2011 Joint Annual Meeting of the Safe States Alliance, SAVIR, and CDC Core I & II State Injury Grantees

OPENING PLENARY PRESENTATION

Iowa City, IA

April 6, 2011

Together we can save millions of lives.

DECADE OF ACTION FOR ROAD SAFETY 2011-2020

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Moving to a society that values prevention: Opportunities in health reform

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Injury Prevention: “Progress through Partnerships”

Iowa City, IA

April 6, 2011

Trust for America's Health
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Who is TFAH?

- Making prevention a national priority
- Evidence-based advocacy
  - Define problems and their solutions
  - Frame important messages
  - Advocate for solutions
  - “Watchdog” implementation and policy
- Independent voice
- Select key issues that frame the case

Nothing less than transformation

- US life expectancy rates among lowest in developed world
- US health care costs are highest in the world
- Current focus is on sick care
- Prevention has been seen as biomedical
  - Our biggest problems – from HIV to obesity – haven't had biomedically-based solutions…and we shouldn't be waiting for them
  - Need to think about context of choice and risk
    - What are structural solutions rather than biomedical or strictly behavioral ones

Health reform offers the potential for this transformation

- What are the prevention elements in the Affordable Care Act?
- How did prevention become a key part of health reform?
- What are the particular challenges ahead for prevention in the new political climate?
  - What are the opportunities for rethinking violence and injury prevention in the context health reform?

Key elements of health reform

- Coverage expansion does have a prevention effect
- First dollar coverage of clinical preventive services
- Government-wide commitment to prevention through the National Prevention, Health Promotion and Public Health Council
  - National Prevention and Health Promotion Strategy
- Commitment to new programs in community prevention
- Public health workforce
- Nutrition labeling

Vast expansion of coverage

- Expansion of Medicaid to all up to 133% of FPL
  - Initial 100% federal match in 2014-16; state option earlier
- Guaranteed issue of health insurance (and mandate to have it) for all (2014)
  - Subsidies up to 400% of poverty – covering both premiums and cost sharing
  - Underwriting limited to age, geography and smoking history
- Pre-existing Condition Insurance Plan
  - Immediate access to subsidized insurance for people who have been denied coverage due to a pre-existing condition

Additional protections

- Immediate:
  - No rescissions
  - No pre-existing condition exclusions for kids
  - No lifetime caps; regulation of annual caps
  - Coverage of kids to 26
- 2014:
  - No pre-existing condition exclusions for adults
  - Coverage of routine costs associated with participation in clinical trials

Coverage of preventive services

- Requires **new** health plans to cover without cost-sharing:
  - Evidence-based items or services rated A or B by the USPSTF
  - ACIP recommended immunizations
  - Preventive care for infants, children, and adolescents recommended by HRSA, and additional preventive care and screenings for women recommended by HRSA.
    - How to translate violence and injury recommendations into coverage?
- Provides 1% FMAP increase for states that offer Medicaid coverage of and remove cost-sharing for A and B USPSTF recommended services and ACIP recommended immunizations. (Effective January 1, 2013)
- Eliminates cost-sharing for Medicare-covered preventive services that are USPSTF recommended A or B services and authorizes the Secretary to modify Medicare coverage of preventive services based on USPSTF recommendations.

Coverage doesn't = access

- Expansion of the safety net
  - $11 billion over 5 years for expansion of community health centers
    - Effort to reduce CHC funding in House FY11 appropriations bill
- Major investment in healthcare workforce
  - $250 million from Prevention and Public Health Fund in FY 2010
- Improved (temporary) reimbursement for Medicaid providers to Medicare rates

Quality improvement

- Major investment in comparative effectiveness research
- Major investment in Health Information Technology
  - Implications for surveillance and for measuring quality of care
    - Prevention Fund investment in health reform surveillance

Real money for prevention

- Prevention and Public Health Fund
  - $15 billion over 10 years
  - Mandatory funding stream

Purpose of the Fund: Non-clinical prevention

- "Typically prevention and public health initiatives are subject to unpredictable and unstable funding. This means that important interventions…often go unfunded from one year to the next. …. The prevention and public health fund in this bill will provide an **expanded and sustained national investment** in programs that promote physical activity, improve nutrition, and reduce tobacco use. We all appreciate that checkups and immunizations and other clinical services are important. But this bill also recognizes that **where Americans live and work and go to school also has a profound impact on our health**. This is the very first opportunity in a generation – one that may never return – to **invest in modernizing the public health system.**" (Senator Harkin, December 21, 2009, Congressional Record, pp. S13661-62.)

Fiscal Year 2010 – $250 million for public health and prevention

- $44 million for approved but not funded ARRA grants
- $16 million for tobacco cessation activities
- $20 million for primary and behavioral health integration
- $16 million for obesity prevention and fitness
- $20 million for Epi and Lab Capacity state grants
- $50 million for state public health infrastructure
- $15 million for public health training centers
- $30 million for HIV/AIDS
- $8 million for public health workforce
- $10 million for Community and clinical preventive services task forces
- $21 million for surveillance

FY 2011 -- $750 million

- Community and State Prevention--$222 million
  - $145 million for CTGs
- Tobacco Prevention -- $60 million
- Obesity Prevention and Fitness -- $16 million
- Clinical Prevention -- $182 million
  - Immunizations
  - Behavioral health and primary care integration
- Public Health Infrastructure -- $137 million
- Research and Tracking -- $133 million

FY 2012 (Proposed) -- $1 billion

- CDC -- $752 million
  - CTGs -- $221 million
  - Chronic Disease Grants -- $158 million
  - Immunizations -- $62 million
  - Unintentional injury -- $20 million
  - Tobacco -- $79 million
- HRSA -- $20 million (workforce)
- SAMHSA -- $92 million (integration)
- OS -- $135 million (tobacco, teen pregnancy)

National Prevention and Health Promotion Strategy

- National Prevention, Health Promotion and Public Health Council
  - Chaired by Surgeon General
    - HHS, HUD, USDA, ED, FTC, DOT, DOL, DHS, EPA, ONDCP, DPC, Asst. Secretary for Indian Affairs
    - Others: VA, DOD
  - Health in all policies
  - Due March 23, 2011
    - Vision: Improve life expectancy in the US, with a focus on disparities
  - External advisory group

Framework for Prevention Strategy

- "…we're putting our focus in the White House on people and places in a way that we believe strengthens neighborhoods and improves health outcomes. We're using a multidisciplinary approach and strategy because, after all, every aspect of life includes health, it includes education, it includes housing and energy and transportation. People don't wake up in the morning and say "I'm going to have an education day today and tomorrow I'm going to have a transportation day." For families, all of these pieces are integrated so we have to start thinking about our policies and our approach in that same integrated fashion. So, for us, what we're trying to insure, is that the days of thinking and working and talking in silos is, in fact, over."
  - Melody Barnes, Domestic Policy Advisor, July 13, 2010

Draft National Prevention Strategy

- Achieve significant gains in life expectancy at birth and at age 65 within a generation
  - Healthy Communities – where people live, learn, work, and play
  - Preventive Clinical and Community Efforts
  - Empowered Individuals
    - Focus on disparities
    - Mental and emotional wellbeing

True community-based prevention

- Community Transformation Grants
  - Requires detailed plan for policy, environmental, programmatic and infrastructure changes to promote healthy living and reduce disparities
    - Create healthier school environments, including healthy food options, physical activity opportunities, promotion of healthy lifestyles
    - Develop and promote programs targeting increased access to nutrition, physical activity, smoking cessation and safety
    - Highlight healthy options at restaurants and food venues
    - NOT limited to chronic diseases or one disease at a time

What might CTGs look like?

- Examples of policy and structural change
  - High impact efforts to make healthy choices easier
  - Sustainable over time
    - Smoke free air laws
    - Improved nutrition choices in schools, supermarkets, corner stores
    - Taxes (tobacco, alcohol)
    - Zoning laws
    - Syringe exchange, condom availability
- Eligibility: State and local government, national networks of CBOs, and local CBOs
- Expectations:
  - Demonstrated ability to bring together a coalition
  - Have or use grants to build policy development capacity
  - Inclusion of state/local public health agencies in coalitions

CTGs (and Prevention Fund) push us to think across silos

- Physical activity: obesity, diabetes, cardiovascular disease, depression, injury, school performance, STDs in young
- Anti-bullying: suicide prevention, HIV/STD prevention

How did prevention – esp. community prevention -- become so important?

- Coverage is important, but what surrounds (or precedes) coverage is also important
  - Achieving good health outcomes requires healthy communities, not just healthy individuals
- Drivers of health care costs (chronic disease) can often be effectively *prevented* in the community as opposed to *managed* in the health care setting
  - Reducing costs as a critical policy outcome
- Disparities in chronic diseases related to disparities in the "health" of communities
  - Poverty, race/ethnicity and obesity
  - Poor communities provide less support for healthy lifestyles (food, physical activity)

How did we get the policy and political support?

- We spoke about health and prevention – not about “public health”
- We spoke about making healthy choices the easy choices
  - We avoided language and policies that sounded like the “nanny state”
- We acknowledged that there is a role for personal responsibility
  - Based on sound polling and messaging research

We weren't afraid to make the economic case

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The New York Academy of Medicine
At the heart of urban health since 1847

Prevention Institute
Putting prevention at the center of community well-being

Urban Institute

Robert Wood Johnson Foundation

The California Endowment

Prevention for a Healthier America: Financial Return on Investment?

With a Strategic Investment in Proven Community-Based Prevention Programs to Increase Physical Activity and Good Nutrition and Prevent Smoking and Other Tobacco Use

INVESTMENT:	**$10 per person per year**
HEATH CARE COST NET SAVINGS:	**$16 Billion annually within 5 years**
RETURN ON INVESTMENT (ROI):	**$5.60 for every $1**

Trust for America's Health

Prevention is central to ACA implementation – government wide

"…[W]e shouldn't be waiting for problems – we should be preventing them. And that means tackling the causes of illness where those causes lie – in our communities, our habits, our social supports, our choices – where we live. America is seriously under-invested in using what we know about preventing illness, and we therefore live with the chronic epidemics of obesity, heart disease, asthma, and depression, for example, that we don't need to live with. I intend to guide CMS toward the Triple Aim as our highest-level goal – better care, better health, and lower per capita costs, and I intend to focus our energies, as much as I can, on those three levels of excellence: excellence in care…, excellence in integration, and excellence in prevention at the community level."

Donald Berwick, CMS Administrator, NASHP Conference, October 2, 2010

Opportunities within CMS

- Accountable Care Organizations, Medical Homes
- Center for Medicare and Medicaid Innovation ($10 billion over 10 years)
  - Care Models Group
  - Integrated Care Models Group
  - Community Improvement Care Models Group
    - Exploring steps to improve public health and make communities healthier and stronger by fighting the epidemics of obesity, smoking, and heart disease
- $100 million Medicaid Incentives for Prevention of Chronic Diseases
- Public health quality standards and measures within current structure

Other opportunities

- Structure of exchanges
  - Essential health benefits
    - Prevention beyond USPSTF
  - Essential health providers
- IRS regulations on community benefit (non-profit hospitals)

What are the opportunities for violence and injury prevention?

- HIT: Thinking about surveillance differently – more data used more creatively
- Make the economic case – especially with regard to Medicaid and Medicare
- Think outside silos (e.g., CTGs)
- Integrating into the new health care system
  - ACOs, Medical Homes
  - *Who* gets reimbursed
  - *What* gets reimbursed
    - *Can we adjust our business model to take advantage of this opportunity?*

Above all – maintaining a focus on transformation/modernization

- Even with the Prevention Fund, base funding for public health may decline
- Do we fill gaps or do we keep our focus on transformation?
- Do we fight across-the-board cuts with a prioritization of what is most important to preserve and expand?

The challenges in a changing political climate….

- Legislative and legal challenges to reform
- Legislative challenges to the Prevention Fund
- Making the case for prevention:
  - ROI from community prevention
  - Messaging about healthy choices vs. nanny state
- Continuing to build the evidence base
  - "Valuing" prevention
  - Success stories

For further information

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