for all PreK-12 students in every community.
2	Expand postsecondary educational opportunities, improve outcomes to foster economic opportunity, and promote an informed, thoughtful, and productive citizenry.
3	Strengthen the quality, accessibility, and use of education data through better management, increased privacy protections, and transparency.
4	Reform the effectiveness, efficiency, and accountability of the ED.

The Center for Disease Control and Prevention's (CDC) Whole School, Whole Community, Whole Child (WSCC) model provides a framework for addressing health in schools.⁵ The WSCC model's 10 components (Figure 1) emphasize the importance of the social and physical environment on health and academic achievement. Healthy and safe environments require participation across all sectors, including the public sector. The ED's policymaking plays a considerable role in shaping the health and educational development of children nationwide. Key to achieving this goal is extending support to all children, including those in vulnerable communities.

The ED recognizes health as a protective component in reducing risk factors that make it more difficult to be successful in school. For example, promoting mental and behavioral health is an essential facet in this work. The ED has directed the integration of mental and behavioral health into many of its efforts, including the Positive Behavioral Interventions & Supports (PBIS) Office of Special Education Programs Technical Assistance center.⁶ Funded by the ED's Office of Special Education Programs and the Office of Elementary and Secondary Education, the PBIS center is the ED's longest-standing investment in mental and behavioral health. Since its establishment in 1997, when Congress amended the Individuals with Disabilities Education Act, the center has delivered technical support to education systems around the country.⁷ Beyond technical assistance, the PBIS center works to change the culture and understanding of mental and behavioral health by implementing a PBIS framework that can be adopted in all schools to support the social, emotional, and behavioral health of all students.⁸

Additionally, the ED has collaborated with other federal departments to protect the health of all school-age children. The Promise Neighborhoods grant program exemplifies this undertaking. The Promise Neighborhoods Program began in 2010 under the legislative authority granted by the Fund for the Improvement of Education.⁹ The Promise Neighborhoods program addresses generational family and community poverty, which can have lasting impacts



on health and school performance.¹⁰ An important development in the Promise Neighborhoods program was the White House Neighborhood Revitalization Initiative, which called for the coordination of other federal community-based programs, including the U.S. Department of Housing and Urban Development (HUD), the U.S. Department of Justice (DOJ), and the U.S. Department of Health and Human Services (HHS).¹¹ Under this initiative, the DOJ transferred \$1.6 million to the Promise Neighborhoods program to fund Public Safety Enhancements among 2011 grantees.¹² From there, the DOJ and the ED provided technical assistance to grantees. As of 2018, over 1,000 national, state, and local organizations have worked with Promise Neighborhoods, benefiting children at over 700 schools.¹³

The ED continues to approach educational success by addressing the social, physical, and behavioral determinants that affect the health of school-age children. The ED has undertaken many meaningful efforts, but this report will focus on one bipartisan measure, the Every Student Succeeds Act.

EVERY STUDENT SUCCEEDS ACT

Originally passed in 1965 as the Elementary and Secondary Education Act (ESEA), the bill was a civil-rights law dedicated to providing access to education to all children.¹⁴ ESEA grants targeted low-income students, funded special education centers, and provided materials to schools. Further, the law provided funds to state educational agencies to improve the quality of education. The reauthorization of the Every Student Succeeds Act (ESSA) in 2015 replaced ESEA.¹⁵

ESSA passed in December 2015 and set K-12 public-education policy for states and schools across the country. This was the first major overhaul of the national education law since the No Child Left Behind Act became law in 2001. ESSA gives states and districts new flexibility to craft policies and spend money to address their most pressing needs. In addition, the law recognizes the need for schools to support the whole child and explicitly acknowledges the importance of mental health and wellness. For example, Title I of ESSA requires states to include a measure of school quality or student success in their state accountability systems. Thirty-six states and Washington, DC, selected *chronic absence* as a measure of school quality.¹⁶ Chronic absence, most commonly defined as missing 10 percent or more of the school year for any reason, is a powerful early warning predictor of student performance and a strong proxy measure for a host of physical and mental health issues.^{17,18} Specifically, Title II of ESSA provides funding to state and local education agencies to support professional-development programming for principals, teachers, and other school personnel.¹⁹ Title II highlights professional-development programming as a way to support school staff in recognizing and addressing student behavioral and mental health needs and chronic absenteeism.

ESSA also lists several requirements to ensure education agencies reach the goals of the act, including:

- **Needs assessments.** ESSA requires local education agencies to conduct needs assessments in several situations, including for schools identified as in need of comprehensive support and improvement—the lowest-performing 5 percent of Title I schools in the state. Agencies must then implement evidence-based interventions to address the issues identified in the assessments.
- **Implementation plans.** Agencies must meet the needs identified in the assessments in their implementation plans.
- **State accountability plans.** Every state must include a measure of school quality or student success in their state accountability systems.

The implementation of ESSA at the federal level and compliance with the law by state and local education agencies, such as state boards of education and school districts, provides a critical opportunity to more fully integrate health and wellness into education policy and practice. As a major piece of legislation in education policy, ESSA shapes the educational environment for children nationwide. Throughout ESSA, the ED

Figure 1



Source: Centers for Disease Control and Prevention, "Whole School, Whole Community, Whole Child (WSCC)," 2019. <https://www.cdc.gov/healthyschools/wscs/index.htm>

acknowledges the need to holistically support students as many determinants of health drive students' ability to learn and play. Just as the ED emphasized the need to integrate mental and behavioral health into schools, it also can enhance protections of mental and physical health by improving access to school health services.

SCHOOL HEALTH SERVICES

Increasing access to school health providers is an important strategy to reach vulnerable and underserved children and to support children's health and academic achievement.^{20,21,22} School health providers include physicians, nurses, social workers, psychologists, and others who work directly for the school or who are serving schools through school-based health centers or other partnerships with local health providers.

Studies show that health care provided in school settings can reduce health care costs and improve access to and quality of care.²³ For example, increasing access to school health services has been shown to reduce students' emergency room visits, resulting in significant health care savings.²⁴ In addition, school health providers can facilitate enrollment in public health insurance programs, including Medicaid and the states' Children's Health Insurance Programs.

While schools have emerged as important places to address childhood asthma, obesity, mental health problems, and other health issues, more than half of public schools do not have a full-time school nurse or counselor, and less than 5 percent of the nation's students have access to services through a school-based health center. Schools serving low-income students have far fewer health services than schools serving middle- and upper-income students.

Fortunately, there are new opportunities for schools and school health providers to better integrate with a health care system that increasingly prioritizes prevention, population health, care coordination, and chronic disease management. For example, Medicaid developed a set of health quality care measures for children that states can voluntarily report on. One of these measures is screening for depression and developing a follow-up plan for children ages 12 to 17.²⁵ In 2024, Medicaid will hold states accountable for these measures as the reporting will become mandatory. Another example is new financing arrangements, such as accountable care organizations, which are pushing the health system to think about partnerships with those who can offer comprehensive health services. Schools are well positioned to be a major part of this transforming health care system.

In addition, the Centers for Medicare and Medicaid Services (CMS) issued a State Medicaid Director's Letter in December 2014 that removed a key barrier to funding school health services: the free care policy.²⁶ The free care policy states that Medicaid funds cannot be used to pay for services that are available without charge to everyone in the community. The policy had long been an impediment to allowing schools to receive reimbursement from Medicaid for services delivered to non-special-education students enrolled in Medicaid. Since CMS reversed the free care policy in the December 2014 letter, schools can now provide students with care and bill Medicaid. The current policy clearly states that schools can provide free care if certain conditions are met: (1) the student is enrolled in Medicaid; (2) the service provided is covered by Medicaid; and (3) the provider meets all federal and state provider regulations.²⁷

While clarification of the free care policy removes a major barrier to accessing funding for school health services and represents an important step toward ensuring that students have access to quality health care in schools, there is a critical need to support states in implementing this policy change.²⁸ Many states are taking important steps toward implementing this change, but they need federal guidance and support to ensure that they are able to effectively leverage this new opportunity.²⁹

KEY CONSIDERATIONS

BPC recognizes the meaningful work that the ED continues to do to create safe and supportive education environments. See below for additional opportunities.

- 1. The ED should integrate health and wellness within existing guidance on needs assessments and evidence-based interventions to provide support for issues related to student behavioral and mental health needs and chronic absenteeism.**



Given the flexibility ESSA allows states and the opportunities the law presents for supporting student health and learning, ESSA presents an important opportunity to ensure students are healthy and ready to learn. The ED can play a key role in supporting states in carrying out effective implementation that emphasizes the connection between health and learning through guidance and technical assistance. Many non-governmental organizations provide valuable resources to support the integration of health in ESSA implementation plans including Healthy Schools Campaign, Alliance for a Healthier Generation, American Heart Association and The Pew Charitable Trusts.^{30,31,32,33}

States can use the ED's What Works Clearinghouse (WWC) as a resource for providing technical assistance. The WWC currently works to review standards and contribute to the development of education programs, products, practices, and procedures. In this case, the WWC can provide the high-quality research and evidence-driven approach that states need to identify what really works in schools. States can then use these valuable insights to develop the interventions that address the needs identified in their state.

2. The ED should develop guidance for measuring chronic absence as a quality indicator in state plans.

ESSA created a strong state accountability system. However, the ED has an opportunity to provide better guidance on quality measures that impact students' mental and physical health. Many states—36 states and Washington, DC—recognize and have selected chronic absence as a measure of school quality.

In consultation with HHS and the CDC, the ED should develop guidance for states and school districts on defining and measuring chronic absence as well as on effectively using chronic absenteeism data in early warning and intervention systems. Since most states have selected chronic absence as an indicator, the ED has an important opportunity to address this urgent need.

3. The ED should support efforts to increase access to school health providers.

Making this commitment presents an important strategy for reaching vulnerable and underserved children and supporting children's health and educational achievement. Given that children spend much of their time at school, the ED can support access to a more comprehensive approach—including social workers and psychologists—to keep children healthy and ready to learn.

Under Title II of ESSA, the ED provides funding for state and local-level education agencies to increase the number of principals, teachers, and other school personnel who are effective in improving student academic performance.³⁴ The ED should work with Congress to include health service professionals under Title II. The funding would allow states to increase access to health service professionals and to more effectively address the needs of the whole child. Due to profound evidence that demonstrates the influence of health on academic performance, the ED has an opportunity to improve health outcomes and thus improve academic performance.

Additionally, the ED can issue a letter to chief state school officers that emphasizes the role school health services can play in advancing student health and achievement and that highlights opportunities for expanding school Medicaid programs, including implementation of the free care policy reversal.



The U.S. Department of Treasury

STRATEGIC PLAN

Treasury endeavors to maintain a strong economy and to promote conditions that allow for economic growth and stability. In their 2018-2022 strategic plan, Treasury details five objectives that contribute to its overall mission. While Treasury does not explicitly mention health in its strategic goals, the outcomes of several of these objectives can positively impact health. The strategic plan highlights the importance of economic growth, financial stability, and workforce opportunities, all of which contribute to socioeconomic status. There is substantial evidence demonstrating that economic stability is a powerful indicator of health.

DEPARTMENT OF TREASURY 2018-2022 STRATEGIC GOALS	
1	Boost U.S. economic growth.
2	Promote financial stability.
3	Enhance national security.
4	Transform government-wide financial stewardship.
5	Achieve operational excellence.

Beyond its broad strategic goals, Treasury has also been tasked by Congress to improve the social circumstances of vulnerable populations through innovative financing models. As part of the Bipartisan Budget Act of 2018, Congress passed the Social Impact Partnerships to Pay for Results Act (SIPPPRA) to support “pay for success” projects that produce “measurable, clearly defined outcomes that result in social benefit and federal, state, local government savings.” Many outcomes of interest under SIPPPRA are directly relevant to population health improvements, including reducing teen and unplanned pregnancy, improving birth outcomes and early childhood health, reducing chronic diseases, and improving the health of those with mental health needs. Additional outcomes relate to the broader social determinants of health, such as improving employment and earnings as well as reducing the rate of homelessness. Treasury will select and announce participating organizations later this year.³⁵

Another important role for Treasury in influencing health outcomes is through federal tax policy. The Low-Income Housing Tax Credit (LIHTC), which provides tax credits to private investors to support the development of affordable, multifamily housing, also contributes to social, economic, and educational benefits for communities and families; it also helps reduce homelessness. Since its inception in 1986, the LIHTC has helped to finance roughly 3 million affordable rental units, which have served approximately 7 million low-income households. BPC’s 2017 report, *Building the Case: Low-Income Housing Tax Credits and Health*, summarized the evidence of how affordable housing, more broadly, contributes to positive health outcomes, particularly for populations with special health needs, such as HIV, asthma, and substance use disorders.³⁶ In line with previous BPC



recommendations, Congress recently introduced a bipartisan, bicameral bill to expand support for the tax credit by 50 percent. Over 10 years, the bill aims to increase affordable housing production by more than 384,000 homes as compared with the number of homes produced today.³⁷

Finally, the Internal Revenue Service (IRS) regulations of charitable organizations have a more direct health-related impact as many hospitals and health care provider organizations may qualify for tax deductions. The section below describes this specific area in-depth and offers insights.

THE HISTORY OF COMMUNITY BENEFITS

Health policy experts have paid a great deal of attention to improving hospital metrics, patient satisfaction, and care. However, with a nod to the social determinants of health, hospital spending and practices can also have a meaningful impact on community health. Tax policy has long provided a space for Treasury to influence hospital spending on community health and development.

Since 1917, the IRS has allowed organized entities that provide charitable care to qualify for tax deductions.³⁸ In 1956, the IRS established a tax-exempt policy that allowed hospitals to qualify as tax-exempt under §501(c)(3) if they conducted charity care for individuals unable to pay for medical services, formally known as the “financial ability standard.”³⁹

Four years after the enactment of Medicaid and Medicare in 1965, the IRS updated the financial ability standard with congressional support to provide a more detailed qualification standard called the “community benefit standard.”⁴⁰ The new standard prioritized health promotion, emphasizing its importance in charity care and necessity in advancing community health. The community benefit standard applies to other health care provider organizations, such as clinics and health maintenance organizations, in addition to traditional hospitals. The 1969 ruling considered several factors in determining whether a hospital qualified as charitable, including:

- An open emergency room to all persons regardless of ability to pay;⁴¹
- An independent board of trustees comprising representatives from the community;
- An open medical staff policy with privileges available to all qualified physicians;
- Provides care for all those in the community able to pay the cost either directly or through third-party reimbursement; and
- Use of surplus funds to improve the quality of patient care, expand its facilities, and advance medical training, education, and research.

The 1969 community benefit standard remains today; however, it has since undergone many congressional amendments to strengthen community health. For example, in 2009, the IRS introduced Schedule H, a new community benefits reporting system. Under Schedule H, hospitals can report activities in the community benefit and community building categories. Schedule H plays an important role for hospitals, as Part I of Schedule H contains a description of the activities that meet community benefit spending standards and Part II explains activities that count toward community building spending.

COMMUNITY BENEFITS

Part I lists categories for community benefit spending under two main categories: (1) Financial Assistance and Means-Tested Government Programs, and (2) Other Benefits. In 2011, providers spent a total of \$62.4 billion on community benefit activities.

Financial Assistance and Means-Tested Government Programs

Financial Assistance and Means-Tested Government Programs include financial assistance at cost. This category captures dollars spent on free or discounted health services to persons in need of financial assistance and to those who are unable to pay, as decided by the organization. Hospitals do not include “bad debt” or “uncollectible charges,” meaning any written-off revenue due to a patient’s failure to pay or the cost of caring for patients who are unable to pay.⁴² Hospitals are also required to submit the difference between the cost of care provided under Medicaid, Medicare, or any other government program and the revenue the hospital received from it.

Other Benefits

According to the IRS, other benefits accounted for 4.2 percent or \$27 million of total hospital community benefit spending in tax year 2011.⁴³ Other benefits is a critical category, as it creates a space for hospitals to record activities outside of direct patient care—activities that advance community health. The following subcategories list other benefits:

- Community health improvement services and community benefit operations;
- Health professional education;
- Subsidized health services;
- Research; and
- Cash in-kind contributions for community benefit.

COMMUNITY BUILDING

The IRS designated Part II of Schedule H for community building spending, separate from community benefit activities. Hospitals report activities that improve community health or safety that they cannot report in Part I. The IRS creates an opportunity for hospitals to maximize their reported community benefit expenditures by allowing some community building activities to also receive Part I credit with a valid explanation. Hospitals must demonstrate the connection between their community building activity and community health improvements. This process can cause confusion among hospitals as the IRS does not detail the level of specificity required.

Community building activities, as described by the IRS, contributes to:

- Physical improvement and housing;
- Economic development;
- Community support;
- Environmental improvements;
- Coalition building;
- Community health improvement advocacy;
- Workforce development; and
- Other.

COMMUNITY HEALTH NEEDS ASSESSMENT

Mandated by the Affordable Care Act, hospitals must conduct a Community Health Needs Assessment (CHNA) every three years to pinpoint specific health needs in their local communities. The IRS provides detailed conditions for the community assessments, including the requirements to make the CHNA written report public, and, in assessing need, the hospital must solicit input from people who represent the community with expertise in public health.⁴⁴ According to the IRS, the CHNA should also define the community that it serves. In its definition of the community, a hospital may not exclude “medically underserved, low-income, or minority populations.”⁴⁵ The CHNA challenges hospitals to identify needs in the realm of clinical care *and* to direct efforts to address social determinants of health, including environmental, social, and behavioral factors. Further, the IRS requires hospitals to create an implementation strategy that addresses the needs identified in the CHNA.

Implementation Strategy

The implementation strategy is meant to compliment the needs identified through the assessment. It serves as an actionable blueprint for hospitals and other health care provider organizations. As such, the IRS states that any health need that the hospital does not plan to address must come with



an explanation of why it will not address it.⁴⁶ There is no legal requirement for the strategy to serve all the needs identified in the CHNA, which means there is no formal accountability to ensure identified needs are met.

Hospitals must update their implementation strategies annually and physically attach it to the Schedule H (Form 990) or provide an internet link to the form. However, unlike the CHNA, there is no explicit requirement to make implementation strategies widely available to the public.

COMMUNITY BENEFIT CHALLENGES

In a 2015 report to Congress, the IRS stated that 92 percent or \$57.4 billion of community benefit spending in 2011 went to clinical care, payment shortages from Medicaid, and other programs, such as graduate medical education, largely leaving out activities that directly affect social determinants of community health.⁴⁷ However, hospitals can play a significant role outside their four walls to improve community health. The CHNA and the implementation strategy have the potential to direct hospitals to make significant improvements to community health through community benefit spending.

KEY CONSIDERATIONS

There are several approaches Treasury, in concert with the IRS, could take to further support a HiAP strategy. These suggestions are generally consistent with previous recommendations from experts at the George Washington University Milken Institute School of Public Health.⁴⁸

1. Congress should require community benefit implementation plans be made public.

It is essential that policymakers, researchers, advocacy groups, and the larger public have easy access to implementation plans to remain informed of hospital community health efforts. Specifically, Congress should require implementation strategies be made widely available comparable to the CHNA public requirement. Hospitals could publish their implementation plans into the national database, Community Benefit Insight, which works to promote transparency and community action.⁴⁹

Requiring public access to the implementation strategy will help facilitate coordination between hospitals and local community organizations. As it stands, this lack of transparency prevents community institutions from understanding how hospitals plan to meet community needs, making it difficult for local organizations to coordinate their community health improvement spending with that of the hospital. If Congress required the implementation strategy to be public, this would encourage coordination and partnerships between local community organizations and hospitals to better address health needs.

2. The IRS and HHS should partner to develop better guidance connecting the CHNA and implementation strategies with community benefit spending.

Hospitals are conducting triennial CHNAs and creating annual implementation strategies to target spending to community needs. While each piece is important to population health improvement, there are no written rules that connect each critical component with community benefit spending. Current Internal Revenue Code does not legally require community benefit spending to go toward service of the implementation strategy or for the implementation strategy to target the highest needs identified in the CHNA.

At a minimum, there should be guidance that links these processes that can help hospitals better target their community benefit spending to the areas of need identified in their local communities. They could model this guidance after the LIHTC guidance and technical assistance, which HUD provides, while the IRS handles compliance.

In the community benefit spending case, the HHS could serve in a technical-assistance capacity by providing the data to develop evidence-based interventions to effectively serve community needs. The IRS could support the efforts by overseeing compliance. This would provide a more integrated process to better serve the needs of local communities. Some have even suggested that states can play a more central role in enforcing implementation strategies aimed at improving community health.⁵⁰

3. The IRS should collapse community building spending under community benefit spending.

Part I of Schedule H defines community benefit activities. Separately, Part II of Schedule H describes activities that fall under the community building category. Currently, the IRS does not explain what level of justification it requires for an activity to count toward community building *and* community benefit spending. The additional documentation required under Part II and vague requirements can serve as a disincentive for investment in non-clinical health determinants.

Broadening the definition of community benefit spending to include community building spending more closely aligns with the evolving understanding of health to include social determinants. Increasingly, federal agencies, such as the CMS, are looking to upstream solutions to improve health.

Many states are already counting community building spending under community benefit spending as a part of state reporting. Collapsing these two categories at the federal level would create better alignment with state activity. By expanding what Treasury includes as part of community benefit spending, it could encourage hospitals to invest in aspects of health outside of a health care setting that substantially affect the well-being of communities and partner with community organizations to develop innovative and sustainable solutions.⁵¹





The U.S. Department of Labor

STRATEGIC PLAN

The DOL’s mission is to “foster, promote, and develop the welfare of the wage earners, job seekers, and retirees of the United States; improve working conditions; advance opportunities for profitable employment; and assure work-related benefits and rights.”⁵² The DOL’s 2018-2022 strategic plan goals are to provide sustainable employment opportunities for all Americans.

DEPARTMENT OF LABOR 2018-2022 STRATEGIC GOALS	
1	Support the ability of all Americans to find good jobs.
2	Promote safe jobs and fair workplaces for all Americans.
3	Administer strong workers’ compensation and benefits.

BACKGROUND

In fulfilling its mission, the DOL’s policies influence American workers’ ability to perform at work and at home. A crucial factor in performing at work and at home is health. Society is increasingly recognizing and valuing the connection between work and health, as more employers are investing in employee wellness programs and beyond in community health initiatives.⁵³ Good jobs often provide a path to addressing significant determinants of health, including access to preventive health care, supportive services, and education. On the other hand, low economic development creates barriers to health. Evidence shows that significant health disparities exist in areas of low socioeconomic status, low levels of education attainment when compared with similar areas with high socioeconomic status and levels of education attainment.⁵⁴ Further, unemployment has been shown to have negative impacts on an individual’s health and well-being.^{55,56} As the agency focused on employment and the workforce, the DOL is in a strong position to effectively utilize a HiAP approach to address these concerns. It is worth noting that the DOL does have an explicit health function through the Occupational Safety and Health Administration (OSHA), but this study does not focus on OSHA and instead looks at how to encourage non-health-related offices within the DOL to consider health in all policymaking.

Many DOL programs under the Employment and Training Administration (ETA) contribute to the goals detailed in the 2018-2022 strategic plan, including the recently ended Trade Adjustment Assistance Community College and Career Training (TAACCCT) grant program and the DOL’s work to address the opioid epidemic, which directly and indirectly influences health outcomes. In both instances, the DOL responded to crises that affected—or continue to affect—the health, economic stability, and quality of life for American workers and their families.

Authorized by the Health Care and Education Reconciliation Act of 2010, TAACCCT provided approximately \$1.9 billion in grants to create pathways to economic sustainability in response to the detrimental effects of the 2008 recession.^{57,58,59} From 2011 to 2018, TAACCCT supported nearly 500,000 students who gained over 320,000 credentials at over 700 community colleges.^{60,61} While every community faces different barriers to employment, TAACCCT provided a tangible opportunity to tailor interventions, employment, and educational opportunities based on community needs. Over 38



percent of TAACCCT participants in Fiscal Year (FY) 2016 were people of color.^{62,63} Historically, racial and ethnic minority communities have been kept out of equal education and employment opportunities, which consequently have impacted the health of these communities.^{64,65}

Although TAACCCT funding has ended, the House Appropriations Committee recently passed the FY 2020 Labor-HHS-Education funding bill, which included a new \$150 million Strengthening College Training Grants (SCCTG) program that looks to be the successor to TAACCCT.⁶⁶ While the bill has not yet become law, it is hopeful that the work TAACCCT did to expand community college workforce education will be continued in SCCTG. Additionally, the DOL continues to support workforce opportunities in a variety of sectors to address growing needs in the United States and in response to crises. In particular, in 2017, the HHS declared a public health emergency in response to the opioid crisis, which has resulted in more than 70,000 deaths from drug overdoses and more than 11.4 million cases of opioid misuse in the past year alone.^{67,68,69,70}

In response, the DOL's ETA launched demonstration grants to address the economic impact associated with the opioid crisis.^{71,72} These grants, authorized under the Workforce Innovation and Opportunity Act (WIOA), encouraged people to enter health care fields to address the growing crisis. WIOA specifically focuses on addressing employment, training, education, and supportive-service issues and barriers.⁷³ Demonstration grant funds have been used to reintegrate workers affected by the crisis and to train workers in health care professions (for example, peer recovery coaches, community health/outreach workers, physical therapists, and other professionals related to addiction) to address opioid misuse within communities, as well as to increase pain management, mental health, and addiction treatment services.⁷⁴ As of July 2019, Phase One and Phase Two of the National Health Emergency Dislocated Worker Grants (DWG) have allocated a combined \$74.3 million to support workforce development, including training and retention of workers in communities impacted by opioid use and abuse as well as for supportive services to address the specific needs of communities.^{75,76,77}

In addition to TAACCCT and opioid DWGs, the DOL has several other grant opportunities to increase employment opportunities. Many of these grants support one of the DOL's primary goals: to create over 1 million apprenticeship positions in coming years in order to grow and train the workforce in growing fields, such as health care, information technology, and other skilled trades.⁷⁸ For example, H-1B grants create a funding pathway to increase employment and training services. Authorized by the American Competitiveness and Workforce Improvement Act of 1998 and funded by H-1B visa employer fees, H-1B grants use a portion of these fees for technical skills training in high-growth industries, such as health care and information technology.^{79,80}

Grants such as H-1B and opioid DWGs share a key similarity in their approach to funding employment and training services opportunities: Both focus on the importance of including supportive services as part of grant funding to increase employment participation and retention. In offering supportive services, these DOL grants have an indirect impact on health.

SUPPORTIVE SERVICES

The DOL's ETA grants connect people with experiences and training activities that will lead to employment opportunities. However, for many individuals, both gaining a job and remaining employed come with additional challenges. One way to improve training programs and job retention is to support the health and well-being of participants by providing them with supportive services, such as transportation, child-care, and financial support, to address these challenges.⁸¹



Evidence shows that providing supportive services increases employee earnings, increases the likelihood of finding work, and results in higher job-training program retention.

Many of these supportive services attempt to address critical social determinants of health that can create barriers to participating in DOL grant-funded programs.⁸² Supportive services—also known as wrap-around services—provide comprehensive resources that consider the totality of workers and their families. Wrap-around services allow workers to remain engaged in employment opportunities.⁸³



Evidence shows that providing supportive services increases employee earnings, increases the likelihood of finding work, and results in higher job-training program retention.^{84,85,86,87} Access to supportive services directly and indirectly connects to health outcomes and is a key component of grant training programs.^{88,89,90} Specifically, supportive services decrease barriers to entry to ensure individuals can participate in employment, education, and training activities.

For example, in June 2019, the DOL announced \$1.5 million in funds to support women in apprenticeships.⁹¹ An important requirement in this grant funding was that organizations must facilitate or provide supportive services for women to improve job retention. Supportive services are critical to job sustainability and, ultimately, health outcomes.

The DOL has dedicated portions of grant funding to cover a variety of supportive services. Grantees may fund these services through several ways, such as through direct support (e.g., child care), vouchers (e.g., public transportation or tokens), or stipends. Table 1 displays a combination of supportive services included in past and current DOL grants. Currently, the DOL does not standardize supportive services details across all grants.^{92,93,94,95,96,97,98}

Table 1

Department of Labor Supportive Services Examples	Assistance with child care and dependent care
	Assistance with transportation
	Food assistance
	Assistance with housing
	Assistance with appropriate work attire or uniforms
	Needs-related payments (e.g., utility bills)
	Fees for training and employment-related activities (e.g., tests, certifications, etc.)

Supportive services are an allowable cost under authorizations such as WIOA and its predecessor, the Workforce Investment Act.⁹⁹ Specifically, under WIOA-authorized grants, any caps on funding toward supportive services occur at the discretion of local Workforce Development Boards. Many grants that cover supportive services have a 10 percent funding cap for these services.¹⁰⁰ According to the DOL, where these limits exist within grants is a result of a law or DOL policy. A few grants, such as the National Health Emergency Phase Two: Disaster Recovery National Dislocated Worker Grants to Address the Opioid Crisis, have allowed a 20 percent funding cap with the ability to apply for more funding. As supportive services directly and indirectly impact health, the funding cap may limit the role that the DOL and grantees can play in shaping health behaviors and outcomes.

Some grants provide a detailed definition of supportive services and/or wrap-around services, whereas others provide examples of services, and still others simply use the words *supportive service* without offering a definition or example. For some grants, this variation even exists within the same grant over different years, such as the case for TAACCCT grants.¹⁰¹ These discrepancies can cause confusion for grant applicants and make standard evaluation challenging.

LANGUAGE AROUND SUPPORTIVE SERVICES

The language used to discuss supportive services generally falls into one of three categories: (1) grants that do not mention supportive services; (2) grants that make broad or vague mentions to supportive services; and (3) grants that provide specific examples and/or definitions of supportive services or wrap-around services.

BROAD LANGUAGE

- “The TAACCCT Grant program outlines priority areas and strategies that correspond to the needs of these trade-affected workers, and **addresses barriers to entry** faced by individuals who are older, less educated, and have been out of both educational institutions and the job market for many years. . . . These workers are served through intensive retraining, income support (known as Trade Readjustment Allowances) and other **supportive services** that help this population attain the skills and education necessary to become re-employed.” —TAACCCT, 2012¹⁰²
- “...access to educational and career counseling and other **supportive services**, directly or indirectly.” —YouthBuild, 2018¹⁰³

SPECIFIC LANGUAGE

- “Needs-related payments are a form of supportive services paid directly to participants that enable the individual to participate in training. . . . [G]rant funds under this FOA [Funding Opportunity Announcement] may be used to **provide needs related payments**, such as those authorized under WIOA **to assist participants with costs related to transportation, child care, food, or other household items, such as paying a utility bill to prevent shut off.**” —Reentry Projects, 2018¹⁰⁴
- “[S]upportive services for training participants include services such as transportation, child care, dependent care, housing, and needs-related payments that are necessary to enable an individual to participate in education and training activities funded through this grant.” —America’s Promise, 2016¹⁰⁵
- “[W]e strongly encourage applicants to collaborate with other partners that can support and advance the work of the apprenticeship partnership. These include: organizations functioning as workforce intermediaries, such as workforce development boards, labor-management organizations, community-based organizations.” —Scaling Apprenticeships Through Sector-Based Strategies, 2018/2019¹⁰⁶
- “Supportive services are a broad range of services that help ensure individuals can participate in employment and training activities or temporary disaster-relief employment.” —Opioid DWG-Phase Two, 2018/2019¹⁰⁷
- “Wrap-Around Supportive Services - Services that are designed to address needs and ensure participant success. Services may include, but are not limited to, childcare, transportation, tools, or work clothes.” —Youth CareerConnect, 2013¹⁰⁸

KEY CONSIDERATIONS

The clearest path to improving health outcomes at the DOL resides in the inclusion of supportive services as part of grants provided. The inclusion of supportive services as part of DOL grants has spanned across administrations. Increasing access and eliminating barriers to entry are goals championed across the aisle. Investment in supportive services enables a healthier workforce.



1. The DOL's ETA should clarify and, where possible, standardize supportive services across all its grants.

While some grants are thorough, describing at length supportive services included (e.g., H-1B Ready to Work; Youth Career Connect, America's Promise, Tech Hire, and National Health Emergency Phase Two), other grants reference "supportive services" but do not detail activities included under these services (e.g., TAACCCT and YouthBuild).¹⁰⁹

The clearest descriptions of supportive services occur in grants that delineate a range of supportive services covered under the grant. Many of these grants require the grantee to provide a proposal tailored to their target population(s) and specify how they will identify and address supportive-services needs among their population(s). These grants also require grantees to provide evidence to support the need and effectiveness of providing supportive services to address barriers to training, employment and retention as part of their application.

In instances where only the words "supportive service" or "wrap-around service" are used, it is unclear if the same services are covered when compared with other grants that use the same language and whether grantees understand the differences in supportive services covered or not covered between grants. The DOL should consider standardizing the language around supportive services in its grant applications to ensure organizational cohesion, increase clarity for grantees, and allow for more efficient and complete applications.

2. The DOL should increase funding flexibility for supportive services.

Many DOL programs allow only 10 percent of funding to go toward providing supportive services. While most of the funding can and should target employment and training services, it is imperative to recognize that including supportive services can effectively improve health outcomes for all American workers who participate in these programs, and, in so doing, this will increase participation, retention, and program satisfaction.

Phase Two of the opioid DWG program serves as a precedent for more flexibility as it allows organizations to apply for more funding toward supportive services as needed to address unique issues faced by respective communities. The DOL should extend the same consideration to all DOL grants.

Considerations for the Executive Office of the President

All executive branch departments should consider adopting a HiAP approach with respect to policymaking whenever feasible. There is precedent for the Executive Office of the President of the United States to catalyze such an effort through its ability to convene departments and provide leadership and coordination on various health issues. For example, the White House Office of National Drug Control Policy seeks to coordinate drug-control and prevention efforts across 16 federal departments and agencies. Previously, the White House Office of National AIDS Policy coordinated federal efforts to reduce new cases of HIV infection and to ensure individuals with HIV/AIDS receive care.

A recent example of executive branch coordination on health matters stems from the Affordable Care Act, which created the National Prevention Council, composed of 17 heads of departments, agencies, and offices (departments) across the federal government and chaired by the U.S. surgeon general. The council created a National Prevention Strategy as well as an Action Plan detailing the efforts of each federal department in contributing toward strategies and priorities that “increase the number of Americans who are healthy at every stage of life.”¹¹⁰ Specifically, the council committed to identify opportunities within departments as well as to encourage partners to consider prevention and health in all appropriate programmatic efforts, increase tobacco-free environments, and increase access to healthy, affordable food.¹¹¹

While reconvening this council is one option, the current administration could support a HiAP approach in several additional ways. First, every four years, the White House Office of Management and Budget (OMB) requires departments to update and revise their respective strategic plans and objectives. As part of this exercise, OMB could ask that departments integrate health into all policies approach as appropriate. OMB could also require that departments consider this approach when preparing their annual budget submissions.

A second option could be for the Office of Information and Regulatory Affairs within OMB to require departmental regulatory proposals to include health impact assessments where applicable. Health impact assessments, according to the CDC, are a tool that helps evaluate the potential health effects of a policy before it is implemented.¹¹² The Office of Information and Regulatory Affairs should also ensure that its technical staff have expertise in health impact assessments so that the potential health impacts of proposed regulations are thoroughly considered.

A third option could be for the White House Domestic Policy Council to convene leaders from select departments to establish a HiAP council. This group would look for opportunities for the administration to further health across the executive branch, particularly outside those departments whose primary mission is to promote health. The HHS could provide technical assistance to the council with regard to the determinants of health and to the evidence-based policies that support them.



Conclusion

This report highlights various examples of executive branch departments that are not primarily health-focused but that are nevertheless impacting population health through policy and programmatic efforts. While the HHS has vast responsibilities in advancing the nation's health, other executive branch departments can also play a significant role. As evidence continues to accrue about the broad drivers and determinants of health, it will be important to raise awareness of the myriad ways in which federal policymaking impacts health.

The Executive Office of the President could catalyze a more robust and comprehensive approach to HiAP across the executive branch. In 2017, the U.S. Commission on Evidence-Based Policymaking jointly sponsored by then-Speaker Paul Ryan and Senator Patty Murray issued unanimous recommendations about how the federal government could better use data to generate evidence for federal policymakers. The evidence is now clear. Health is impacted not only by health care but also a plethora of societal factors. The time is ripe for all federal policymakers to appreciate their respective roles in creating a healthier America.

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Notes








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