

December 19, 2019

Ed Simcox, Chief Technology Officer
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: PreventionX Request for Information

Dear Mr. Simcox:

On behalf of the undersigned organizations, we are pleased to offer comments in response to the Department of Health and Human Services' (HHS) request for information (RFI) on PreventionX.

The \$3.36 trillion spent annually on health in the U.S. has not translated into optimal well-being for all Americans. Six out of every ten American adults suffer from at least one chronic disease, including hypertension, diabetes, heart disease, and obesity and 40 percent have two or more chronic diseases.¹ Chronic diseases account for approximately 75 percent of aggregate health care spending, or an estimated \$5,300 per person annually.² Although most are preventable, chronic diseases are the leading causes of mortality in the nation, killing more than 1.7 million Americans — seven out of 10 deaths — each year.³ Substance misuse, including alcohol use disorder, is also a form of chronic disease that is increasing in the U.S.

As communities across the nation continue to face serious, ongoing, and costly health problems, the United States must focus increased attention on strengthening prevention strategies. As organizations invested in the health of all Americans, we support HHS' efforts to catalyze the scaling and deployment of effective prevention strategies. We applaud the PreventionX initiative's use of the *Three Buckets of Prevention*, including the focus on innovative clinical prevention and community-wide prevention efforts. We also applaud HHS's ongoing efforts to scale up value-based payment models, which provide strong incentives for reimbursement of prevention services, programs and policies.

Our response to the RFI is an attempt to constructively address the excellent questions that it poses. We have identified nine thematic areas where there are both barriers and opportunities.

¹ Centers for Disease Control and Prevention. About Chronic Diseases. October 2019. Available at: <https://www.cdc.gov/chronicdisease/about/index.htm> Chronic Diseases in America. Available at <https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm>

² National Association of Chronic Disease Directors. Why we need public health to improve health care. Decatur, GA: National Association of Chronic Disease Directors. Accessed November 26, 2019. Available at https://cdn.ymaws.com/www.chronicdisease.org/resource/resmgr/white_papers/cd_white_paper_hoffman.pdf

³ American Public Health Association. Public health and chronic disease: Cost savings and return on investment. Washington, DC: American Public Health Association. Accessed November 25, 2019. Available at www.apha.org/~media/files/pdf/factsheets/chronicdiseasefact_final.ashx

Under each, we identify the barrier, make a recommendation for what could overcome the barrier and offer an example of a relevant current practice. Our responses address the following questions:

- In your estimation, what have been the most significant barriers to more effective prevention and delayed progression of chronic health conditions in the US?
- Are you aware of examples of effective public-private partnerships at any scale?
- What sectors or stakeholders should HHS prioritize for engagement as part of this effort?
- What are some of the most effective, but not well-publicized prevention strategies (e.g. those found in CDC's 6|18 and HI-5 programs) within Buckets 2 and 3 (or anywhere on the continuum between them)? What has been their key to success? Specifically, we are also interested in interventions that have proven effective on a smaller (e.g., health system or community) scale and are candidates for further testing or expansion.

1. Inconsistent Federal and State Cross-Agency Collaboration

The issue: Unlike infectious disease where a vaccine or a single intervention is often a possible option, effectively addressing the social determinants of health requires a multi-pronged approach. The nature of many illnesses requires changes on several fronts and ones that involve multiple sectors. For example, to decrease the prevalence of diabetes, it is necessary to reduce obesity and promote physical activity and healthful food consumption. However, as stated in Trust for America's Health's latest *State of Obesity* report,⁴ this requires a wide variety of interventions ranging from those related to the location and content of food stores to the transportation system, from school policies on food and recess to city and county adoption of Complete Streets strategies, from health care screening and counseling to public health education and reimbursement of the Diabetes Prevention Program by insurers. Similar cross-agency approaches are needed for other chronic illnesses such as heart disease and asthma. Therefore, the policy responses need to be multifactorial with coordinated actions and funding streams.

The recommendation: **The Department of Health and Human Services (HHS) and other federal agencies should establish an inter-agency working group on the Social Determinants of Health (SDOH) with the goal of establishing and coordinating federal SDOH efforts to improve health and control costs. This federal working group could consider establishing sub-groups with specific goals and that include representatives from the private sector and from local, state, tribal and territorial governmental agencies.**

The creation of an inter-agency working group at the federal level would set an example that could be replicated at the local and state levels and encouraged or incentivized by HHS agencies through their grant-making processes.

The examples: The New York Council on Children and Families has been coordinating state health, education, and human services systems for over 40 years to improve services for children and families. The Council's role is to function as a neutral body within the state government

⁴ Trust for America's Health. The State of Obesity 2019: Better Policies For A Healthier America. Washington, DC: Trust for America's Health, 2019. Available at <https://www.tfah.org/wp-content/uploads/2019/09/2019ObesityReportFINAL-1.pdf>

responsible for developing solutions to interagency issues. Its mission of developing a coordinated system of care has assisted New York in overcoming challenges facing the 12 agencies that makes up its membership.⁵

A different type of example is offered by Healthy Baton Rouge (Louisiana).⁶ It is a collaboration convened by the mayor of Baton Rouge and includes many private sector partners including five competing hospitals and scores of community partners. Collectively they assessed the needs of a local parish and selected four priority areas: adult and childhood obesity, high HIV/AIDS rates, mental health, and overuse of emergency departments. An advisory committee of the mayor's Initiative coordinates the activities. This led to a Joint Community Health Needs Assessment by all the hospitals and a unified Community Implementation Plan.

2. Underfunding of Chronic Disease Prevention Programs

The issue: Today's health challenges also require a stable and adequately funded public health system. Such funding is needed to support the core public health infrastructure of the nation at the federal, state, local, territorial and tribal health levels. Currently, less than three percent of national health spending —\$274 per person—is directed to public health and prevention.⁷ Funding for public health varies greatly across localities, and some parts of the country have minimal resources to fulfill the most basic foundational capabilities that form the backbone of comprehensive public health systems. These capabilities include infrastructure upgrades, workforce development, program evaluation, policy development and support, communications, and accountability and performance management.

An Institute of Medicine panel concluded that public health agencies, such as the Centers for Disease Control and Prevention (CDC), are markedly underfunded, and that U.S. health spending is out of balance, with spending for clinical care disproportionately higher compared with spending for “population-based activities that more efficiently and effectively improve the nation's health.”⁸ And CDC's budget has declined since this Institute of Medicine report was issued in 2012.

Overall, more than 60 percent of the CDC's funding supports state and local health departments and other community-based organizations.⁹ However, adjusting for inflation (and excluding one-time-only emergency funds), the CDC's budget has declined by approximately 10 percent in the

⁵ New York State. Council on Children and Families. New York. Available at: <https://www.ccf.ny.gov/about-us/>

⁶ Healthy BR. www.healthybr.com

⁷ Centers for Medicare and Medicaid Services. National health expenditure accounts (2018). Available at www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical

⁸ Institute of Medicine Committee on Public Health Strategies to Improve Health: Board on Population Health and Public Health Practice. For the public's health: Investing in a healthier future (2012). Available at www.ncbi.nlm.nih.gov/books/NBK201023/pdf/Bookshelf_NBK201023.pdf

⁹ National Association of County & City Health Officials. The Centers for Disease Control and Prevention: Critical partner to local health departments (2017). Available at www.naccho.org/uploads/downloadable-resources/flyer-advocacy-aboutCDC.pdf

past decade,¹⁰ failing to keep pace with the nation’s growing public health needs and emerging threats. The limited size of the agency’s budget has had a significant impact on local efforts throughout the nation, undermining efforts to hire, train, and retain a strong public health workforce, which in turn limits governments’ ability to effectively protect and promote the health of their communities. Over the past decade, 56,360 local health departments jobs have been eliminated.¹¹

The recommendation: HHS should seek additional funding - both public and private – to strengthen the nation’s foundational public health capabilities and guarantee a more equitable availability of core public health services. This could be done in several ways:

- **The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary should extend the cost savings evaluation period of Center for Medicare and Medicaid Innovation (CMMI) demonstration projects to 10 years, particularly for conditions that have not proven to be responsive to short-term interventions, such as obesity.**
- **CMS/CMMI, CDC, Health Resources and Services Administration (HRSA) and/or Substance Abuse and Mental Health Services Administration (SAMHSA) could develop integrated pilots with pooled or braided funding to address certain chronic diseases where a multi-sector, collective impact is most likely to be successful. This could take the form of a single application for funding from multiple agencies.**
- **HHS should explore how to further build upon the shift to value-based contracting to integrate core public health services into new payment and delivery models.**
- **HHS could explore ways to leverage federal dollars to generate increased contributions from other sources including private ones. Such approaches could involve requirement for matching dollars for certain grant awards, incentives for the creation of prevention trusts and/or pay for performance mechanisms.**

The examples: The BUILD Challenge¹² is a national initiative in which ten foundations pool resources to support local partnerships between community-based organizations, hospitals and health systems, and local health departments. To be eligible the local communities must commit to raising local funds that match or exceed the requested grant funding and work collaboratively across multiple sectors towards a common goal. For example, each grant application for BUILD must include a resource commitment from a local health system that is at least as large as the amount being requested from BUILD.

Another example of a local community that developed multiple public and private funding sources to improve health is Broward County, Florida. To address multiple health challenges, leaders from government, businesses and nonprofits came together to improve the health and wellbeing of the county residents. Funding was sought from public and private sources. The collaborative successfully supported the approval of a one-cent, 30-year surtax to increase

¹⁰ Trust for America’s Health. The Impact of Chronic Underfunding of America’s Public Health System: Trends, Risks, and Recommendations, 2019. Washington, DC: Trust for America’s Health, 2019. Available at <https://www.tfah.org/wp-content/uploads/2019/04/TFAH-2019-PublicHealthFunding-06.pdf>

¹¹ National Association of County and City Health Officials. 2018. The Forces of Change in America’s Local Public Health System, accessed December 16, 2019 at <http://nacchoprofilestudy.org/wp-content/uploads/2018/12/2018-Forces-of-Change-Main-Report.pdf>.

¹² BUILD Challenge. <https://buildhealthchallenge.org/>

transportation options. In addition, the public-private partners gained funding for free preventive dental care to children in public schools.¹³ (<https://www.rwjf.org/en/library/features/culture-of-health-prize/2019-winner-broward-county-florida.html>)

3. Categorical Funding Barriers Inhibit Cross-Agency Collaboration

The issue: As noted above, given the nature and underlying causes of many chronic diseases, community-based approaches are needed that bridge health care, public health, social services, and other relevant sectors to find upstream solutions. A challenge to effective implementation of such a model is that public health departments, which could play a central role in such multi-sector endeavors, are funded by categorical, disease-specific funding streams. Restrictions on categorical funding has historically created barriers to the participation of public health and other agencies in such collaborative endeavors. As noted in the Institute of Medicine’s 2012 report, “For the Public’s Health: Investing in a Healthier Future,” categorical funding limits the range of issues that public health departments can address.¹⁴

The recommendation: **HHS agencies should allow greater flexibility in the uses of categorical funding. This could be achieved by designating a certain percentage of categorical funding as usable for action steps that are not narrowly focused on a single disease or condition. This also could be achieved by taking administrative steps to allow and coordinate the blending and braiding of various grant streams. However, such flexibility should not be accompanied by reductions in overall funding, the threat of which would discourage innovation and disincentivize such efforts.**

The example: The leaders of the Rhode Island Department of Health were determined to create healthful conditions in high risk communities referred to as Health Equity Zones. To achieve this goal the Department wanted to mobilize the residents of the Zones to determine which conditions to focus on. The departmental leaders used extraordinary creativity and expert planning to identify a way to braid categorical grants from multiple sources. This required several internal administrative steps as well as coordination and joint planning with the federal funding agencies. Despite the complexity “behind the scenes,” the process to apply for the funding was simplified for the community residents. The funds were used for such health-promoting, non-categorical activities as transforming vacant lots into urban farms; implementing chronic disease self-management programs; building affordable housing; and increasing parks, open spaces, and walking paths.

4. Lack of Multisectoral Focus on Communities’ Social and Economic Conditions

The issue: Increasingly, clinicians, health care systems and payers have begun to recognize that the prevention and treatment of disease can only be effective if there are changes to the

¹³ RWJF Culture of Health Prize Winners: Broward County, Florida. Robert Wood Johnson Foundation. <https://www.rwjf.org/en/library/features/culture-of-health-prize/2019-winner-broward-county-florida.html>

¹⁴ Committee on Public Health Strategies to Improve Health; Institute of Medicine. For the Public’s Health: Investing in a Healthier Future. Washington (DC): National Academies Press (US); 2012 Apr 10. 2, Reforming Public Health and Its Financing. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK201015/>

underlying social and economic conditions in people’s lives that impact their health.¹⁵ Where and how people live is often more important than the medical treatment they receive in determining health outcomes, yet investments focus on clinical solutions to disease.¹⁶

In a noteworthy 2018 speech, Secretary of Health and Human Services (HHS) Alex Azar stated that HHS spends over \$1 trillion a year on health care through Medicare and Medicaid, and the Department has begun exploring how to address social determinants of health as a major driver of those costs.¹⁷ CMMI’s *Accountable Health Communities Model (AHC)* has led more and more clinicians to screen patients for their needs and subsequently seek non-medical services to address those needs.

In 2019, the Centers for Medicare & Medicaid Services (CMS) announced that Medicare Advantage and Part D plans could pay for non-health related transportation and other social needs under certain circumstances.¹⁸

While these are very positive developments, there is a need to expand the SDOH focus beyond reimbursement for addressing nonmedical social needs of individual patients. Such efforts should be complemented by public health and other sector approaches to change the policies, laws and regulations that affect the population-wide social and economic conditions in cities, counties and states.¹⁹

The potential benefits of this expanded *Bucket 3* approach are illustrated by the evidence that has been compiled by CDC’s *Health Impact in 5 Years (HI-5)* initiative, TFAH’s *Promoting Health and Cost Control in States*, and de Beaumont Foundation’s *CityHealth* program.^{20,21,22}

The recommendation: HHS should support funding for the Centers for Disease Control and Prevention (CDC) to provide grants, training and technical assistance to state and local public health departments to lead and coordinate multisector Bucket 3 approaches to address the SDOH.²³ Such funding could link CMS’s AHC sites and other health care

¹⁵ Taylor, L et. al, “Leveraging the Social Determinants of Health: What Works?” Yale Global Health Leadership Institute and the Blue Cross and Blue Shield Foundation of Massachusetts, June 2015

https://blucrossmafoundation.org/sites/default/files/download/publication/Social_Equity_Report_Final.pdf

¹⁶ Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine* 50(2):129-135.

¹⁷ Azar, AM. The Root of the Problem: America’s Social Determinants of Health. HHS. November 14, 2018.

<https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the-root-of-the-problem-america-social-determinants-of-health.html>

¹⁸ CMS finalizes Medicare Advantage and Part D payment and policy updates to maximize competition and coverage. <https://www.cms.gov/newsroom/press-releases/cms-finalizes-medicare-advantage-and-part-d-payment-and-policy-updates-maximize-competition-and>

¹⁹ Auerbach, J. Social Determinants of Health Can Only Be Addressed by a Multisector Spectrum of Activities. *Journal of Public Health Management and Practice*. Nov/Dec 2019, Vol 25. No. 6.

²⁰ Health Impact in 5 Years (HI-5). Centers for Disease Control and Prevention, 2016.

<https://www.cdc.gov/policy/hst/hi5/index.html>

²¹ Promoting Health and Cost Control in States. Trust for America’s Health, 2019.

<https://www.tfah.org/initiatives/promoting-health-cost-control-states-phaccs/>

²² CityHealth. de Beaumont Foundation and Kaiser Permanente, 2019. <https://www.cityhealth.org/>

²³ “Proposal: CDC Capacity-Building Support of Local Partnerships to Address Social Determinants of Health.”

Trust for America’s Health, 2019. <https://www.tfah.org/wp-content/uploads/2019/09/SDOHProposalFactSheet.pdf>

systems with public health agencies, community-based organizations and local and state policymakers.

The examples: CityHealth, an initiative of the de Beaumont Foundation and Kaiser Permanente, has prepared and promoted a package of evidence-based policy solutions for consideration by local communities. Many of the policies are focused on improving the social and economic factors that impact health such as educational opportunities, the environment, financial security, housing, nutrition, public safety and transportation. Its focus is exclusively on upstream policies that prevent health problems, not on medical treatment and care. Cities are awarded an overall city-wide medal based on how many policy medals they have earned. This approach appears to be working. Since 2018, ten cities have improved their overall medal status, and three quarters of cities earned an overall medal, compared to less than half in 2017.

5. Chronic Disease Disparities Continue to Widen

The issue: There is overwhelming evidence of the impact of inequality in health outcomes that is rooted in present day discrimination and the legacy of centuries of oppression of people of color. Black, Latinx, Native American/Alaska Native and certain Asian American populations experience higher burdens of chronic disease and worse health outcomes compared to White populations. These disparities are closely related to differences in neighborhood characteristics and socioeconomic status (SES) as well as the direct experience and impact of racism. For example, obesity disproportionately affects racial and ethnic minorities as a result of the social, economic and environment obstacles to healthful foods and physical activity.²⁴ Many of the obstacles are related to a lack of educational and economic opportunity rooted in poverty. But, even when controlling for socio-economics, health outcomes are often worse for people of color due to the added burdens of racism and the accumulated impact of the legacy of slavery and genocide.

The recommendations: **HHS should ensure that funding is directed to communities of color and other at-risk population to promote equity and eliminate gaps in health outcomes. This requires the distribution of grants in proportion to the burden of risk, illness, injury and preventable deaths.**

Special efforts should be made to promote authentic involvement and leadership of the members of the affected communities themselves in assessment of need, priority setting and program implementation and evaluation. HHS should allow the adaptation of programmatic approaches to reflect the specific needs, culture and traditions of the recipient communities. HHS should consider a public-private partnership to identify and reward initiatives that demonstrate effective community-driven approaches to eliminate inequities in health outcomes.

²⁴ National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al. Communities in action: Pathways to health equity. Washington, DC: National Academies Press. Published January 11, 2017.

The example: CDC’s Good Health and Wellness in Indian Country, launched in 2014, provides grants to tribal organizations to address chronic diseases and risk factors. A key characteristic of the program is its support of practices by the funded organizations that reflect the culture and traditions of the tribal members. An early evaluation of this program demonstrated increased access to healthier foods and physical activity.²⁵ This work has also informed other federal agencies as they seek to improve the health and well-being of American Indians and Alaska natives.²⁶

CDC’s Racial and Ethnic Approaches to Community Health (REACH) program funds 31 recipients to reduce health disparities among racial and ethnic populations with the highest burden of chronic disease. It allows recipients to plan and implement local, culturally appropriate programs that address a wide range of health issues among African Americans, American Indians and Alaska Natives, Hispanics/Latinos, Asian Americans and Pacific Islanders. REACH programs have demonstrated decreases in smoking prevalence and reductions in obesity, among other successes.²⁷

6. Evidence-Based Approaches are Not Being Broadly Implemented

The issue: All too often the funded interventions to prevent chronic disease have not been tested and found to be effective. This can result in well-intentioned but ineffective efforts. Especially because it is so complicated to address these diseases, it is essential that resources are directed to those efforts which have shown positive results. Therefore, whenever possible the approaches to preventing and controlling chronic disease need to be evidence-based or evidence-informed.

***The recommendation:* HHS should increase the use and implementation of evidence-based policy solutions that shape healthy communities at the total population level. Priority should be given to funding and/or assistance to adopt programs and supporting policies with the strongest track record of efficacy. It should consider such incentives as high-profile awards and/or cash prizes to those communities that have taken creative steps to expand evidence-based efforts. Additional support for the CDC Community Guide should also be sought from both public and private sources.**

The example: A few organizations have carefully reviewed the available findings regarding the effectiveness of preventive interventions and identified those with the strongest track record of improving health, controlling costs and showing results quickly. The CDC created the *Health Impact in 5 Years (HI-5)* initiative to highlight community-wide policy interventions that improve health and well-being in as little as five years.²⁸ Trust for America’s Health (TFAH)

²⁵ Lawrence T, James R. Native American Wellness Collection: Measuring Impact Through an Indigenous Lens, 2014–2019. *Prev Chronic Dis* 2019;16:180655. DOI: <http://dx.doi.org/10.5888/pcd16.180655>

²⁶ Andrade NS, Espy DK, Hall ME, Bauer UE. A Holistic Approach to Chronic Disease Prevention: Good Health and Wellness in Indian Country. *Prev Chronic Dis*. 2019;16:E98. Published 2019 Aug 1. doi:10.5888/pcd16.190081

²⁷ REACH Program Impact. Centers for Disease Control and Prevention. https://www.cdc.gov/nccdphp/dnpao/state-local-programs/reach/program_impact/index.htm

²⁸ Health Impact in 5 Years. Centers for Disease Control and Prevention. <https://www.cdc.gov/policy/hst/hi5/interventions/index.html>

established the *Promoting Health and Cost Control in States (PHACCS)* initiative to identify the most promising policies that promote healthy lifestyles and reduce costs in states.²⁹ Each of these efforts have summarized the data, provided examples of best practices and offered accessible tools.

7. Community Assets and Voices are Not Being Leveraged Effectively

The issue: The approaches to preventing and controlling chronic disease need to tap the assets of and voices from the affected communities. Those in the most affected communities are most directly aware of the specific barriers to good health. In addition, they are aware of the strengths or assets within their communities, including the individuals and organizations that can provide resources and leadership. Yet all too often, decisions are made, programs are funded, and efforts undertaken without the input or involvement of those likely to be most affected. Minimally it is likely to reduce the potential positive impact. But the danger exists that mistakes will be made that have unintentional, negative consequences, for example, if efforts to reduce the environmental health risks of a community lead to gentrification and displacement of the long-time community residents.

The recommendation: **HHS should support community-based prevention models that demonstrate innovative approaches to ensuring meaningful community involvement in planning, priority-setting and decision-making. Special efforts should be made to tap the experience and strengths of existing community leaders, train new leaders including adolescents and young adults and pay community members for their involvement and/or hire them.**

The examples: The California Endowment began the Building Healthy Communities initiative in 2010 with a 10-year, \$1 billion commitment to support the health and wellbeing of the residents of 14 low-income communities. Rather than select the health issues to focus on, the Endowment funded processes whereby community members could select the priorities and actively participate in the oversight of the work. The Endowment sought ways to strengthen the leadership of community members – especially young residents - with training, mentoring and direct involvement in all aspect of decision-making. Their goal was to have a lasting positive effect by increasing civic engagement and promoting the involvement in policymaking by those most affected.

In the 100 Million Healthier Lives initiative, convened by the Institute for Healthcare Improvement, community residents with lived experience make up one third of improvement teams, together with system leaders and community facilitators. This engagement led, for example, to enhancements of the Diabetes Prevention Program for women experiencing homelessness and diabetes in Los Angeles that achieved a 92 percent improvement in blood

²⁹ Lustig, A. & Cabrera, M. (2019). Promoting health and cost control in states: How states can improve community health and well-being through policy change. Washington, DC: Trust for America's Health.

pressure and a 44 percent improvement in A1c levels, using existing assets and resources in the community compared with matched controls.³⁰

8. Coordination Between the Health Care Sector, Public Health and Other Sectors Must Be Further Incentivized and Improved

The issue: Historically the health care sector has operated within a silo, somewhat separated from other sectors including public health. However, with growing recognition of the importance of social factors to health outcomes, cross-sector coordination has begun to increase. Several delivery and payment models have emerged to that take steps to address the SDOH. Such models often involve screening of patients for their health-related, non-medical social needs and striving to address those needs in part through strong linkages with organizations in non-health sectors, such as housing. There is a growing recognition that a multisectoral approach is needed to overcome policy and resource barriers and ensure that SDOH efforts are not focused on any single population or condition.³¹ Public health departments are well-positioned to build bridges with the health sector and to convene other sector partners in collaborative efforts to create conditions that foster health.³²

The recommendation: **To integrate this cross-sector perspective HHS should prioritize the active involvement of local, state, tribal and territorial public health departments in building collaborations with the health care and other sectors, both public and private. Collectively these multi-sector efforts should review the need, identify priorities and develop action plans to promote health. CDC should have a SDOH unit and award grants to public health agencies to convene and staff such efforts throughout the nation.**

The example: Oregon's coordinated care model is an example of a public-private partnership to link the health care sector with other sectors including public health. The backbone of this model is the 15 Coordinated Care Organizations (CCOs), which are a network of health care providers (physical health, behavioral health and dental care) who have committed to collaborate in their local communities to serve Medicaid beneficiaries.³³ A focus of the CCOs is on prevention efforts and assisting beneficiaries manage chronic diseases. The CCO model brings other sectors to the table and provides an opportunity for community members to make recommendations on how to best improve the quality of care and services delivered in their community.³⁴ Some CCOs are making sustained investments in public health, such as Trillium Community Health Plan which has invested more than \$13 million in Lane County to expand access to primary care,

³⁰ Callender S, Calleros M, Chen S, et al. *Improving Health Outcomes for Women Experiencing Homelessness in the Skid Row Community of Los Angeles*. Los Angeles, CA: Downtown Women's Center;2017.

³¹ Auerbach, J. Social Determinants of Health Can Only Be Addressed by a Multisector Spectrum of Activities. *Journal of Public Health Management and Practice*. Nov/Dec 2019, Vol 25. No. 6.

³² Trust for America's Health. Proposal: CDC Capacity-Building Support of Local Partnerships to Address Social Determinants of Health. Available at: <https://www.tfah.org/wp-content/uploads/2019/09/SDOHProposalFactSheet.pdf>

³³ Oregon Health Authority. Oregon Health Plan – Coordinated Care Organizations (CCO). Available at: <https://www.oregon.gov/oha/HSD/OHP/Pages/Coordinated-Care-Organizations.aspx>

³⁴ Oregon Health Authority. Oregon Health Plan – CCO Community Advisory Councils. Available at: <https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Community-Advisory-Councils.aspx>

expand prevention services to reduce tobacco use and obesity, integrate community behavioral health services and address the social needs of their vulnerable patients, including housing, education, and access to healthy food.³⁵ Another CCO in Oregon, Yamhill Community Care, is also investing in Community Prevention and Wellness through their support of the Good Behavior Game and Positive Family Supports.³⁶

9. Shared measures across sectors that facilitate collaborative prevention should be prioritized, integrated and incentivized.

The issue: We improve what we measure. Health and health care measurement has traditionally prioritized and incentivized downstream disease management rather than prevention or health equity. Moreover, although improvement in health outcomes requires cross-sector collaboration, different sectors have developed measures specific to their work that do not always make cross-sector collaboration easy. Very few measures used in the health care sector are aligned toward outcomes that would drive prevention and improvement in outcomes for the population as a whole across sectors. Almost none prioritize behavioral health, equity or social determinants of health, despite epidemic levels of deaths of despair and decreased life expectancy three years in a row.

Recently, with the support of the National Committee on Vital and Health Statistics and 100 Million Healthier Lives, more than 100 multi-sector organizations, communities and federal agencies developed the Well-being In the Nation (WIN) framework and measures³⁷ as a set of common measures co-designed across sectors to support multi-sector collaboration to address equity and social determinants of health. These measures prioritize prevention over the life course, are aligned with the objectives of Healthy People 2030, and provide common measures that meet the needs of a diversity of sectors and can facilitate cross-sector collaboration to improve population health with an equity and social determinant of health lens.

***The recommendation:* HHS should adopt shared measures that prioritize prevention across sectors, such as the WIN measures and Healthy People 2030 Objectives, into its prevention strategy as well as support integration into the Federal Data Strategy across agencies. These measures should inform learning and evaluation as well as incentives. Population health strategies should be developed to move these measures and they should be tracked over time. HHS should assure that common measures used across sectors are integrated into federal data collection processes and that the data should be accessible in an equitable way to communities at the local sub-county level. Finally, HHS should put processes and protections into place to assure that data cannot be used to harm subpopulations and communities.**

The example: In the state of Delaware, multiple agencies across sectors (health care, public health, police, corrections, social services) are using the WIN measures to improve the health and well-being of people with mental health and addictions. They have set common outcome

³⁵ Trillium Community Health Plan. <https://www.trilliumohp.com/about-us/trillium-background.html>

³⁶ Community Prevention and Wellness Committee. Yamhill Community Care. <https://yamhillcco.org/about-us/cpw-committee/>

³⁷ Well Being in the Nation (WIN) Measures. <https://www.winmeasures.org/statistics/winmeasures>

goals around well-being, years of life gained/lost, reduced deaths of despair, as well as measures specific to each sector and collaboration across sectors. This process has led them to develop mechanisms to share information across sectors and to plan for the population over the life course as part of an integrated improvement effort across sectors.

Conclusion

We hope that this offering issues, recommendation and examples is helpful. Thank you again for the opportunity to offer input into HHS' PreventionX Request for Information. We look forward to working you further to advance effective prevention strategies. For more information, please contact John Auerbach, President and CEO of Trust for America's Health, at jaeurbach@tfah.org.

Sincerely,

100 Million Healthier Lives
American Public Health Association
Association of Schools and Programs of Public Health
Big Cities Health Coalition
Institute for People, Place and Possibility
The Los Angeles Trust for Children's Health
National Academy for State Health Policy
Prevention Institute
Public Health Foundation
Trust for America's Health
Well Being and Equity in the World
Well Being in the Nation Network