

PREVENTION FIRST



**Transforming
a Fragmented
Healthcare System
Into a System Designed
to Produce Health**

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Foreword

The United States stands at a defining moment for health. For decades, we have built a healthcare system that is extraordinarily good at treating illness once it has taken hold, yet far less effective at preventing disease in the first place. The consequences are now impossible to ignore. Chronic disease continues to rise, health disparities remain pervasive, and costs place growing strain on families, employers and public programs. If we are serious about improving health outcomes and reducing healthcare costs, we must begin with a clear understanding of where health is created. Health is shaped every day in homes, schools, workplaces and neighborhoods. It is influenced by access to nutritious food, safe housing, safe places to play, clean air and water, education, transportation, meaningful work and social connection. Medical care matters deeply, but medical care alone cannot produce health. A system that focuses primarily on episodic treatment will always fall short.

These facts call for a new plan, an overarching strategy for a fundamental shift in how we organize healthcare and public health in the United States. Prevention must become the central purpose of the system, not an afterthought or a limited set of services. That shift requires aligning how care is financed, delivered, measured and led so that success is defined by fewer preventable illnesses and injuries, longer healthy lives and measurable progress toward equity. Achieving this transformation will require leadership that can operate across traditional boundaries. We need leaders who understand both individual patient care and population health, who can translate data into action and who can connect healthcare systems with public health agencies, community organizations and policymakers. The specialty of Preventive Medicine was built for this moment. Preventive Medicine physicians are trained in clinical prevention, epidemiology, biostatistics, behavioral and environmental health, informatics and health systems management. This combination equips them to design and lead prevention strategies and systems that work for the individual, community, state and national levels, delivering real results.

For more than seventy years, the American College of Preventive Medicine has worked to advance this vision and prepare physicians to lead at the intersection of medicine and public health. This document builds on that legacy and responds to the urgency of the present moment. It outlines a practical, ten-year strategy organized around eight core pillars that strengthen prevention across medical education, workforce development, care delivery, financing, community integration, data infrastructure, private-sector engagement and national leadership. This framework is offered as both a call to action and an invitation. Building a prevention-first healthcare system will require sustained commitment from government, healthcare organizations, employers, insurers, academic institutions, philanthropy and communities themselves. With shared responsibility and coordinated effort, we can move from a system that primarily reacts to disease to one that actively protects and promotes health for all Americans.

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Executive Summary

The United States “healthcare system” was not designed to proactively produce health. It was designed to reactively respond to disease.

Over generations, American medicine has achieved extraordinary advances in diagnosis and treatment. These advances have saved lives and transformed once-fatal conditions into manageable illnesses. Yet the nation’s healthcare system remains fundamentally oriented toward treating disease after it develops (and tragically, very often at late stages) rather than preventing illness before it occurs. Preventable chronic disease notably accounts for the majority of morbidity, mortality and healthcare spending, driven by well-understood risks and conditions that the healthcare system does not consistently address. The central problem is not scientific uncertainty or lack of resources. The central problem is fragmentation, with little or no focus on prevention.

Responsibility for health is distributed across healthcare providers, insurers, public health agencies, employers, community organizations and multiple levels of government. Payment systems operate independently. Public and private coverage systems function in parallel. Community institutions address social and environmental conditions separately from clinical care. Data systems remain disconnected across programs and sectors. Individuals move repeatedly between coverage systems without continuity of prevention strategy or sustained accountability for long-term outcomes. Each institution contributes to health, but no institution is responsible for health.

This fragmentation prevents the United States from addressing the underlying causes of disease in a coordinated and sustained way. Healthcare institutions focus primarily on treatment. Public health agencies address population conditions with limited integration into clinical care. Community organizations operate through independent programs. Employers and insurers bear long-term costs but have limited ability to influence the organization of care. Data systems capture episodes of illness more effectively than trajectories of health. Without alignment across these domains, prevention remains episodic and improvement remains difficult to sustain. *Fragmentation is the central barrier to prevention.*

The Prevention First strategy begins from a single organizing premise:

Improving health requires transforming a fragmented healthcare system into a coordinated system accountable for long-term health outcomes and preventing the root causes of disease.

“Prevention First” does not treat prevention as a set of services to be expanded within the existing system. It treats prevention as a primary structural responsibility of the healthcare system itself.

A Prevention First health care system must accept responsibility not only for treating illness but also for addressing the conditions that produce illness.

Health outcomes are shaped by behavioral risks, environmental exposures, social conditions and the built environments in which people live and work. Healthcare organizations alone cannot address these drivers of health, but the health system must be organized so these factors are systematically identified, measured and addressed through coordinated action across clinical care, public health, employers, community organizations and government programs. This requires an expansion of accountability.

Prevention First calls for shared accountability for long-term health outcomes across the institutions that shape health. Providers, insurers, public health agencies, employers, community organizations and government programs must operate within a framework that accepts responsibility for improving health across populations over time. Without shared accountability, prevention remains optional and improvement remains temporary. Shared accountability requires measurement.

A Prevention First healthcare system must be able to identify health risks early, coordinate prevention strategies and evaluate outcomes across populations and communities. Reliable population-level measurement is essential for guiding prevention strategies and sustaining improvement over time. Without shared measurement, transformation cannot be guided or sustained. Prevention First therefore approaches healthcare reform as a problem of system design.

For decades, reform efforts have often focused on individual programs, demonstration projects or isolated policy changes. These efforts have produced important advances but have not changed the underlying structure of the healthcare system. Prevention First instead recognizes that improving health requires a coordinated system in which training, workforce capacity, delivery systems, financing, community institutions, private-sector organizations, data infrastructure and national leadership operate within a shared framework.

Payment reform is necessary but not sufficient. Delivery reform without workforce capacity cannot be sustained. Workforce development without training reform cannot be implemented. Prevention programs without measurement cannot improve. Community initiatives without clinical integration cannot achieve lasting impact. Data systems without coordination cannot guide decision-making. Leadership without system redesign cannot produce results.

A preventive healthcare system emerges only when these elements develop together. For this reason, the Prevention First strategy is organized around eight mutually reinforcing pillars, each representing a structural component of a preventive healthcare system:

- **Pillar 1 — Reform Medical Training to Build a Prevention First Healthcare System**
Prepare clinicians across specialties to identify health risks, apply prevention strategies, and manage health improvement across populations.
- **Pillar 2 — Build the Preventive Medicine Workforce**
Develop the physicians and interdisciplinary leaders capable of designing and sustaining prevention-centered health systems.

- **Pillar 3 — Prevention-Centered Care Delivery**
Align payment and delivery systems around sustained reduction of major health risks and long-term improvement in outcomes.
- **Pillar 4 — Financing Prevention and Aligning Incentives**
Reduce fragmentation across payment and coverage systems so universally accepted prevention strategies can operate continuously across populations.
- **Pillar 5 — Private Sector Engagement**
Engage employers, insurers, and healthcare organizations as active and invested partners in prevention-first transformation and shared measurement.
- **Pillar 6 — Community and State-Level Prevention Systems**
Coordinate healthcare providers, public health agencies, and community organizations to measurably address the root causes of disease and improve the conditions that shape long-term health outcomes.
- **Pillar 7 — Prevention Data Infrastructure**
Build prevention-first measurement and coordination capabilities on top of existing public and private data systems while strengthening privacy protections and public trust.
- **Pillar 8 — Prevention First Leadership and Implementation**
Establish durable national leadership capable of coordinating prevention-first transformation and sustaining accountability across sectors and levels of government.

These pillars are not independent initiatives. They are interdependent elements of a single, preventive health system. Training reform without delivery reform will not change practice. Financing reform without measurement cannot sustain improvement. Community prevention without shared accountability cannot address root causes of disease. Data infrastructure without coordinated leadership cannot guide transformation.

Prevention First succeeds only when all pillars advance together.

The Prevention First strategy builds on existing institutions rather than replacing them. Medicare, Medicaid, employer-sponsored insurance, public health agencies, healthcare organizations and community programs already contain many of the elements required for Prevention First healthcare. The goal of this strategy is to align and strengthen these systems, so they synergistically function as a coordinated framework for improving health.

Preventive Medicine provides the intellectual and operational foundation for this transformation. As the only ACGME/ABMS-recognized medical specialty integrating clinical care, epidemiology, general population health and health system design, Preventive Medicine is uniquely positioned to lead the development of a healthcare system organized around improving long-term health and preventing disease, and not merely one that is limited to reaction to episodic illness.

Prevention First transformation is too large and too important to be left to fragmented implementation. It requires sustained leadership capable of coordinating action across sectors and maintaining accountability for results.

The United States has the knowledge, the tools and the institutional capacity required to build the world's first, best and only Prevention First healthcare system. What has been missing is a strategy for alignment.

Prevention First provides that strategy.

Pillar 1

Reform Medical Training to Build a Prevention First Healthcare System

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Introduction

Achieving a Prevention First healthcare system requires strengthening preventive competencies across the clinical workforce and ensuring prevention becomes a central component of clinical training and practice. Prevention cannot be confined to a limited number of specialists or isolated programs. Instead, clinicians across specialties must be prepared to identify health risks, apply evidence-based prevention strategies, support behavior change and monitor health outcomes over time.

Medical education plays a central role in preparing the clinical workforce to deliver prevention-oriented care. A healthcare system organized around prevention requires clinicians who understand population health and the drivers of disease, can apply prevention strategies both individually and systematically and can evaluate outcomes across individuals and populations.

Despite broad recognition of the importance of prevention, current medical education does not consistently prepare clinicians to deliver prevention-centered care. Preventive competencies are often fragmented across curricula, not consistently integrated into clinical training. Strengthening preventive competencies and instilling a prevention-focused mindset across the clinical workforce is therefore an essential step toward achieving a Prevention First healthcare system.

Section 1 – The Structural Problem: Training Does Not Support Prevention First Care

Current medical education does not consistently prepare clinicians to deliver comprehensive prevention-oriented care across populations. Training programs often emphasize diagnosis and treatment of disease (very often late-stage disease) rather than systematic prevention and long-term health improvement. Preventive competencies are frequently treated as supplemental rather than core clinical skills.

This pattern begins during undergraduate medical education and continues through graduate medical education. Clinical training in the third and fourth years of medical school is frequently organized around hospital-based experiences and specialty rotations, emphasizing diagnosis and treatment of established disease in predominantly tertiary care settings. While these experiences provide essential clinical preparation, they do not consistently expose trainees to longitudinal prevention, population health management or community-based approaches to improving health.

Graduate medical education reinforces these patterns. Residency programs are largely organized around hospitals and specialty services, and trainees spend much of their clinical education in environments focused on acute illness and complex disease management. The emphasis is frequently around amassing a minimum number of invasive procedures performed or complex hospital admissions managed. These experiences are essential for the treatment of late-stage disease or catastrophic injury, but do not by themselves prepare clinicians to deliver prevention-centered care.

Training experiences frequently do not provide sufficient exposure to prevention in community settings or to longitudinal approaches to health improvement. As a result, clinicians may enter

practice without consistent preparation in systematic risk reduction and long-term preventive strategies, in essence, only knowing how to treat established disease, and not knowing how to promote whole-person wellness.

Training environments shape clinical practice. When medical education is organized primarily around hospital-based care, clinicians naturally learn models of practice centered on episodic treatment of illness. A Prevention First health system requires training environments that consistently emphasize prevention, population health and long-term risk reduction alongside the diagnosis and treatment of disease. The only way to decrease disease burden and make America healthier is to intervene along the entire health continuum, but most importantly before disease processes ever start.

Section 2 – Universal Preventive Competencies

The Prevention First framework proposes developing universal preventive competencies that apply across the clinical workforce. These competencies support prevention-oriented clinical practice across specialties and practice settings.

Risk Identification and Assessment

- Identify major health risks across patient populations
- Apply evidence-based screening and risk assessment tools
- Recognize behavioral, environmental, and social contributors to health risk
- Stratify patients according to levels of health risk

Evidence-Based Prevention

- Apply evidence-based preventive interventions
- Implement guideline-based preventive services
- Integrate prevention into routine clinical care
- Tailor preventive strategies to individual patient needs

Behavioral and Lifestyle Interventions

- Support behavior change using evidence-based methods
- Counsel patients on nutrition, physical activity, sleep and substance use
- Apply principles of lifestyle medicine
- Support long-term adherence to prevention strategies

Population Health Skills

- Understand population health principles
- Interpret population health data
- Apply risk stratification methods
- Participate in population health improvement activities

Data, Measurement and Improvement Skills

- Use data to guide prevention strategies
- Monitor prevention outcomes
- Evaluate program effectiveness
- Participate in continuous quality improvement activities

These competencies should be integrated into undergraduate medical education, graduate medical education and continuing professional education, and reinforced throughout clinical practice. Prevention requires continuous measurement and refinement of interventions over time. Clinicians must be prepared not only to deliver preventive services, but also to evaluate their effectiveness and improve prevention strategies based on observed outcomes. Training programs should prepare clinicians to use data to monitor health risks, assess progress toward improvement and refine preventive approaches over time. These skills support continuous quality improvement and are essential for prevention-centered clinical practice.

As with anything, “what gets measured gets done.” More importantly, clinicians need to understand what is important to monitor; why, when and how to intervene; and how to determine if the intervention has been successful or requires redirection. Clinicians should be prepared to evaluate preventive training and intervention outcomes and improve prevention programs using continuous quality improvement methods.

Section 3 – Prevention Training Environments

Training programs should provide opportunities for clinicians to develop preventive skills across clinical and community settings, and not merely focus on reactionary, procedure-intense care in late-stage settings. Prevention education should include experience in settings where clinicians can address health risks over time and across populations.

Training environments should include:

- Primary care practices
- Community health centers
- Public health agencies
- Rural health systems
- Employer-based health programs
- Non-governmental organizations
- Area Health Education Centers

Exposure to prevention-oriented practice environments allows clinicians to develop skills in longitudinal prevention and population health improvement. Prevention is delivered through sustained engagement that includes surveillance, monitoring, outreach, treatment adjustment, behavioral support and continuous quality improvement. Training environments should provide opportunities for clinicians to participate in these activities and understand how prevention is implemented in real-world settings.

Prevention-centered clinical environments are characterized by longitudinal engagement with defined populations, systematic monitoring of health risks and coordinated delivery of prevention services over time. Clinicians in these environments work as part of interdisciplinary teams and use data to guide prevention strategies and monitor progress toward improved outcomes.

Training experiences should include participation in preventive activities such as population risk identification, ongoing risk monitoring, targeted prevention outreach and coordination of clinical and community-based services. Trainees should gain experience using data systems to identify high-risk populations, track preventive activities and evaluate outcomes over time. These operational capabilities distinguish prevention-centered practice from traditional episodic models of care and should be reflected in prevention training experiences.

Section 4 – Prevention Across All Specialties

Prevention is a responsibility shared across the clinical workforce and should not be limited to specific specialties. Clinicians in all specialties play an important role in prevention through risk identification, patient counseling, and evidence-based preventive interventions.

Training programs should prepare clinicians to incorporate prevention into routine clinical practice. This includes the following:

- Risk factor identification
- Patient education
- Behavior change support
- Chronic disease prevention
- Preventive care coordination
- Longitudinal risk monitoring
- Prevention/mitigation of disease impact

Prevention should be treated as a core clinical function integrated into routine patient care across specialties and practice settings. A Prevention First health system requires clinicians to view prevention as a central component of clinical responsibility rather than an optional activity layered onto treatment-focused care. Clinicians across specialties should understand that long-term risk reduction and health improvement are core objectives of clinical practice.

Prevention should be integrated into routine clinical workflows so that identification of health risks, support for behavior change and monitoring of long-term outcomes become standard components of care. This approach positions prevention as a shared responsibility across the clinical workforce and supports consistent delivery of prevention-oriented care.

Prevention is a core clinical responsibility, rather than an optional addition to treatment-focused care. Prevention should be a central organizing principle of clinical practice, with longitudinal risk reduction as a clinical responsibility, which fosters integration of prevention into routine care across specialties.

Section 5 – Training Reform as System Reform

Medical education influences clinical practice patterns and the organization of healthcare delivery. Efforts to strengthen prevention within the healthcare system depend on clinicians who are prepared to deliver prevention-oriented care. Reforming medical education is therefore an essential component of healthcare transformation. Payment reform and delivery system redesign alone cannot produce a Prevention First health system without corresponding changes in clinical training.

Training environments that emphasize prevention and population health will help produce clinicians who organize care around long-term health improvement. Over time, these practice patterns will support the development of healthcare systems that place prevention at the center of care delivery.

Training environments shape models of care. Clinicians trained in hospital-centered environments tend to foster hospital-centered systems, while clinicians trained in prevention-centered environments develop models of care organized around long-term health improvement. Prevention-centered training produces prevention-centered practice, and prevention-centered practice supports the development of prevention-centered delivery systems. Without reform of medical training, structural healthcare reform will remain incomplete.

Training reform is a vital component of healthcare system transformation: training environments shape models of care; prevention-centered training produces prevention-centered practice; and prevention-centered practice supports prevention-centered delivery systems. Without reform of medical training, structural healthcare reform will remain incomplete, if not altogether impossible.

Section 6 – Policy Recommendations

Establish Universal Preventive Competencies

Universal prevention competencies should be incorporated into undergraduate medical education, graduate medical education, and continuing professional education. Accreditation standards and certification requirements should support the development and assessment of prevention competencies across specialties.

Preventive competencies should include:

- Risk identification and assessment
- Evidence-based prevention strategies
- Behavioral interventions and lifestyle medicine
- Population health approaches
- Data-informed decision making
- Continuous quality improvement

Training programs should demonstrate that graduates are prepared to apply prevention competencies in clinical practice.

Expand Preventive Training Environments

Training programs should include structured experiences in prevention-oriented settings that allow clinicians to develop skills in longitudinal prevention and population health improvement.

Training experiences should include meaningful participation in:

- Risk identification and monitoring
- Prevention outreach activities
- Behavioral interventions
- Longitudinal prevention management
- Continuous quality improvement activities

Training environments should include community-based clinical settings, public health agencies, rural health systems, and population health organizations. Training programs should provide sufficient duration and intensity of prevention experiences to allow meaningful skill development.

Align Accreditation and Certification with Prevention Competencies

Accrediting bodies and specialty boards should support the integration of preventive competencies into clinical training and professional standards. Certification and accreditation standards should recognize prevention as a core clinical responsibility across specialties and support the integration of prevention competencies into clinical training, evaluation and continuing education.

Pillar 2

Building the Preventive Medicine Workforce

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Introduction

A Prevention First health system requires a workforce capable of improving health at both the individual and population levels. Clinicians must be prepared not only to diagnose and treat disease but also to identify health risks, support behavior change, design prevention strategies, evaluate outcomes and continuously improve health systems over time. Building such a specialized physician workforce is essential to achieving the broader transformation outlined in this document.

The strategies described in Pillar 1 cannot be implemented at scale without a workforce prepared to design, lead and sustain prevention-centered systems. Pillar 2 therefore addresses the workforce foundation required to make prevention-first healthcare achievable in practice.

Preventive medicine physicians serve as system architects for prevention-first healthcare. They help design prevention-centered delivery systems, guide implementation across clinical and community settings, and support continuous improvement through measurement and evaluation. Preventive medicine physicians also serve as clinicians caring for individual patients, leaders of multidisciplinary teams, educators who prepare other clinicians to deliver prevention-oriented care and advisors to organizations working to improve population health. Through these roles, preventive medicine physicians help translate prevention principles into practical models that improve health outcomes.

A Prevention First health system depends on a specialized physician workforce prepared to lead long-term health improvement. The development and support of preventive medicine physicians is therefore a national priority. Expanding this workforce will strengthen the nation's ability to design, implement and sustain prevention-centered healthcare systems and will support the broader transformation described throughout this document.

Section 1 – Defining Preventive Medicine

Preventive medicine physicians play a central role in the transition to a Prevention First health system. Their specialized training prepares them to integrate clinical care, public health practice and health system design in ways that support long-term health improvement. Preventive medicine is an ACGME/ABMS-recognized medical specialty focused not only on the health of individuals, but also on the health of populations. And equally important, focused not only on curing disease, but also on preventing disease and promoting wellness through clinical care, public health practice and health system leadership. Physicians in this field are trained to diagnose and manage disease risk at both the individual and population levels using tools from epidemiology, biostatistics, behavioral science, environmental and occupational health, informatics and policy analysis.

What distinguishes preventive medicine from other specialties is their dual training. Preventive medicine physicians complete clinical training focused on prevention and population-level conditions along with formal public health education, typically through a Master of Public Health degree. Training includes rotations in a variety of public health and health system settings, preparing physicians to address health risks at both the individual and population levels — across the spectrum from whole-person health promotion to late-stage disease interventions.

Preventive medicine physicians work in diverse settings including healthcare systems, public health agencies, academic institutions, government programs, community organizations and private industry such as insurance, pharmaceutical and workplace health. In these settings, they design and implement programs to improve health outcomes, reduce disease burden and strengthen healthcare delivery systems. Their work spans roles at the patient bedside, in health system leadership and in policy and program development.

Preventive medicine physicians contribute to healthcare improvement in several key ways:

- Providing clinical preventive services and managing patients with chronic conditions and health risks
- Designing and implementing population health improvement initiatives
- Developing and evaluating prevention programs
- Leading interdisciplinary teams and multi-sector collaboratives
- Translating scientific evidence into clinical and public health practice
- Evaluating programs to ensure effectiveness and return on investment
- Designing healthcare delivery and payment models that support prevention
- Advising policymakers and organizational leaders on prevention strategies

Preventive medicine physicians uniquely combine clinical expertise with population health training. Their training prepares them to understand how healthcare delivery systems, public health infrastructure, and community conditions interact to influence health outcomes. This combination allows preventive medicine physicians to serve as integrators across sectors and to align clinical care with broader preventive strategies.

Because preventive medicine physicians are trained to work across clinical and population levels, they play a critical role in connecting healthcare delivery with public health and community-based prevention efforts. The breadth of preventive medicine training allows physicians in this specialty to unify aspects across clinical care, public health and community-based prevention. This integrative capability is essential to the Prevention First healthcare strategy described in this document, which depends on coordinated action across sectors and sustained improvement over time. Moreover, preventive medicine training uniquely positions physicians in this specialty to serve as neutral arbiters of evidence-based best practices at both the individual patient and population levels.

Key Domains of Preventive Medicine Practice

Clinical Prevention and Lifestyle Medicine

Preventive medicine physicians work with individuals to promote wellness, prevent disease, mitigate infectious disease spread and manage chronic disease risk factors. In clinical settings they implement screening protocols, provide counseling and coordinate follow-up care for preventive interventions. Their work spans diverse clinical environments including primary care, sexually transmitted infection clinics, obesity treatment programs, travelers' health services and prevention-focused infectious disease programs, to name just a few. Many preventive medicine physicians also practice lifestyle medicine, using evidence-based approaches such as nutrition

improvement, physical activity, sleep optimization, stress management, social connection and avoidance of harmful substances to reduce health risks and improve long-term outcomes.

Population Health and Epidemiology

Preventive medicine physicians use population health data to identify trends, disparities and emerging threats. They conduct surveillance, investigate disease outbreaks, assess community health needs, design and implement prevention programs, and evaluate program effectiveness. Advanced training in epidemiology and biostatistics enables preventive medicine physicians to translate data into actionable insight that informs policy and strategy. Preventive medicine physicians work within local and state health departments as well as federal agencies and international health organizations, improving health outcomes across defined populations and communities.

Health Systems Leadership and Management

Preventive medicine physicians frequently serve in leadership roles within healthcare organizations. They design programs to improve quality, safety and equity, and lead initiatives related to infection control, emergency preparedness, chronic disease management and population health improvement. Preventive medicine physicians also serve in public and private payer organizations, contributing to alternative practice and payment models that improve outcomes and cost-effectiveness at scale. Their systems-level training positions them to coordinate prevention activities across clinical departments, public health agencies, payers and community organizations.

Public Health Preparedness and Emergency Response

Preventive medicine physicians play essential roles in public health preparedness and emergency response. They bring expertise in crisis and risk communication, vaccination strategies, risk mitigation, environmental health and toxicology and coordination with emergency management partners. Preventive medicine physicians serve as trusted messengers who translate scientific evidence into clear guidance for the public and for decision-makers.

Occupational and Environmental Medicine

A subset of preventive medicine physicians is board-certified in the ABMS-recognized specialty of Occupational and Environmental Medicine, addressing workplace safety, industrial hygiene, environmental exposures and injury prevention. These physicians help promote and maintain workforce productivity and well-being while supporting compliance with health and safety regulations. Combined with the preparedness and emergency response functions described above, these preventive medicine physicians help maintain business continuity in the face of population-level health risks.

Addiction Medicine and Behavioral Health

Another growing subspecialty is addiction medicine. Preventive medicine physicians diagnose and treat substance use disorders using evidence-based therapies, harm reduction strategies and behavioral interventions. Their work supports recovery services and contributes to broader efforts to reduce the burden of substance-related harm. Preventive medicine physicians working

in the domain of addiction medicine may also develop and promote policies that operate on the population level.

Clinical Informatics and Data-Driven Innovation

Many preventive medicine physicians work in clinical informatics and data science roles, applying information systems and analytics to improve care delivery. They contribute to electronic health record design, predictive modeling and the strengthening of privacy and interoperability. These capabilities are increasingly central to preventive strategies that depend on early identification of risk, targeted interventions and coordinated data systems.

Section 2 – The Preventive Medicine Workforce Challenge

The Structural Need for Prevention-Oriented Workforce Development

The U.S. healthcare system faces mounting costs, uneven access to care, a growing burden of chronic disease and persistent disparities that threaten long-term population health and productivity. While technological advances have delivered life-saving interventions, they have also reinforced a model overly focused on tertiary and end-of-life care. The system continues to reward volume over value, acute treatment over prevention and high-cost intervention over early health promotion and disease prevention delivered through clinical and community-based vehicles.

Health is created in everyday life — in homes, workplaces, schools and neighborhoods — and is shaped by access to nutritious food, green spaces, safe housing, safe places to play, transportation, education, meaningful employment and social connection. Yet, the current U.S. healthcare model remains largely siloed from these upstream, non-medical drivers of health and fails to leverage the full range of tools available to promote well-being and prevent disease across the lifespan.

Recent public health emergencies, workforce shortages and growing fiscal pressures have exposed the limits of a treatment-first model and underscore the urgency of prevention-focused reform. A Prevention First healthcare system requires physicians and other professionals who are trained to diagnose and manage disease risk at both the individual and population levels, using tools from epidemiology, biostatistics, behavioral science, environmental health, informatics and policy analysis.

Preventive medicine physicians are uniquely prepared to lead and support this work within multidisciplinary teams because their training integrates clinical care with population health and systems leadership. However, the current workforce is not large enough to meet the growing need for prevention-oriented leadership across healthcare systems, public health agencies and community organizations.

The Workforce Gap

The United States lacks sufficient preventive medicine physicians to even support the current health system and public health infrastructure, and this gap becomes even more profound in terms of supporting a transition to a Prevention First health system. As healthcare systems increasingly emphasize prevention, population health and value-based care, demand is growing

for professionals who can design and lead prevention-centered strategies. However, the preventive medicine workforce remains small relative to the size and complexity of the U.S. healthcare system.

In 2025, fewer than 3,000 physicians were certified in Public Health and General Preventive Medicine, representing less than 0.5 percent of the U.S. physician workforce. This limited workforce constrains the nation's ability to design, implement, and sustain prevention-centered healthcare systems. The shortage of preventive medicine physicians is not simply a workforce issue within a single specialty. It represents a structural limitation on the nation's ability to build and sustain prevention-first healthcare systems. Without sufficient prevention-oriented leadership and expertise, efforts to improve population health and reduce long-term healthcare costs will remain fragmented and difficult to sustain.

Training Capacity Constraints

Preventive medicine residency programs represent the primary pathway for training board-certified preventive medicine physicians. However, the number of available residency positions remains limited due to lack of funding, and training capacity has not kept pace with the growing need for prevention-oriented leadership within the healthcare system.

Unlike most other residency programs, which are supported through stable Medicare Graduate Medical Education (GME) funding tied to hospital-based training, preventive medicine residency programs often rely on a patchwork of short-term funding sources, including federal grants, state support and institutional funding. This funding structure reflects a training system historically designed to support hospital-based care rather than prevention-oriented practice.

Preventive medicine training differs fundamentally from hospital-based specialty training. Preventive medicine residents typically spend substantial portions of their training and clinical time in public health agencies, community health programs, healthcare system leadership roles and population health initiatives rather than in inpatient hospital settings. These training environments are essential for developing the skills needed to design and manage prevention-centered systems of care, but they do not fit easily within traditional hospital-based GME funding models.

As a result, preventive medicine residency programs often cannot rely on the stable funding mechanisms that support hospital-based specialties. Instead, programs must assemble funding from multiple sources and frequently operate with uncertain or time-limited support.

The federal training grants, state support and institutional funding for preventive medicine varies from year to year. This funding uncertainty makes it difficult for programs to expand and creates challenges for long-term planning. In some cases, programs must reduce the number of trainees they accept or delay recruitment because funding cannot be guaranteed. In fact, year in and year out, preventive medicine residency programs receive more applications than the number of positions they are recruiting to fill. Those same programs are typically accredited and approved for more positions than they are filling but are forced to scale back their recruitment due to insufficient funding. Thus, each year training institutions could train many more preventive medicine physicians to address this workforce shortage but cannot do so because of the funding gap.

The unique structure of preventive medicine training is a strength of the specialty, but it also creates structural barriers to workforce expansion within a financing system built around hospital-based training. Without more stable and scalable training pathways that reflect the realities of prevention-oriented practice, the supply of preventive medicine physicians will remain insufficient to support even current needs, let alone long-term system transformation.

Limited Exposure to Prevention-Oriented Careers

Preventive medicine remains underrepresented within medical education and training. Most medical students and residents receive limited exposure to prevention-centered models of care or to the role of preventive medicine physicians. This limited exposure reflects historic and antiquated structural priorities within medical education rather than a lack of interest in prevention on the part of medical students, who routinely identify many of the previously noted preventive medicine topics as areas of high interest.

Undergraduate and graduate medical education in the United States are largely organized around hospital-based training environments that emphasize diagnosis and treatment of acute illness. These environments provide essential clinical experience, but they often provide limited opportunities to learn about disease prevention, health promotion or how health systems can be organized to improve long-term health outcomes across populations.

As a result, prevention and population health are often treated as secondary components of medical training, and many physicians complete their education with limited or no understanding of how prevention-centered systems operate or how preventive medicine physicians contribute to health system improvement. This structural imbalance contributes to workforce shortages and limits the nation's capacity to build prevention-oriented healthcare systems.

Workforce Distribution Challenges

Preventive medicine physicians work across a wide range of sectors, however, access to expertise in preventive medicine remains uneven across regions and organizations. Many healthcare systems, public health agencies and community-based programs operate without physicians trained and certified in prevention and population health, limiting these organizations' ability to design and implement effective preventive strategies. These same limitations are felt by many healthcare organizations, who are increasingly responsible for improving health outcomes across defined populations, yet lack access to preventive medicine physicians.

As healthcare systems increasingly adopt value-based payment models and population health approaches, the demand for preventive medicine expertise is growing. Healthcare organizations require professionals who can analyze population health data, design prevention programs, evaluate outcomes and guide system improvement efforts. Public health agencies and community organizations similarly require professionals who can connect clinical care with population-level prevention strategies.

Despite this growing demand, the supply of these physicians remains limited, primarily due to the training and funding constraints referenced. Organizations could benefit from preventive medicine expertise, but lack the resources or workforce pipelines needed to recruit and retain

prevention-oriented physicians. Without deliberate workforce expansion and development, many regions and organizations will continue lacking expertise needed to apply these principles.

Consequences for System Transformation

The limited size and capacity of the preventive medicine workforce constrain the nation's ability to transition to a Prevention First healthcare system. Payment reform, delivery system redesign, community health initiatives and population health programs all depend on professionals who understand prevention and population health and who can translate prevention principles into operational models.

Without a sufficient workforce trained in preventive medicine, prevention efforts will remain fragmented across healthcare systems, public health agencies and community organizations. Programs may be implemented inconsistently, evaluated incompletely or sustained only for limited periods of time. The absence of prevention-oriented leadership limits the ability of organizations to coordinate prevention activities, measure progress and continuously improve outcomes.

Expanding the preventive medicine workforce is therefore not only a matter of strengthening a single medical specialty, but also a necessary condition for building and sustaining prevention-centered health systems. Without deliberate investment in workforce development, the broader goals of Prevention First healthcare reform will be difficult if not impossible to achieve.

Section 3 – Policy Recommendations

A Prevention First healthcare system cannot be built without a workforce capable of designing, implementing and sustaining prevention-centered models of care. Payment reform and delivery system transformation depend on professionals who understand prevention at both the clinical and population levels and who can translate prevention principles into operational practice. Expanding and strengthening the preventive medicine workforce is therefore a necessary condition for achieving the broader system transformation outlined in this document. Workforce development policies are essential enabling mechanisms for the broader system transformation described in this strategy.

Preventive medicine physicians play a unique role in this transformation. Their training integrates clinical care, population health, epidemiology and health system design, preparing them to serve as leaders of prevention-centered healthcare systems. Preventive medicine physicians help organizations identify health risks, design preventive strategies, evaluate outcomes and continuously improve system performance over time. Without sufficient preventive medicine expertise, prevention efforts will remain fragmented and difficult to sustain.

The following policy recommendations outline the structural changes needed to expand training capacity, stabilize financing and develop sustainable career pathways for preventive medicine physicians. These recommendations are designed to support a Prevention First health system by ensuring that prevention-oriented leadership and expertise are available across healthcare delivery systems, public health agencies and community organizations.

Expand and Stabilize Preventive Medicine Residency Training

Preventive medicine residency programs are essential to the development of the prevention-oriented physician workforce but remain financially unstable due to limited and inconsistent funding mechanisms. Preventive medicine residencies typically rely on combinations of federal grants, institutional support and trainee tuition rather than stable graduate medical education funding streams. This financing structure limits training capacity and creates ongoing uncertainty for programs.

Policy actions should include:

- Fully fund all 350 ACGME-accredited residency training slots in Public Health and General Preventive Medicine (PH/GPM), requiring an estimated \$56 million annually. This should be structured as predictable, multi-year support to reduce annual volatility in program planning and stabilize the recruitment and retention of residency applicants, who presently routinely and significantly outnumber the limited number of available positions being filled (due to funding constraints) at any given program.
- Increase annual HRSA appropriations for the Preventive Medicine Residency Program from \$8 million to at least \$60 million, to support funding for existing slots and enable further program growth and prioritizing health professional shortage areas and states without existing PH/GPM programs.
- Structure a HRSA-administered grant program modeled after the Rural Residency Planning and Development Program (or expand the Rural Residency Planning and Development Program) to support new PH/GPM program development, especially in rural and under-served regions. Grants should prioritize states without existing PH/GPM programs and jurisdictions with high preventable disease burden.
- Provide direct-to-program funding mechanisms rather than routing funds through hospitals that may deprioritize non-inpatient specialties. Funding should be portable across training sites, including local health departments, FQHCs, rural health clinics and community-based organizations.

Reform Graduate Medical Education Financing

Graduate Medical Education financing policies should be modernized to support prevention-oriented training. Current Medicare GME financing mechanisms primarily support hospital-based training and do not adequately recognize non-hospital-based, prevention-oriented training environments.

Policy Actions:

- Reform federal GME policy to allocate no less than 10–20% of all GME funds (\$2.4–\$4.8 billion) to non-hospital and community-based training settings. This reallocation should be phased in over five years to allow institutional transition.
- Designate at least \$240 million of these reallocated funds specifically for Preventive Medicine training and dual-certification pathways (e.g., Internal Medicine/Preventive Medicine, Family Medicine/Preventive Medicine, Pediatrics/Preventive Medicine, Psychiatry/Preventive Medicine, OB-Gyn/Preventive Medicine). Funding should support both residency positions and required MPH tuition/field training costs. Of note, an

ACGME/ABMS-approved pathway already exists for such training, and there is consistent interest among residents in these specialties, but the necessary funding has not been available.

- Consolidate GME oversight under the Bureau of Health Workforce within HRSA, enabling a unified and forward-looking approach to physician workforce development.
- Use GME funding to incentivize innovation in residency models that emphasize ambulatory care, public health engagement and interdisciplinary collaboration. Priority should be given to models that measurably improve preventive service uptake and chronic disease risk reduction in the communities where residents train.

Strengthen Workforce Development Pathways

Policy Actions:

- Offer competitive federal stipends and loan repayment incentives to physicians who complete Preventive Medicine board certification as a primary or secondary specialty. Eligibility should include physicians transitioning from primary care and other high-impact specialties, with service commitments in high-need settings.
- Develop more four- or five-year combined residency programs (e.g., Family Medicine/Preventive Medicine, Internal Medicine/Preventive Medicine) that include full training in both specialties.
- Integrate preventive medicine rotations and MPH coursework into traditional residency tracks as a pipeline to dual certification. This includes standardized elective blocks, public health field placements and mentorship pathways beginning in the first post-graduate year (PGY-1). At a minimum, this will enhance the preventive medicine skills and awareness of physicians practicing in these specialties, even if they do not ultimately enter preventive medicine careers.

Recognize Preventive Medicine as Critical Workforce Infrastructure

Policy Actions:

- Include Preventive Medicine in specialties listed in relevant Office of Personnel Management (OPM) listings for Medical Officer (Series 0602).
- Encourage CMS and HRSA to define Preventive Medicine as a key workforce category in national strategic planning and funding announcements.
- Federal and state policymakers should recognize Preventive Medicine board certification as a preferred or required qualification for leadership roles in public health and clinical quality programs. Federal agencies and state health authorities should model this recognition in hiring standards, grant requirements and contracting language.

Recommendation 5 – Strengthen Prevention Workforce Education Infrastructure

Policy Actions:

- Mandate the inclusion of board-certified preventive medicine specialists in medical school faculty and curriculum planning committees. Federal training grants and accreditation expectations should explicitly value preventive medicine representation.

- Require a minimum of two months of training in preventive medicine during the first two years of the standard medical school (MD/DO) curriculum. This should include, at a minimum, integrated introductory training in: epidemiology; biostatistics; principles of evidence-based medicine; health economics, policy and systems administration; clinical informatics and applications of AI; clinical preventive and lifestyle medicine (physical activity, nutrition, restorative sleep; avoidance of toxic substances, and mindfulness connectedness); occupational and environmental medicine; and addiction medicine.
- Require availability of a one-month elective in preventive medicine during the fourth year of the standard medical school (MD/DO) curriculum, which would reinforce the above-referenced experiences and provide real-world experiences in their application.
- Require residency programs across all specialties to incorporate PH/GPM modules, including rotations at state and local health departments and preventive care sites.
- Encourage academic medical centers to have departments or divisions of public health and preventive medicine, and/or inclusion of preventive medicine faculty in academic health center departments of family medicine, internal medicine, pediatrics and psychiatry, particularly for those institutions without specific departments or divisions of public health and preventive medicine.
- Provide national funding for GME-level continuing education focused on the role of prevention in emerging health threats, chronic disease and behavioral health.

Pillar 3

Prevention-Centered Care Delivery

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Introduction

A Prevention First health system requires a fundamental shift in how care is delivered. The current U.S. healthcare system is structurally organized around hospitals and specialty care, largely designed to treat illness after it develops. Prevention is often treated as an additional service layered onto this structure rather than as a central function of care.

A prevention-centered system must instead be organized around sustained relationships with patients and communities, with the primary goal of reducing the risk factors that drive negative long-term health outcomes. This requires clinical and operational redesign so that prevention becomes a core function of healthcare delivery rather than a secondary activity.

Section 1 – Structural Limits of the Hospital-Based System

The United States healthcare system is optimized for episodes of illness rather than trajectories of health. Payment systems reward procedures and visits rather than sustained reductions in patient risk. Clinical infrastructure is designed to support diagnostic testing and acute treatment rather than longitudinal risk management. Data systems track encounters and utilization but rarely provide a clear picture of how population health risks are changing over time.

Even recent delivery reforms such as Accountable Care Organizations represent only partial steps toward prevention-centered care. Many ACOs remain organized around hospital systems whose financial stability depends heavily on admissions and procedures. When institutions responsible for managing population health are financially dependent on treating advanced disease, prevention efforts inevitably compete with hospital-based incentives.

Patient-centered medical homes offer a clinical environment more aligned with prevention-centered care, emphasizing primary care relationships and coordination across services. However, medical home models have often lacked the operational infrastructure and financial support needed to sustain comprehensive prevention activities at scale. As a result, neither hospital-based ACOs nor primary-care-centered medical homes have consistently demonstrated the ability to reorganize care around the long-term reduction of population risk.

These experiences highlight a fundamental structural question: *what type of organization should be responsible for managing the health of a population?* The United States healthcare system has often assumed that hospitals should serve as the organizing center for comprehensive care, yet hospitals are primarily designed to treat advanced illness rather than to manage long-term risk and promote health. A Prevention First system requires delivery structures explicitly designed around wellness of individuals, communities and populations rather than admissions and procedures at facilities and episodes of care.

Section 2 – Prevention First Care Delivery

Section 2A. The Prevention-Centered Care Model

A Prevention First health system must be organized around the management and reduction of health risk rather than episodic treatment of illness. Instead of organizing

care primarily around visits and procedures, prevention-centered systems organize care around defined populations and systematic reduction of major health risks over time.

Responsibility for patient outcomes must extend beyond individual encounters. Health systems must be able to identify the populations they serve, measure major health risks within those populations and organize clinical activities to reduce those risks over time. Prevention is delivered through sustained engagement that includes monitoring, outreach, treatment adjustment, behavioral support and continuous quality improvement.

Operationally, prevention-centered care requires clinical teams responsible for managing defined panels of patients over time. Care teams must be able to identify patients with uncontrolled risk factors, track progress toward improvement and intervene when progress stalls. This work includes medication adjustment, remote monitoring, behavioral support and coordination with community-based resources that influence health behaviors. Care teams must also systematically screen for asymptomatic and/or as yet undetected but predictable risk factors and similarly intervene to mitigate their potentially adverse effects.

Existing billing mechanisms such as Chronic Care Management and the Collaborative Care Model demonstrate how prevention work can be integrated into clinical care by supporting engagement between visits. However, prevention-centered care requires these capabilities to be organized systematically across entire populations rather than applied only to limited groups of eligible patients or constrained by one-size-fits-all reimbursement structures.

Health systems must allocate preventive resources according to patient risk, with more intensive support directed toward patients whose risks are greatest or most persistent. Organizing care in this way allows prevention resources to be used efficiently while maximizing long-term health gains.

Section 2B. Organizational Structures for Prevention-Centered Care

A prevention-centered healthcare system requires organizations that accept responsibility for the long-term health risks of defined populations and have the operational capacity to manage those risks over time. These organizations must be able to identify the populations they serve, monitor major health risks, deliver longitudinal prevention services and coordinate care across clinical and community settings.

While hospitals play an essential role in acute and specialty care, prevention-centered delivery does not require hospitals to serve as the primary organizing structure. Organizations that are more closely aligned with primary care and community health may often be better positioned to manage long-term population risk.

Organizations that accept responsibility for population health may be structured in different ways. Prevention-centered delivery organizations may take multiple forms. Large primary care groups, integrated delivery systems with strong primary care foundations, risk-bearing provider organizations, academic medical centers with substantial ambulatory practices and payer-supported delivery organizations can all

potentially serve this role if they have the operational capacity to manage prevention effectively. The key requirement is not institutional form, but the ability to manage defined populations and sustain long-term risk reduction.

Section 2C. What Makes a Prevention-Centered System Different

Organizations capable of managing population health already exist in the United States healthcare system, including ACOs, integrated delivery systems and risk-bearing provider groups. These models represent important progress toward population accountability, but prevention remains secondary to treatment in most current arrangements.

Even in advanced population-based models, success is typically measured in terms of utilization and spending rather than sustained reductions in health risk. Prevention activities often depend on short-term initiatives or limited programs rather than permanent operational infrastructure. A Prevention First system requires a shift in expectations so that organizations responsible for defined populations are explicitly accountable for reducing major modifiable health risks over time. Responsibility for population health must include systematic measurement of risk factors along with organized clinical efforts to reduce those risks across defined populations.

In a prevention-centered system, infrastructure for population risk management becomes a permanent and central feature of healthcare delivery. Prevention activities are no longer optional enhancements or temporary programs but core operational functions. Total cost of care remains an essential measure of system performance, but it does not capture the full value of a prevention-centered healthcare system. A Prevention First system should evaluate performance using a combination of cost trends, improvements in major modifiable risk factors and long-term clinical outcomes. Improvements in risk and outcomes represent meaningful progress even when financial savings emerge gradually over time and are the foundational goals of any prevention-centered health system.

Section 2D. Cultural Transformation of Prevention-Centered Care

The transition to prevention-centered healthcare represents not only a structural change in how care is delivered, but also a cultural shift in how health professionals understand their role. A workforce trained primarily in hospital-based environments will naturally reproduce hospital-centered systems, while a workforce trained in prevention-centered settings will build organizations designed around long-term health improvement. The training reforms described in Pillars 1 and 2 are therefore essential to the successful implementation of preventive health delivery systems.

Structural reforms alone are not sufficient. Prevention-centered care requires clinicians and health system leaders who think in terms of population risk, long-term health trajectories and organization of care beyond individual encounters. As prevention becomes a central function of healthcare delivery, success will increasingly be defined not by the volume of services delivered but by sustained improvements in health across

populations. This cultural transformation is essential to the success of the Prevention First health system and sustaining a continuously healthier population — as opposed to the current system that only treats an increasingly sick one.

Section 3. Policy Recommendations

Align Population Accountability with Meaningful Risk and Outcome Improvement

Federal population-based payment models should expand accountability beyond total cost of care to include sustained improvements in major clinical risk factors and long-term health outcomes. Total cost of care remains an essential measure of system performance, but it does not capture the full goals of a prevention-centered healthcare system — particularly when prevention investments may take years to translate into measurable cost savings.

Organizations responsible for defined populations should be evaluated using a balanced set of measures that includes (1) cost trends, (2) improvement in major modifiable risk factors such as blood pressure control, tobacco use, metabolic risk, and obesity, and (3) improvement in downstream clinical outcomes over time. Risk-factor improvement and outcome improvement should be treated as meaningful progress even when financial returns accrue gradually.

Payment models should explicitly reward sustained improvement in risk and outcomes alongside responsible cost management, so that organizations are not penalized for making evidence-based prevention investments whose benefits emerge over longer time horizons.

Support Risk-Based Longitudinal Prevention Services

Prevention-centered care requires sustained longitudinal support tailored to patient risk rather than uniform service limits. Existing billing mechanisms such as Chronic Care Management and the Collaborative Care Model demonstrate how prevention-oriented work can be supported between visits, but current implementation can be too rigid to meet variable patient needs.

Federal health programs should support risk-based longitudinal prevention services in which the duration and intensity of support are determined by patient risk and periodically reassessed. Patients with persistent or high-risk profiles should be eligible for sustained engagement over extended periods, while lower-risk patients may require intermittent monitoring and targeted touchpoints.

Expanded flexibility should be paired with appropriate guardrails: clear documentation of clinical need, periodic reassessment of risk, and program-integrity monitoring to reduce the potential for misuse while enabling prevention to be delivered at the level required to improve risk trajectories.

Establish a Standardized Prevention Reporting Framework

A prevention-centered healthcare system requires consistent measurement of major modifiable risk factors across populations. Federal health programs should establish standardized reporting of prevention indicators using routinely collected electronic health record data focused on a limited, high-value set of measures that reflect prevention performance.

Standardized reporting should enable community-level and organizational-level monitoring while complementing existing national surveillance systems such as NHANES and BRFSS, which provide valuable national estimates but are often insufficient for local, population-specific measurement.

Critically, this reporting framework should enable continuous evaluation and improvement: health systems and policymakers should be able to use these measures to identify which prevention strategies are working, refine programs over time, and track whether risk and outcomes are improving across defined populations.

Align Regional Care Systems Around Prevention

Federal health policy should support regional care systems in which rural providers focus on prevention, chronic disease management, and essential stabilization services while complex specialty care is delivered through regional referral networks and centers of excellence.

This approach should strengthen rural health sustainability by ensuring rural providers are paid in a way that supports the services their communities rely on most — especially prevention and longitudinal chronic disease management — rather than forcing rural hospitals to compete on low-volume specialty services that can be delivered more effectively at regional centers.

Regional models should preserve longitudinal responsibility locally while ensuring reliable pathways to specialty care when needed, and should be evaluated over time for both financial sustainability and improvement in population health outcomes.

Pillar 4

Financing Prevention and Aligning Incentives

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Introduction — Prevention Requires Financing That Matches Its Goals

A Prevention First health system requires financing structures that support long-term health improvement rather than short-term treatment of illness. While the United States spends more on healthcare than any other nation, a relatively small share of spending supports activities that reduce long-term health risk.

U.S. health spending reached approximately \$5.3 trillion in 2024 — about 18 percent of GDP. A large share of spending remains concentrated in hospital care (roughly 31 percent of total health expenditures), and hospital spending has been one of the fastest-growing components of national health spending in recent years. Retail prescription drugs account for approximately 9 percent of spending. These patterns reflect a financing system historically oriented toward acute and facility-based care rather than sustained risk reduction and long-term health improvement, with payment incentives that reward procedures and episodes of care more consistently than long-term prevention.

This imbalance reflects financing structures that reward treatment of illness more consistently than reduction of risk. As a result, the prevention activities that are easiest to define, code and deliver as discrete services — preventive screening and immunizations — have become the most visible and well-supported components of prevention policy. However, prevention extends far beyond screening and requires sustained clinical engagement, multidisciplinary support and long-term risk reduction strategies.

CMS has led significant progress in prevention-oriented payment reform, including recommended preventive service coverage, Chronic Care Management reimbursement, Accountable Care Organizations and Innovation Center demonstrations. These initiatives show that payment reform can support prevention-oriented care. However, experience has also shown that payment reform alone is not sufficient to produce a Prevention First healthcare system. Training, delivery system design, workforce development and data infrastructure must evolve alongside payment policy. Payment reform is therefore a necessary, but not sufficient condition for Prevention First transformation.

A Prevention First healthcare system must build on existing payment structures while expanding the financing mechanisms that support sustained prevention activities. Even well-designed reimbursement policies will fall short if the clinical workforce is not trained to deliver prevention (Pillars 1–2), if delivery systems remain hospital-centric rather than prevention-centered (Pillar 3), if population-health infrastructure remains fragmented across healthcare, public health and community systems (Pillar 6), and if data and evaluation capabilities are not built into routine operations (Pillar 7). This pillar therefore focuses on financing as a necessary enabler of prevention, while reinforcing that durable change requires coordinated progress across all pillars.

Section 1. Fee-for-Service Prevention Infrastructure

Fee-for-service payment remains a dominant financing mechanism in U.S. healthcare and will continue to play an important role in supporting prevention services. Prevention activities must

therefore be supported through coding and payment structures that recognize the time and resources required to reduce long-term health risk.

Preventive screening services are among the best-supported components of prevention within current payment systems. Coverage of recommended screening tests and immunizations has improved substantially over time and has contributed to increased use of evidence-based preventive services. These services represent an important foundation for prevention policy, but in the long term, they are only part of the set of prevention-focused activities that must be meaningfully reimbursed.

Section 2. What Medicare Already Pays For — And Where Gaps Remain

Medicare already reimburses several evidence-based prevention and chronic-disease-management services, including diabetes self-management education and support (DSMES; HCPCS G0108–G0109), medical nutrition therapy (CPT 97802–97804; HCPCS G0270–G0271), cardiac and pulmonary rehabilitation (94625–94626), tobacco cessation counseling (99406–99407), alcohol misuse screening and brief counseling (G0442–G0443), depression screening (G0444) and Annual Wellness Visits (G0438–G0439).

Medicare also supports longitudinal management through Chronic Care Management (CCM; CPT 99490, 99439, 99487, 99489), Principal Care Management (PCM; CPT 99424–99427), behavioral health integration and collaborative care (CPT 99484, 99492–99494) and device-enabled monitoring through remote physiologic and therapeutic monitoring pathways. These are important building blocks — but as ACPM noted in its 2025 Physician Fee Schedule comments, they remain too limited, inconsistently implemented and often underutilized due to administrative complexity and relative undervaluation compared with procedural services.

Key gaps include uneven parity for FQHCs and rural health clinics when services rely on the Physician Fee Schedule, limited reimbursement for prevention services delivered outside traditional clinic encounters and missing pathways for proven self-management interventions that do not fit existing CPT/HCPCS structures. In addition, current payment systems rarely recognize prevention success when it reduces downstream utilization—for example, when a patient’s condition improves enough that medications can be safely de-intensified or discontinued. A Prevention First framework should reward verified risk reduction and durable outcome improvement, while maintaining guardrails that protect against fraud and inappropriate overuse.

A clear example is medication de-intensification: today there is no standard way to code and bill for the work of safely stopping or reducing a medication because a patient’s diabetes, lipid profile or hypertension (or another chronic conditions) have improved. If it cannot be coded, it cannot be reliably billed. If it cannot be billed, it is hard to sustain. If it cannot be tracked, it is difficult to measure savings and outcomes from prevention success. As previously mentioned, what gets measured (and adequately reimbursed) gets done. Screening tests and immunizations are essential foundations, but meaningful prevention requires sustained engagement to reduce long-term health risk.

Existing payment mechanisms such as chronic care management, behavioral health integration and structured lifestyle-based programs focused on whole-person health demonstrate that longitudinal prevention services can be financed within current frameworks. These models provide important examples but remain limited in scale and unevenly implemented.

Current payment structures often favor brief encounters and procedure-based care over sustained prevention services. Activities such as behavior change counseling, longitudinal risk monitoring and coordination with community-based services remain difficult to sustain financially in many clinical settings. Strengthening of the fee-for-service prevention infrastructure will require the following:

- Coverage for longitudinal prevention services
- Payment structures that support sustained risk reduction over time
- Recognition and support for multidisciplinary prevention teams
- Administrative simplification of prevention billing where appropriate
- Improved valuation of prevention-oriented services relative to procedural and facility-based care

Prevention Requires Team-Based, Longitudinal Care

Effective prevention rarely occurs through isolated clinical encounters. Most prevention-oriented care requires sustained engagement over time and coordination among multiple professionals working at different levels of intensity. A Prevention First health system must support team-based approaches that allow patients to receive the right level of preventive support at the right time.

Clinicians play a central role in prevention by identifying health risks, discussing prevention options with patients and guiding decisions about appropriate interventions. However, many prevention activities require time and expertise that extend beyond what can be delivered during routine clinical encounters. Effective prevention often depends on coordinated teams that include physicians, nurses, dietitians, health educators, behavioral health specialists and other professionals who can provide sustained support over time.

A Prevention First healthcare system does not require every clinician to deliver every preventive intervention directly. Instead, clinicians should be prepared to identify prevention needs, explain the risks and benefits of available options and connect patients with appropriate preventive services. Financing systems should support coordinated teams that can deliver prevention services efficiently and consistently across populations, as well as the physician time and effort required to coordinate them.

Current healthcare financing often favors short-term interventions such as medications or procedures while providing limited support for sustained prevention-oriented care. Lifestyle-based preventive strategies often require longer time horizons and more intensive engagement yet financing mechanisms frequently do not support the infrastructure needed to deliver these interventions reliably.

As a result, patients who are willing to pursue prevention-oriented approaches may have limited access to appropriate services. Prevention programs may be available only in limited geographic areas or may operate at insufficient scale to meet demand. These access challenges are particularly significant in rural and under-resourced communities, where preventive services are often the most needed.

A Prevention First healthcare system must support preventive services across multiple levels of intensity, including in-person programs, community-based services and virtual models of care. Financing mechanisms should allow prevention programs to operate at sufficient scale to remain viable while ensuring access for patients across diverse geographic settings.

Programs such as intensive lifestyle-based cardiac rehabilitation illustrate both the potential and the challenges of prevention-oriented care. These programs can produce substantial improvements in health outcomes but often face financing barriers related to staffing requirements, facility costs and enrollment variability. Payment models should support flexible delivery models that allow prevention programs to operate sustainably while expanding access through virtual and hybrid approaches.

Supporting team-based prevention care requires financing mechanisms that align incentives across clinicians and preventive service providers. Payment systems should reward sustained risk reduction and long-term health improvement rather than focusing primarily on short-term service delivery.

Value-Based Payment and Distributed Accountability

Value-based payment models offer important opportunities to support prevention, but existing models have often emphasized short-term cost control rather than long-term health improvement. Many accountable care models remain operationally centered on primary care organizations or hospital systems. While these organizations play essential roles in coordinating certain types of care, prevention-oriented healthcare requires accountability that extends across the full range of providers involved in patient care.

Emerging payment models that assign accountability to specialty providers represent an important evolution in value-based care. Recent ambulatory specialty models proposed for conditions such as heart failure and low back pain illustrate approaches in which specialists accept responsibility for outcomes and resource use across defined episodes or populations. These models move beyond traditional structures in which prevention and cost control are seen primarily as responsibilities of primary care organizations.

A Prevention First health system requires shared accountability across providers. Clinicians who care for patients with chronic conditions should be accountable not only for treatment decisions but also for coordination of care and efficient use of resources. Financing models should encourage providers to work collaboratively to improve outcomes and reduce unnecessary or duplicative services.

Distributed accountability can support prevention by aligning incentives across providers so that all participants benefit from improved health outcomes and more efficient care delivery. Effective prevention financing within value-based models requires the following:

- Multi-year accountability periods that support long-term improvement
- Population-based payment approaches that allow investment in prevention infrastructure
- Flexibility to invest in prevention services and community-linked supports where appropriate
- Measurement approaches that recognize long-term outcomes and sustained risk reduction
- Incentives aligned with collaboration and coordinated care delivery across the continuum
- Benefit Design and Access to Prevention Services

Insurance benefit design plays a critical role in determining whether prevention services are accessible to patients. Even when preventive services are clinically appropriate and supported within payment models, patients may face barriers related to coverage limitations, cost sharing or network availability.

A Prevention First health system requires benefit designs that support access to prevention services at appropriate levels of intensity. Patients with elevated health risks should have access to services that provide sustained support for risk reduction, including behavioral interventions, multidisciplinary prevention programs and structured lifestyle interventions.

Coverage policies should recognize that prevention often requires ongoing engagement rather than isolated clinical encounters. Benefit designs should support prevention services delivered through in-person programs, community-based services and virtual care models.

Improved benefit design should support:

- Access to multidisciplinary prevention services
- Coverage for evidence-based behavioral interventions and structured prevention programs
- Support for virtual and hybrid prevention services where appropriate
- Coverage pathways that allow tailoring of prevention intensity to patient risk
- Reduced barriers to participation in prevention programs, including administrative obstacles

Prevention Requires Multiple Levels of Care

Preventive services must be available at multiple levels of intensity in order to match the needs of different patients. Some individuals require only brief counseling and routine preventive services, while others require structured programs that provide sustained support for behavior change and risk reduction.

Effective prevention systems require a continuum of prevention services ranging from low-intensity counseling to comprehensive multidisciplinary programs. These services should be accessible across both urban and rural communities and should include both in-person and virtual delivery options.

Many intensive prevention programs remain difficult to sustain financially under current payment structures. Programs such as intensive cardiac rehabilitation demonstrate the effectiveness of

structured lifestyle interventions but remain limited in availability because financing and operational requirements make them difficult to maintain at scale.

Payment and benefit structures should support preventive services at appropriate levels of intensity so that patients have access to interventions that match their clinical needs.

Evaluation and Continuous Improvement

To make prevention financing work in practice, CMS and other payers should pair payment policy with a continuous evaluation and improvement cycle. This includes measuring uptake, access and outcomes for preventive services; identifying underutilization driven by administrative burden, site-of-service constraints or misaligned incentives; and updating codes, payment rates and coverage rules based on evidence over time.

CCM and behavioral health integration codes offer a useful example; the goal should not only be to establish reimbursement, but also to monitor real-world utilization and outcomes and refine program rules to maximize effectiveness while minimizing fraud and low-value use. A Prevention First payment strategy should therefore invest in the analytic infrastructure needed to evaluate ROI, risk reduction and long-term outcomes — not just short-term utilization and total cost of care.

Policy Recommendations

Standardize Access to High-Value Preventive Services for High-Risk Populations

Many preventive services that are essential for high-risk populations are not consistently available across states, health systems or insurance programs. While recommended preventive screenings and immunizations are generally well covered, access to other high-value preventive services varies depending on payer policies, geography and state program design. Inconsistent coverage creates barriers to prevention and undermines efforts to improve population health outcomes. Greater alignment across federal and state programs would strengthen prevention-oriented care and improve health outcomes.

Coverage of evidence-based preventive services represents one of the most successful prevention policies in U.S. healthcare. Recommended preventive services such as immunizations and evidence-based screenings are widely covered across Medicare, Medicaid and commercial insurance and have become the foundation of national prevention policy. However, screening in and of itself without follow-up with appropriate preventive services not only will fail to improve health outcomes, but also is morally unconscionable.

Expanding prevention beyond screening requires financing structures that support sustained engagement rather than isolated clinical services. These services fit well within traditional clinical workflows and represent essential components of a Prevention First health system. However, important gaps remain in access, consistency and implementation — particularly for high-risk populations.

Example: High-Risk Pregnancy Care

High-risk pregnancy care illustrates the challenges created by inconsistent preventive service coverage. States vary in the number of covered prenatal visits, the availability of depression

screening and treatment and the use of home blood pressure monitoring and remote patient monitoring for high-risk pregnancies.

These services can prevent serious complications such as preeclampsia, preterm birth and postpartum mental health crises, yet access remains inconsistent across Medicaid programs. Greater alignment of preventive service coverage for pregnancy and postpartum care would strengthen prevention efforts and improve maternal and child health outcomes.

Policy Actions

- Maintain full coverage of recommended preventive services without cost-sharing
- Improve consistency of preventive service coverage across Medicaid programs
- Encourage state Medicaid programs to cover evidence-based preventive services for high-risk populations
- Support Innovation Center demonstrations that expand access to prevention services
- Reduce administrative barriers to preventive service delivery

Expand Coding and Payment Pathways for Prevention

A Prevention First health system requires financing mechanisms that support measurable improvement in health risk and long-term outcomes. Current payment systems are designed primarily to reimburse the diagnosis and treatment of disease. Although preventive services such as screening and immunization are well supported, many meaningful preventive activities remain difficult to code, bill and evaluate within existing payment structures.

If preventive activities cannot be coded, they cannot be billed. If they cannot be billed, they cannot be sustained in routine clinical practice. Coding limitations also make prevention difficult to measure and evaluate, limiting the ability of policymakers and health systems to identify successful strategies and scale them effectively.

Expanding coding pathways for prevention represents one of the most important structural steps toward making prevention-first healthcare operational within existing payment systems. Many important prevention activities involve reducing disease risk or reversing disease progression rather than initiating treatment. These improvements are central to prevention-oriented care but are not consistently recognized within current coding and payment systems.

For example, there is currently no clear mechanism to code or track clinical improvement when a patient is able to reduce or discontinue medication because of improved health status. A patient who successfully lowers blood glucose through lifestyle change and discontinues diabetes medication represents a meaningful prevention success, yet this improvement is not systematically captured in billing or quality measurement systems. Without mechanisms to code and track such improvements, prevention achievements remain largely invisible within healthcare financing systems.

Similarly, preventive activities often require sustained clinical engagement over time, including monitoring health risks, adjusting care plans, coordinating team-based services and supporting long-term behavior change. Existing payment models do not consistently support these activities or capture their long-term benefits.

CMS has made important progress through payment strategies such as Chronic Care Management and value-based payment models, which demonstrate that financing structures can support longitudinal care and population health improvement. However, additional work is needed to ensure that payment systems fully support prevention-oriented care.

Policy Actions:

- Development of new coding pathways that allow clinicians to document meaningful reductions in disease risk and improvements in health status
- Expansion of billing mechanisms that support longitudinal prevention activities, including risk monitoring, behavior-change support, and team-based preventive services
- Development of coding and documentation standards that allow prevention activities and outcomes to be measured consistently across healthcare systems
- Alignment of payment models with measurable reductions in disease risk and improvement in long-term health outcomes
- Support for demonstration projects that test innovative payment approaches for prevention-oriented care

Align Payment with Measurable Health Outcomes

A Prevention First health system must ultimately be evaluated by its ability to reduce health risk and improve long-term outcomes. Current payment and quality measurement systems appropriately emphasize process measures such as screening rates, documentation requirements and service utilization. These measures have played a critical role in expanding the delivery of preventive services and remain an essential foundation of prevention policy.

Process measures such as blood pressure screening, cholesterol testing, diabetes risk screening and recommended preventive services should continue to be supported and strengthened. These services identify health risks early and enable timely intervention. Continued coverage and measurement of recommended preventive services remain a core priority for a prevention-oriented healthcare system.

However, process measures alone cannot capture the full impact of prevention-oriented care. A Prevention First health system must build on this foundation by incorporating measures of sustained risk reduction and long-term clinical outcomes.

For example, measuring whether blood pressure is screened is fundamentally different from measuring whether blood pressure is controlled over time, or when blood pressure medications can be reduced or discontinued due to improved diet and exercise. Screening identifies risk, but prevention requires sustained engagement to reduce that risk and prevent long-term complications.

Payment models that incorporate accountability for outcomes provide an important foundation for prevention-oriented care. Accountable Care Organizations and other value-based payment models create incentives for providers to improve long-term health outcomes while managing total cost of care. Similarly, Chronic Care Management reimbursement supports sustained engagement with patients living with chronic disease and demonstrates how financing structures can support prevention-oriented care over time.

These models illustrate important progress, but outcome measurement remains uneven and often focuses on short-term utilization or cost metrics rather than sustained improvement in health risk. A Prevention First health system requires measurement structures that track meaningful health improvements over time and support continuous refinement of preventive strategies. Outcome-based measurement should complement — not replace — process measures by focusing on indicators such as the following:

- Sustained improvements in control of chronic disease risk factors such as blood pressure, blood glucose and lipid levels
- Reductions in disease progression and complications
- Decreased need for high-intensity medical interventions
- Improvement in functional status and quality of life
- Reduction in avoidable hospitalizations and emergency department use

Together, process and outcome measures provide a more complete understanding of prevention performance and allow policymakers and health systems to identify effective preventive strategies.

Policy Actions:

- Continued support for coverage and measurement of recommended preventive services
- Expansion of outcome-based quality measures that reflect meaningful reductions in disease risk and improvements in long-term health outcomes
- Alignment of value-based payment models with sustained improvement in clinical outcomes in addition to process performance
- Integration of outcome measurement into prevention-oriented payment models including Accountable Care Organizations and Chronic Care Management reimbursement
- Development of standardized methods for measuring longitudinal health improvement across healthcare systems
- Support for continuous evaluation of prevention-oriented payment models to identify effective approaches and guide future policy development

Enable Risk-Based Delivery of Prevention Services

A Prevention First health system must support prevention services tailored to patient risk rather than limited to uniform service definitions or fixed utilization thresholds. Many preventive services are currently delivered using standardized visit schedules or fixed service definitions that do not reflect differences in patient risk. Patients with higher levels of clinical or behavioral risk often require more intensive and sustained engagement than patients with lower risk profiles. A one-size-fits-all approach to prevention limits the effectiveness of services and can discourage appropriate use of prevention resources.

Existing reimbursement approaches such as Chronic Care Management demonstrate that flexible payment structures can support sustained engagement with higher-risk patients. These approaches allow clinicians to provide ongoing monitoring, outreach, care coordination and treatment adjustment in ways that reflect patient needs.

A Prevention First healthcare system should build on these models by supporting preventive services that are delivered at an intensity appropriate to patient risk and clinical need. Risk-based delivery of preventive services allows healthcare organizations to focus resources where they can achieve the greatest long-term health improvement while avoiding unnecessary services for lower-risk patients.

Policy Actions:

- Support for reimbursement approaches that allow prevention services to be delivered at an intensity appropriate to patient risk
- Continued support for reimbursement structures such as Chronic Care Management that enable flexible prevention services for higher-risk populations
- Development of risk-adjusted prevention payment approaches within value-based payment models
- Support for evaluation of prevention programs to determine which levels of service intensity produce meaningful improvements in outcomes

Align Accountability across Primary Care and Specialty Care

Prevention First healthcare requires aligned accountability across the full continuum of care. Responsibility for long-term health outcomes cannot rest solely with primary care organizations or population-based entities. Specialists and subspecialists who manage patients with chronic conditions must also share accountability for improving long-term outcomes and reducing avoidable risk.

CMS has begun expanding accountability models across both primary care and specialty care. Population-based models such as ACO REACH and primary care transformation initiatives such as Making Care Primary strengthen accountability for prevention and long-term outcomes across defined populations. Emerging ambulatory specialty models extend similar accountability to specialists managing high-burden chronic conditions such as heart failure and musculoskeletal disorders. These models represent important steps toward aligning incentives across the full continuum of care.

Policy Actions:

Accountability models should increasingly incorporate outcome measures that reflect meaningful reductions in long-term health risk. Total cost of care remains an important metric, but prevention-first payment models must also reward sustained improvements in health outcomes that may reduce costs over longer time horizons. Future payment models should build on these efforts by ensuring the following:

- Providers share responsibility for long-term patient outcomes across care settings
- Incentives support coordination rather than fragmentation of care
- Payment models discourage unnecessary testing and duplicative services
- Specialists are accountable not only for procedures and episodes of care but also for sustained improvements in patient health

Support Team-Based Preventive Care

A Prevention First health system requires sustained engagement that extends beyond brief clinical encounters. Many effective preventive strategies depend on multidisciplinary teams that provide ongoing support for behavior change, chronic disease risk reduction and long-term health improvement. Physicians should be able to refer patients to appropriate prevention services delivered by qualified team members who are reimbursed in ways that support sustained engagement. Payment policy plays a critical role in determining whether multidisciplinary prevention teams can be sustained in routine clinical practice.

Preventive services often require longitudinal support from dietitians, behavioral health specialists, health educators, nurses and other trained professionals. Current payment systems often support short clinical encounters more reliably than extended prevention support, limiting the availability of preventive health programs even when evidence demonstrates their effectiveness.

Policy Actions:

CMS should continue to expand payment models that support team-based prevention services and allow patients access to the appropriate level of prevention care. Payment policies should support:

- Referral-based access to prevention services delivered by multidisciplinary teams
- Virtual and community-based prevention programs where appropriate
- Access to prevention services in rural and underserved areas
- Financing structures that support sustained engagement rather than one-time interventions
- Financing structures that support coordination of team-based prevention services

Prevention-first payment systems should allow clinicians to discuss prevention-oriented options with patients and connect them to appropriate services without creating incentives for unnecessary treatment or fragmented care.

Pillar 5

Private Sector Engagement

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Section 1 — Introduction

A Prevention First health system cannot presently be built by public programs alone. Employers and private payers finance and shape a large share of U.S. healthcare, set benefit design and network expectations and increasingly sponsor programs that influence chronic disease risk, access and consumer experience. Private-sector decisions about benefits, incentives, provider contracting and digital services therefore materially determine whether prevention is operationalized — or remains aspirational.

Private-sector stakeholders are also major operators of public coverage. Health plans administer large portions of Medicare and Medicaid through managed-care arrangements and contracted provider networks. More than half of Medicare beneficiaries are enrolled in Medicare Advantage plans, and roughly three-quarters of Medicaid beneficiaries receive coverage through managed-care organizations. These arrangements make private-sector organizations key implementers of public-sector health policy and essential partners in prevention-first transformation.

Employer-sponsored insurance remains the largest source of coverage for Americans under age 65, covering approximately 154 million people. Employers and private insurers together finance a substantial share of national health spending, which reached approximately \$5.2 trillion in 2024 — nearly 18 percent of the U.S. economy. Decisions made by employers and private insurers therefore influence healthcare delivery for a large share of the population and shape the environment in which prevention strategies are implemented.

Private-sector stakeholders are also important sources of innovation in healthcare delivery. Employers and health plans increasingly deploy prevention-oriented tools such as centers-of-excellence programs, digital health platforms, incentive programs, advanced analytics and more. These efforts demonstrate strong interest in improving health outcomes while controlling costs, but they remain unevenly distributed and are rarely coordinated across organizations.

Preventive medicine physicians have long worked across a wide range of domains, including but not limited to payers, employers, occupational and environmental health, population health and clinical informatics. This pillar describes how private-sector stakeholders — employers, health plans, TPAs, consultants, provider networks and benefit innovators — can accelerate Prevention First transformation while reducing fragmentation that currently limits systemic change. It also reinforces Pillar 2's workforce imperative, scaling prevention-oriented capability in the private sector requires more clinicians trained to lead prevention strategy and implementation, not just deliver discrete services.

Section 2 — Problem: Prevention First Mindset Blocked by Structural Barriers

Private-sector organizations often demonstrate strong interest in prevention and innovation. Employers and health plans face steadily rising healthcare costs and have powerful incentives to improve long-term health outcomes while maintaining access to high-quality care. Many private-sector organizations actively invest in prevention programs and innovative benefit designs, reflecting a prevention-oriented mindset.

However, structural barriers limit the ability of private-sector organizations to implement Prevention First healthcare at scale. Fragmentation of responsibility, uneven expertise and limited coordination across employers, health plans, consultants and providers prevent preventive strategies from producing consistent system-wide change.

Providers must operate within multiple payment and reporting systems simultaneously, including Medicare, Medicaid and numerous commercial plans. Each system uses different benefit designs, quality measures, payment models and reporting requirements. These differences create administrative complexity and make it difficult for providers to implement consistent prevention-oriented care strategies across patient populations.

Private-sector organizations often implement prevention initiatives as individual programs rather than as coordinated strategies for long-term risk reduction. As a result, investments in prevention frequently produce uneven results and are difficult to scale across populations.

Employers also face regulatory constraints that can make it difficult to implement innovative prevention programs while maintaining compliance with nondiscrimination protections. These constraints can slow responsible experimentation even when strong safeguards for employees remain in place.

Employers as Prevention Innovators

Employers are often among the most active innovators in prevention-oriented healthcare. Because employers bear a large share of healthcare costs directly, they have strong incentives to improve long-term health outcomes while maintaining employee satisfaction and access to high-quality care. Large employers frequently operate sophisticated health programs with the following:

- Dedicated health management teams
- Advanced analytics capabilities
- Direct relationships with providers and health plans
- Flexible benefit design authority
- Capacity to pilot new approaches

Many large employers function operationally much like health plans, managing large covered populations and designing comprehensive health strategies. Employers frequently implement prevention-oriented programs such as the following:

- Incentive-based wellness programs
- Advanced primary care arrangements
- Centers-of-excellence programs
- Second-opinion services
- Digital health platforms
- Occupational health programs
- On-site and near-site clinics

Employers also have unique opportunities to influence health behaviors through workplace environments and organizational policies. Some employers provide financial incentives for

completing preventive services or achieving health goals. Others design physical environments that promote physical activity and healthy nutrition. Employers with distributed or remote workforces are increasingly developing innovative virtual prevention programs. These initiatives demonstrate the potential for employers to serve as laboratories for prevention-first innovation.

However, employer capabilities vary widely. Smaller employers often depend heavily on health plans, third-party administrators and consultants for benefit design and program implementation. This dependence creates variability in program quality and limits the ability of employers to implement coordinated prevention strategies.

Health Plans as Risk Managers and System Integrators

Health plans play a central role in prevention-first healthcare because they manage financial risk across large populations and maintain comprehensive data on healthcare utilization and outcomes.

Health plans develop benefit designs, manage provider networks and implement population health programs. Many operate advanced analytics systems capable of identifying clinical risk and targeting interventions. Health plans therefore possess capabilities essential to prevention-first healthcare, including:

- Population-level risk identification
- Claims-based analytics
- Provider network management
- Utilization management
- Value-based contracting
- Care management programs

Health plans have increasingly tested value-based and risk-based payment models that align provider incentives with long-term outcomes. These include the following:

- Accountable Care Organization–type arrangements
- Shared-savings contracts
- Capitated primary care models
- Episode-based payment models

These approaches represent important steps toward prevention-oriented healthcare by encouraging providers to improve long-term outcomes and manage total cost of care across populations.

However, health plans face structural limits on their ability to reshape care delivery. Health plans must maintain strong provider networks and minimize administrative friction in order to remain competitive. As a result, they often cannot impose major changes in care delivery without provider cooperation. This creates a structural paradox: Health plans have strong incentives to reduce long-term risk but limited authority to redesign care delivery on their own.

Fragmentation Limits Systemic Change

Unlike federal health programs, the private sector lacks a unified policy framework for prevention. Employers differ widely in size and capabilities. Health plans operate in competitive markets with varying regulatory environments. Benefits consultants and third-party administrators influence program design across thousands of employers.

Even when prevention programs succeed in individual organizations, they often do not spread efficiently across the broader market. Fragmentation therefore limits the ability of the private sector to implement Prevention First healthcare at population scale.

Section 3 — Solution Framework: Building a Prevention First Private Sector

Private-sector stakeholders must be full partners in building a Prevention First healthcare system. Employers and health plans have both the motivation and the operational capabilities to advance prevention, but fragmentation has prevented these efforts from producing consistent system-wide change.

Prevention First transformation requires coordinated action across public and private stakeholders operating from a shared framework. Preventive strategies should be designed so that successful approaches can be implemented across coverage systems and sustained over time as individuals move between sources of insurance.

A Shared Prevention First framework

A Prevention First health system requires public and private stakeholders to operate from a shared understanding of preventive goals, measurement strategies, and long-term outcomes. Public and private organizations should share a common commitment to prevention-oriented transformation in which success is measured not only by service delivery but by sustained improvements in population health and reductions in long-term disease risk.

A shared, Prevention First framework allows employers, health plans, providers and public programs to align prevention strategies and evaluate progress toward common goals while adapting implementation approaches to different populations and organizational capabilities.

Coordinated Prevention Models across Coverage Systems

Individuals frequently move between employer-sponsored insurance, Marketplace coverage, Medicaid and Medicare. Preventive investments made in one coverage system often produce benefits in another, weakening incentives for long-term investment.

Prevention-oriented healthcare requires coordinated preventive strategies across coverage systems so that investments produce sustained benefits regardless of payer transitions. Multi-payer prevention models represent an important opportunity to align incentives across public and private systems.

For example, multi-payer accountable care arrangements could allow provider organizations to operate under consistent prevention-oriented payment models for both public and private patients. Coordinated prevention models would reduce administrative complexity and support

more consistent prevention-oriented care delivery across the healthcare system. Accountability can be assessed as individuals move between different payers and providers.

Collaborative Learning and Open Exchange

Transformation requires mechanisms for shared learning across public and private organizations. Successful preventive strategies developed by employers, health plans, and provider organizations should be disseminated broadly so that effective approaches can be adopted across the healthcare system. Existing employer coalitions, professional associations and payer collaborations provide important foundations for shared learning.

Private Sector as Prevention Innovation Laboratories

Employers and private payers provide important environments for rapid experimentation in preventive strategies. Private-sector innovation can identify effective prevention programs that may later be adopted across both public and private coverage systems.

Workforce Alignment with Pillar 2

As described in Pillar 2, expansion of the preventive medicine workforce would enable greater integration of prevention expertise into employer and payer decision-making.

Section 4 — Policy Recommendations

Private-sector organizations are essential partners in building a Prevention First health system. Employers and health plans already invest heavily in prevention-oriented programs and have the flexibility to innovate rapidly. However, structural barriers limit the ability of private-sector efforts to produce consistent system-wide change.

Policy actions should support coordination across public and private stakeholders, strengthen incentives for long-term prevention investment, and expand the ability of employers and health plans to implement effective prevention-first strategies.

Establish a Shared Prevention Measurement Framework

Prevention First healthcare requires a shared framework for measuring performance across public and private coverage systems. Public and private organizations should operate from a common prevention-oriented measurement framework that emphasizes sustained reductions in health risk and long-term improvement in clinical outcomes.

Success in a Prevention First healthcare system should be measured by meaningful improvements in health status over time, not solely by delivery of preventive services. Success and/or accountability can be assessed as individuals move between payers and/or providers. A shared framework would allow progress toward Prevention First goals to be tracked at regional and national levels while allowing flexibility in implementation across populations.

Policy Actions:

- Convening a multi-agency prevention measurement initiative involving CMS, CDC, AHRQ and private-sector stakeholders

- Development of standardized, outcome-oriented prevention measures focused on sustained reductions in health risk
- Development of longitudinal prevention measures that allow prevention progress to be tracked across coverage transitions
- Public reporting of prevention-first outcome measures at regional and national levels while protecting patient privacy

Expand Prevention Data Sharing and Collaborative Learning

Prevention First healthcare requires systematic learning across organizations and coverage systems. Fragmentation of data across employers, health plans, providers and public programs limits the ability to evaluate preventive strategies and identify successful approaches. Improved prevention data sharing would support collaborative learning and accelerate adoption of effective interventions across both public and private sectors.

Policy Actions:

- Development of data-sharing frameworks that allow outcomes to be tracked across coverage transitions.
- Support for multi-payer prevention evaluation initiatives.
- Standardized outcome reporting across public and private programs.
- Secure mechanisms for longitudinal tracking outcomes while protecting privacy.

Enable Responsible Employer Prevention Innovation

Employers have unique ability to influence health behaviors through benefit design, workplace environments and incentive programs. These capabilities make employers important innovation laboratories for prevention-first healthcare.

However, regulatory complexity and uncertainty can make it difficult for employers to implement innovative prevention programs while remaining confident that programs comply with nondiscrimination protections and wellness program regulations. Prevention First policy should support responsible employer innovation while maintaining strong protections against discrimination and coercion.

Policy Actions:

- Issue joint regulatory guidance from the Departments of Labor, Treasury and Health and Human Services clarifying permissible employer preventive incentives

Expand Multi-Payer Prevention Models

Investments in prevention often produce benefits over long-time horizons and across multiple coverage systems. Fragmentation of coverage weakens incentives for long-term investment.

Multi-payer prevention models can align incentives across public and private coverage and allow prevention investments to produce sustained benefits regardless of payer transitions over time.

Policy Actions:

- Support for multi-payer accountable care models that align incentives across Medicare, Medicaid and commercial coverage
- Development of aligned prevention-oriented value-based payment models across payer types
- Innovation Center demonstrations that incorporate employer and private-payer partnerships
- Shared evaluation frameworks across public and private prevention initiatives

Pillar 6

Community and State-Level Prevention Systems

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Section 1 — Introduction

A Prevention First health system requires accountability for health that extends beyond the walls of healthcare institutions. Accountable care cannot end at the front door of a hospital, the entrance to a clinic or the boundaries of a provider organization. Long-term health outcomes are shaped by the conditions in which people live, work, learn and interact with public systems every day.

While federal programs and private-sector organizations play essential roles in financing and delivering healthcare, many of the systems that influence long-term health outcomes operate at the state and community levels. State health agencies, Medicaid programs, local public-health departments, healthcare providers and community-based organizations all influence the environments in which preventive strategies are implemented.

Healthcare organizations increasingly accept responsibility for patient outcomes through value-based payment models and accountable care arrangements. However, prevention-oriented transformation requires coordination across the full set of institutions that influence community health. Improving long-term health outcomes requires collaboration across healthcare systems, public-health agencies, social-service programs and community institutions.

Addressing community and state-level prevention systems will support Prevention First transformation by strengthening coordination across institutions and aligning responsibility for long-term health outcomes at the community level.

Section 2 — Problem: Root Causes of Disease Extend Beyond Healthcare

Many of the most important drivers of health exist outside traditional healthcare settings. Housing stability, food access, transportation, education, environmental conditions and neighborhood safety all influence health risks and long-term outcomes. These factors shape whether preventive strategies succeed or fail.

Healthcare organizations can deliver high-quality clinical care, but long-term health outcomes depend heavily on conditions in the communities where people live and work. A Prevention First health system requires attention to the upstream factors that shape health outcomes. Preventive medicine has long emphasized the importance of identifying and addressing the root causes of disease — the environmental, social and behavioral conditions that influence health long before individuals seek medical care.

Public health agencies and community organizations have long worked to address these determinants of health, yet their efforts often operate separately from healthcare delivery systems and payment models. A Prevention First approach therefore requires coordination beyond healthcare delivery systems alone.

Fragmented Responsibility for Communities

Responsibility for the conditions that shape health is distributed across many organizations at the state and community level. State and local health departments operate programs focused on chronic disease prevention, maternal and child health, infectious disease control and

environmental health. Medicaid agencies finance and oversee care for vulnerable populations. Social-service agencies support individuals experiencing housing instability, food insecurity, disability or economic hardship. Schools, housing agencies, transportation authorities and local governments influence many of the environmental conditions that affect health outcomes.

Healthcare providers and Accountable Care Organizations increasingly accept responsibility for improving patient outcomes and managing total cost of care. However, accountability for health outcomes often stops at the boundaries of the healthcare delivery system. Most accountability models attribute patients to provider organizations but do not formally connect providers with the public agencies responsible for housing, education, environmental health or social services within the same communities.

A Prevention First health system requires a broader understanding of accountability — one that reflects the shared responsibility for health across healthcare providers, public agencies and community institutions. Fragmentation across these systems makes it difficult to coordinate preventive strategies or sustain long-term improvements in population health. Organizations responsible for different aspects of community well-being often operate with separate funding streams, data systems and performance measures. As a result, efforts frequently occur in isolation rather than as coordinated strategies for improving community health.

Fragmentation Across Human Service Systems

Fragmentation also exists across the agencies responsible for supporting individuals with complex needs. Individuals experiencing homelessness, involvement with the justice system, foster care placement, disability services or behavioral health conditions often interact with multiple public agencies. Each system maintains its own eligibility rules, service structures and data systems.

These systems frequently operate with limited coordination or information sharing. Healthcare providers may have little visibility into whether a patient is receiving housing support, child welfare services, reentry assistance following incarceration or additional services. Public agencies similarly may have limited access to health information that could support more effective service delivery.

Lack of coordination across human service systems makes it difficult to implement preventive strategies for individuals facing the highest health risks. Without coordinated information and aligned objectives across agencies, opportunities for prevention and early intervention are often missed.

Built Environment and Community Conditions

The physical environments in which people live also shape health outcomes in ways that healthcare systems alone cannot address. Community design influences physical activity, transportation patterns, access to healthy food, environmental exposures and social connection. Housing quality, neighborhood safety, walkability and transportation access all contribute to long-term health outcomes.

These conditions represent important opportunities for prevention-oriented strategies, but responsibility for these systems lies outside healthcare organizations. Fragmentation across

agencies responsible for planning and infrastructure makes coordinated preventive strategies difficult to implement at the community level.

Limits of Current Accountability Models

Current healthcare accountability models focus primarily on clinical outcomes and healthcare utilization. Accountable Care Organizations and value-based payment models encourage providers to manage total cost of care and improve patient outcomes. These models represent important progress toward prevention-first healthcare.

However, healthcare accountability models typically focus on services delivered within healthcare settings and on patients attributed to specific provider organizations. A Prevention First healthcare system requires accountability that extends beyond clinical services to include the upstream conditions that shape health outcomes over time.

Accountability does not require healthcare organizations to control community conditions, but it does require healthcare providers and community agencies to coordinate strategies that address the root causes of disease. Without such coordination, prevention-first transformation will remain incomplete.

Section 3 — Solution Framework: Building Prevention First Communities

Shared Accountability for Root Causes of Disease

A Prevention First health system requires shared accountability for addressing the root causes of disease at the community level. Current health systems primarily measure and manage care delivered within healthcare settings. Prevention First communities recognize that long-term health outcomes are shaped by conditions across healthcare, public health and community systems.

Prevention First transformation therefore requires coordinated responsibility for improving the conditions that shape health over time. Health outcomes are influenced not only by clinical care, but also by housing conditions, food access, transportation systems, environmental exposures, education and economic stability. Responsibility for these conditions is distributed across healthcare organizations, public agencies and community institutions.

Prevention-oriented communities require these organizations to operate with a shared understanding that improving health outcomes depends on coordinated action across sectors. This approach does not require healthcare organizations to control non-medical systems. Rather, Prevention First accountability means recognizing that long-term health outcomes depend on factors both inside and outside healthcare settings and working collaboratively to address them.

Shared accountability requires structures that support coordination across healthcare providers, public health agencies, Medicaid programs and social-service systems. Prevention-first communities should operate from a shared understanding of goals and long-term health outcomes, with participating organizations working toward common objectives even when their operational responsibilities differ.

Coordinated Community Prevention Strategies

Prevention-first communities require mechanisms for coordinating preventive activities across healthcare systems and community agencies. Healthcare providers and public agencies often serve the same populations but operate with limited coordination. Preventive strategies are frequently developed independently rather than as part of unified community health efforts. More effective coordination could include the following:

- Joint planning between healthcare organizations and public health agencies
- Shared prevention priorities across community institutions
- Coordinated outreach strategies for high-risk populations
- Alignment of prevention programs across healthcare and social-service systems
- Interoperability of data and information systems

Such coordination would allow preventive strategies to reinforce one another rather than operating as isolated initiatives. Coordinated community initiatives would improve the effectiveness of preventive investments and support sustained improvements in population health.

Community-Level Measures of Success

Shared accountability for prevention-first communities requires measurement systems that reflect the root causes of disease at the community level. Current healthcare performance measures focus primarily on services delivered and outcomes within healthcare systems. These measures do not fully capture whether communities are becoming healthier over time.

Prevention-first communities require a defined set of community-level measures that track the upstream conditions that shape long-term health outcomes. These measures should reflect progress toward addressing the root causes of disease and improving the environments in which people live. Examples of community-level prevention measures could include:

- Rates of preventable chronic disease
- Tobacco use and obesity prevalence
- Housing stability and food security
- Access to primary care and preventive services
- Physical activity environments and transportation access

Community-level measures would allow healthcare providers, public agencies and community organizations to evaluate progress toward shared preventive goals. These measures would not assign responsibility to any single organization. Instead, they would provide a shared framework for assessing whether prevention-first strategies are improving community health over time.

Community-level prevention measures would provide an essential accountability structure for prevention-oriented communities. Community-level prevention measures would also provide a framework for effectively targeting tailored interventions to those at greatest risk due to these upstream factors.

Shared Data and Cross-System Coordination

Communities require improved coordination across data systems and service agencies. Individuals with complex needs often interact with multiple public and private systems, including healthcare providers, Medicaid programs, housing services, behavioral health programs, schools and justice-system agencies. However, these systems frequently operate with limited data sharing and coordination. Better coordination could include the following:

- Improved data-sharing agreements across agencies
- Shared identification of high-risk populations
- Coordinated service planning across agencies
- Integrated referral systems across healthcare and social services

Improved cross-system coordination would allow communities to identify risks earlier and intervene more effectively. Data coordination is particularly important for individuals facing the highest health risks, where fragmented systems often produce the poorest outcomes.

The Built Environment as a Preventive System

Prevention-first communities must also address the physical environments in which people live. Community design influences physical activity, transportation patterns, access to healthy food, environmental exposures and social connections. Housing quality, neighborhood safety, walkability and transportation access all contribute to long-term health outcomes.

Prevention-oriented strategies should recognize these environmental influences and incorporate them into community health planning where feasible. Healthcare organizations cannot control the built environment, but coordination with community planning and infrastructure agencies can support prevention-oriented community development. Even modest alignment between health priorities and community planning can produce long-term improvements in population health.

Section 4 — Policy Recommendations

Establish a Prevention First Community Transformation Initiative (PFCTI)

Building prevention-first communities requires coordinated action across healthcare systems, public health agencies, Medicaid programs and community institutions. Fragmentation across these systems limits the ability of communities to address the root causes of disease and achieve sustained improvements in health outcomes.

Federal policy should support state and community efforts to build prevention-first infrastructure that aligns healthcare delivery, public health programs and community systems around shared prevention goals.

A Prevention First Community Transformation Initiative (PFCTI) should provide competitive funding to states and communities to establish Prevention First Transformation Offices responsible for coordinating prevention strategies across agencies and community partners. Participating states would develop Prevention First Transformation Plans aligned with national preventive priorities while tailored to local needs and conditions. Plans would describe

how states and communities will coordinate efforts to address the root causes of disease and improve long-term health outcomes.

States would be required to demonstrate cross-agency collaboration and establish governance structures capable of coordinating prevention strategies across healthcare, public health and human service systems. Funding should support both planning and implementation and should require measurable progress toward prevention-oriented goals. Prevention First Community Transformation Initiatives should include the following core elements:

- **Community Preventive Governance**

Participating states and communities should establish Prevention First Transformation Offices responsible for coordinating prevention strategies across healthcare systems, public health agencies, Medicaid programs and community organizations. These offices would serve as the primary coordinating body for implementation within participating states or regions. Governance structures should include representation from above organizations to ensure coordinated action across the institutions that shape health outcomes.

- **Healthcare–Community Prevention Integration**

PFCTI programs should support mechanisms that allow healthcare providers, public health agencies and community organizations to coordinate preventive strategies for shared populations. This coordination may include referral pathways between healthcare and community-based prevention services, shared care coordination for individuals with elevated health risks and partnerships addressing upstream drivers of disease such as housing instability, food access, environmental exposures and transportation barriers. The goal is to enable communities to address the root causes of disease through coordinated action across clinical care and community institutions.

- **Shared Prevention Measurement**

Participating states should implement shared measurement frameworks capable of tracking prevention progress across populations and communities. Measurement should include indicators related to major chronic disease risks, preventive service delivery, community conditions influencing health and long-term health outcomes. These measures should allow states and communities to evaluate whether preventive strategies are producing sustained improvements in population health. Shared measurement frameworks should align with national measurement standards where available while allowing flexibility for state and community priorities.

- **Implementation Capacity and Technical Support**

PFCTI funding should support the development of local implementation capacity required to sustain effective transformation. This includes workforce development, analytic capacity, cross-agency coordination infrastructure and technical assistance for participating communities. Federal support should prioritize building durable institutional capacity that allows states and communities to sustain preventive initiatives beyond the initial funding period.

- **Learning Networks and Evaluation**

The initiative should also support national learning networks that allow participating states and communities to share best practices, evaluate strategies, and accelerate the spread of effective approaches. Continuous evaluation should assess program performance and inform future improvements in prevention-oriented community systems.

Cross-Agency Prevention Coordination

States should establish governance structures that coordinate preventive strategies across:

- State and local health departments
- Medicaid agencies
- Healthcare delivery systems
- Human-service agencies
- Community organizations

Transformation plans should describe how participating agencies will align strategies and coordinate services to address the root causes of disease.

Community-Level Prevention Measurement

States should develop community-level prevention measurement systems that track progress in addressing the root causes of disease, based on agreed upon, standardized, national metrics.

Measurement systems should include indicators reflecting:

- Chronic disease risk factors
- Maternal and child health outcomes
- Behavioral health indicators
- Environmental health risks
- Social and economic conditions affecting health

Community-level prevention measures would allow states and communities to track progress toward prevention-first goals and identify opportunities for improvement.

Cross-Agency Data Sharing and Infrastructure

States should establish data-sharing mechanisms that allow appropriate coordination across healthcare and human-service systems while protecting privacy and security. Transformation plans should describe how participating agencies will:

- Share data appropriately across programs
- Improve coordination for high-risk populations
- Support prevention-oriented service delivery
- Enable evaluation of prevention strategies

Improved data coordination would support more effective prevention initiatives and allow communities to evaluate long-term outcomes.

Coordination Across Healthcare and Community Systems

Transformation plans should describe how healthcare providers, public health agencies and community organizations will coordinate preventive strategies. Plans should include approaches to the following:

- Align goals across healthcare and community systems
- Support coordinated preventive strategies
- Improve continuity of preventive services across settings
- Strengthen connections between healthcare providers and community programs

Accountability for Root Causes of Disease

Transformation initiatives should support shared accountability for addressing the root causes of disease at the community level. Plans should describe how participating organizations will coordinate efforts to improve the conditions that influence long-term health outcomes, including:

- Housing stability
- Vocational opportunities
- Food access
- Environmental conditions
- Transportation access

Prevention First accountability requires coordinated action across organizations responsible for different aspects of community well-being.

Pillar 7

Prevention Data Infrastructure

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Section 1 — Introduction

A Prevention First health system requires reliable information to support both individual care and population-level decision-making. Prevention depends on the ability to identify risks early, coordinate services and evaluate outcomes across healthcare systems and communities.

Data infrastructure is also essential for monitoring progress towards achieving transformational goals. A Prevention First system must be able to track changes in health risks, chronic disease and community conditions over time in order to evaluate whether preventive strategies are working. Without reliable population-level measurement, prevention-oriented transformation cannot be sustained or held accountable.

The United States already maintains extensive health data through Medicare, Medicaid, commercial health plans and public-health systems. Prevention First data infrastructure should build on these existing systems while improving coordination, access and analytic capability.

Strong privacy protections must remain central to data systems. Health information should remain under the stewardship of the organizations that collect it and should be used only for legitimate care, program administration and population health purposes. Individuals should also have meaningful access to their own health information and appropriate control over how it is used.

Prevention First data infrastructure supports every pillar of transformation. Reliable data are necessary to measure progress in prevention delivery, payment reform, workforce development, community prevention systems and private-sector engagement. Without shared measurement across these domains, Prevention First transformation cannot be effectively guided or sustained.

Section 2 — Problem: Prevention First Transformation Requires Better Data Infrastructure

Current data systems were largely designed to support billing, regulatory reporting and individual clinical encounters rather than long-term prevention. As a result, existing data infrastructure does not adequately support prevention-oriented decision-making or accountability.

A Prevention First health system requires data infrastructure capable of supporting both individual care and population-level monitoring of health outcomes. Transformation is dependent on the ability to track long-term health risks, evaluate preventive strategies and measure progress toward improved population health.

Data fragmentation, limited interoperability, uneven analytic capacity and privacy concerns together limit the ability of healthcare systems and public agencies to monitor health outcomes and evaluate prevention strategies effectively. Without stronger data infrastructure, transformation cannot be reliably implemented or sustained.

Monitoring a Prevention First Health System

A Prevention First health system requires the ability to monitor population health and evaluate progress toward prevention-first goals. Current national health surveillance systems provide only limited visibility into the health of the population. Many surveillance systems rely on periodic surveys or delayed reporting and cannot provide timely or detailed visibility into changing health risks or prevention outcomes.

Administrative healthcare data and electronic health records contain far more detailed information about health status and healthcare utilization, but these data sources are rarely integrated in ways that allow comprehensive population-level monitoring.

A Prevention First health system requires a more complete and timely understanding of national, state and community health conditions. Integrated data systems could support ongoing visibility into preventive performance and allow policymakers and healthcare organizations to evaluate whether Prevention First strategies are improving long-term health outcomes. Without improved data infrastructure, it is difficult to measure progress toward goals or identify opportunities for improvement.

Fragmented Healthcare Data Infrastructure

Healthcare data currently fragmented across multiple systems, rarely operating as a unified infrastructure. Medicare and Medicaid programs maintain extensive administrative data. Commercial health plans maintain similarly detailed claims and enrollment data. Healthcare providers maintain electronic health records that include clinical information not captured in administrative data.

Although each of these systems contains valuable information, they often operate independently with limited interoperability. Individuals frequently move between coverage programs, creating discontinuities in available data. Differences in data standards and reporting practices further limit integration across systems.

Payers and systems often hold much of their data as proprietary. While one can certainly recognize the business need for such designations in certain instances, there must also be an agreed-upon set of rules to identify critically necessary shared data elements for a more seamless prevention-focused health information system.

These limitations make it difficult to follow outcomes over time or evaluate preventive strategies across populations. Existing initiatives such as patient-access tools and data-exchange standards represent important progress, but current infrastructure remains insufficient to support Prevention First transformation at a national scale.

Fragmented Data on the Root Causes of Disease

Prevention First healthcare requires the ability to understand and monitor the root causes of disease at the population level. Many of the factors that shape long-term health outcomes — including housing stability, food access, education, workforce needs, environmental conditions, transportation access and involvement with public service systems — are documented in administrative data systems outside traditional healthcare settings.

However, these data systems are rarely connected to healthcare data in ways that support prevention-oriented decision-making. Housing agencies, education systems, Medicaid programs, public-health departments, human-service agencies and justice-system programs each maintain their own data systems with limited interoperability. These systems often serve the same individuals and communities but operate with separate reporting requirements and analytic tools.

As a result, policymakers and healthcare organizations often lack the ability to understand how community conditions and public systems influence health outcomes over time. Fragmentation across these data systems limit abilities to identify root causes of disease and evaluate preventive strategies at the community level. Without improved integration of healthcare and community data, accountability for addressing the root causes of disease cannot be fully realized.

Limited Capacity to Use Data Effectively

Even where data exist, many organizations lack the analytic capacity needed to support prevention-first decision-making. Public programs such as Medicare and Medicaid maintain large and complex data systems but often face significant challenges in using these data to answer policy and population-health questions in a timely manner. State Medicaid agencies in particular frequently lack sufficient analytic resources to evaluate program performance or identify emerging health risks.

Healthcare providers and community organizations often have even more limited analytic capabilities. Commercial health plans and some large employers have developed advanced analytic capabilities, but access varies widely across the healthcare system. As a result, the ability to use data effectively remains uneven and often insufficient. Without improved analytic capacity, expanded data infrastructure alone will not produce meaningful improvements in prevention.

Privacy and Trust Considerations

Expanded use of health data must maintain strong protections for privacy and individual control of information. Healthcare organizations and public programs already maintain extensive personal health data under established legal and regulatory frameworks. Medicare, Medicaid and private health plans routinely collect detailed information about healthcare utilization and health status.

Prevention First data infrastructure should build upon existing systems rather than creating entirely new repositories of personal health information. Data should be used only for legitimate healthcare and public-health purposes and should be protected from commercial misuse or unauthorized access. Population-level analysis can often be conducted using de-identified data, while identifiable information should be accessible only to properly authorized users involved in care delivery or program administration. Public trust will be essential to prevention-first data infrastructure. Systems must be designed to improve coordination and effectiveness while maintaining strong safeguards for privacy and individual rights. Without clear protections and

transparent governance, expanded data use could undermine public confidence and weaken efforts.

Section 3 — Solution Framework: Building a Prevention First Data Infrastructure

Patient-Controlled Data Sharing Built on Existing Systems

The goal is to improve coordination and responsible use of existing data rather than create entirely new centralized data systems. Individuals should have meaningful control over how their health information is shared across healthcare providers, health plans and public programs. Federal programs such as Medicare have already established this principle through Blue Button, which allows beneficiaries to access and share their health information. Blue Button demonstrates that patient-directed data sharing can be implemented within existing systems while maintaining strong privacy protections. Prevention First data infrastructure should extend this model across coverage systems so that individuals can authorize appropriate sharing of their data when it supports their care and goals.

Individuals should also be able to authorize the inclusion of selected data from personal health technologies and digital health programs when relevant. For example, individuals could choose to share information from connected devices such as blood pressure monitors, glucose sensors or from digital health programs that support lifestyle change. Participation in such data sharing should always be voluntary and under individual control. Prevention First data infrastructure should operate on a layered privacy model. At broader system levels, data should be used primarily in de-identified form to support population-level understanding and prevention measurement. Identifiable information should be accessible only to appropriately credentialed users involved in care delivery or program administration. This approach allows data infrastructure to support both individual care and population-level understanding while preserving strong protections for privacy and security.

A National Understanding of Health

The ability to understand health outcomes at the population level in a consistent and timely way is required to achieve a prevention-oriented data infrastructure. Current public health surveillance systems provide important information about disease prevalence and risk factors, but they rely heavily on surveys and delayed reporting. These systems provide only a partial picture of population health and do not allow policymakers and health systems to track progress in near real time.

Prevention First data infrastructure would support a more complete understanding of health by responsibly linking administrative data, clinical data and prevention-related information across systems. Data from Medicare, Medicaid and commercial insurance programs, combined with clinical information from electronic health records, could provide a more accurate and timely understanding of population health trends.

This capability is essential not only for improving individual care but also for evaluating the effectiveness of prevention-oriented policies and programs. A preventive health system requires

the ability to measure whether health risks are declining and whether preventive strategies are producing meaningful improvements over time.

A shared understanding of population health would allow federal and state policymakers, health systems and communities to track progress toward goals and identify areas where additional effort is needed.

Integrating Data on the Root Causes of Disease

Prevention First data infrastructure must also support understanding of the root causes of disease. Health outcomes are strongly influenced by conditions outside healthcare settings, including housing stability, food access, transportation, environmental exposures and community conditions. Data related to these factors are often collected by public agencies and community organizations but remain disconnected from healthcare data systems.

Integrating selected information on these upstream drivers of health would improve the ability of healthcare providers and community agencies to coordinate prevention strategies and identify populations at elevated risk. Such integration does not require universal sharing of all data across systems. Rather, preventive-oriented infrastructure should support appropriate and privacy-protected use of relevant information to improve coordination and understanding of health risks. Better integration of data related to the root causes of disease would support earlier identification of risks and more effective preventive strategies across healthcare and community systems.

Strengthening Analytical Capacity Across Health Systems

In addition to improving data infrastructure, prevention-oriented healthcare requires stronger capacity to analyze and use health data effectively. Many public agencies and healthcare organizations have access to large amounts of health data but lack the analytic tools and workforce needed to translate data into actionable insights. State Medicaid agencies and federal programs often face significant challenges in answering basic population health questions, evaluating programs or identifying opportunities for improvement of prevention.

Private-sector organizations such as health plans and large employers have often developed more advanced analytic capabilities, but these capabilities are unevenly distributed and are not consistently connected to public-sector prevention efforts. A Prevention First health system requires analytic capacity that allows public agencies, healthcare organizations and community partners to understand health risks, evaluate prevention programs and identify opportunities for improvement.

Strengthening analytic capacity is therefore an essential component of Prevention First data infrastructure. Without the ability to interpret and use data effectively, improvements in data collection and sharing will not translate into meaningful improvements in health outcomes. Strong analytic capacity is also essential for accountability. Policymakers, health systems and communities must be able to determine whether preventive strategies are producing measurable improvements in health outcomes over time. Without reliable analytic capability, Prevention First goals cannot be evaluated or sustained.

Section 4 — Policy Recommendations

Establish a Prevention First Data Infrastructure Initiative

A Prevention First health system requires data infrastructure capable of supporting coordinated prevention strategies, population-level measurement and continuous improvement. While the United States already maintains extensive health data through Medicare, Medicaid, commercial health plans and healthcare providers, these systems operate with limited coordination and uneven analytic capability.

Federal policy should support development of a Prevention First data infrastructure that builds on existing systems while improving interoperability, analytic capability and responsible data use. The goal is not to create new centralized repositories of personal health information, but to improve coordination and effective use of data already maintained by healthcare programs and organizations.

A Prevention First data infrastructure initiative should support development of interoperable systems that enable prevention-first decision-making while maintaining strong protections for privacy and individual control. Core elements should include federal leadership, state and Medicaid data system improvements, private-sector participation and strong privacy protections.

Federal Leadership

The federal government should establish national standards and infrastructure that support prevention-oriented data use across healthcare and public programs. Federal actions should include the following:

- **Expansion of Blue Button–Style Data Access**

Individuals should have access to their health information through secure tools similar to Medicare Blue Button, regardless of coverage source. Blue Button–style capabilities should be extended to Medicaid programs and commercial insurance so that individuals can access and authorize sharing of their own health information.

This approach reinforces the principle that individuals have meaningful control over their health information while enabling responsible data sharing that supports prevention and coordinated care.
- **Common Prevention-Focused Data Standards**

National data standards should support consistent reporting of prevention-first measures across healthcare systems. Standards should include the following:

 - Core claims-data standards across Medicare, Medicaid, and commercial plans
 - Standardized reporting of selected prevention-first clinical measures through electronic health records
 - Consistent definitions for chronic disease and preventable conditions
 - Data elements necessary to evaluate prevention outcomes over time

These standards should focus on prevention-relevant information rather than attempting to standardize all clinical data. It should also clearly delineate what information can and cannot be held as “proprietary” by payers and providers.

- **Longitudinal Person-Level Data Linkage**
Federal standards should support the ability to follow health outcomes over time across coverage programs while maintaining strong privacy protections. Individuals frequently move between Medicaid, employer-sponsored insurance, Marketplace coverage and Medicare. These transitions create discontinuities in data that make it difficult to evaluate long-term preventive outcomes. Prevention First data infrastructure should support privacy-protected methods for linking records across coverage systems in order to enable longitudinal understanding of health risks and outcomes.
- **Modernization of Federal Health Data Systems**
Existing federal data infrastructure should be strengthened to support prevention-first analysis and coordination. Efforts such as Medicare Claims Core modernization represent important steps toward improving analytic capabilities and data usability. Continued modernization should focus on improving data quality, accessibility and analytic capability to support prevention-oriented decision-making. Federal data modernization efforts should be framed as supporting Prevention First transformation rather than regulatory oversight.
- **National Guidance on Prevention-Oriented Population Analytics**
The federal government should develop guidance describing core analytic capabilities needed to support Prevention First healthcare. Guidance should address the following:
 - Population risk identification
 - Evaluation of prevention programs
 - Measurement of prevention outcomes
 - Monitoring of chronic disease trends
 - Integration of healthcare and community data

Such guidance would ensure that public agencies and healthcare organizations develop analytic capabilities aligned with goals without requiring centralized analytic systems.

State and Medicaid Data Systems

State governments play a central role in Prevention First data infrastructure through administration of Medicaid programs and coordination of public health and human-service data systems. State actions should include the following:

- **Improved Medicaid Data Completeness and Usability**
States should maintain complete and accurate claims and encounter data for Medicaid populations. Medicaid managed-care organizations should be required to submit complete encounter data at the claims level in standardized formats that

support prevention-oriented analysis and evaluation. Reliable claims-level data are essential for understanding health risks, evaluating prevention programs and measuring long-term outcomes in Medicaid populations.

- **Enhancement of Medicaid Data Standards**

Federal and state governments should work together to improve Medicaid data systems such as T-MSIS so that they support prevention-oriented analysis while reducing unnecessary reporting burden on states. Improvements should focus on the following:

- Data completeness and consistency
- Timeliness of reporting
- Usability for population health analysis
- Alignment with prevention-first measurement goals

These improvements should be framed as supporting Prevention First transformation rather than compliance enforcement.

- **Integration of Healthcare and Human Service Data**

States should strengthen appropriate coordination across healthcare and human-service data systems. Improved coordination could include the following:

- Data-sharing agreements across agencies
- Identification of shared populations
- Support for prevention-oriented service coordination
- Evaluation of prevention strategies addressing root causes of disease

Such coordination would improve the ability of states to understand health risks and evaluate prevention strategies across populations, and to better focus and coordinate preventive interventions to those at greatest risk.

Private Sector Participation

Private sector organizations maintain a large share of U.S. health data and must be active participants in Prevention First data infrastructure. Private-sector actions should include the following:

- **Participation in Prevention-Focused Interoperability Standards**

Commercial health plans and healthcare providers should participate in national interoperability standards that support measurement and coordination. Participation should support consistent reporting of prevention-relevant data while minimizing administrative burden.

- **Support for patient-directed data sharing**

Healthcare organizations and health plans should support secure mechanisms that allow individuals to access and authorize sharing of their health information. Patient-directed data sharing should follow principles established by Blue Button-style access tools and allow individuals to coordinate information across coverage systems and providers.

- **Contribution to Prevention First measurement**
Private sector organizations should support reporting of standardized preventive measures that allow consistent evaluation of progress of disease prevention across populations. Consistent reporting would allow preventive strategies developed in private systems to inform broader transformation.

Privacy and Individual Data Control

Prevention First data infrastructure must strengthen privacy protections while improving responsible use of health information. Data systems should build upon existing legal and regulatory protections governing healthcare data while strengthening transparency and individual control. Key principles should include the following:

- **Data Stewardship within Existing Systems**
Health data should remain under the stewardship of the organizations that collect it, including healthcare providers, health plans and public programs. Data infrastructure should improve coordination across these systems rather than creating new centralized repositories of identifiable personal data.
- **De-Identified Population-Level Analysis**
Population-level analysis should rely primarily on de-identified data wherever feasible. De-identified data can support Prevention First measurement and evaluation while minimizing risks to individual privacy.
- **Authorized Access for Care and Program Administration**
Identifiable information should be accessible only to appropriately credentialed users involved in care delivery or program administration. Access should be limited to credible and legitimate preventive care, care coordination and program-administration purposes.
- **Individual Control of Supplemental Data Sharing**
Individuals should be able to authorize inclusion of selected information from personal health technologies and digital health programs when relevant. Such data sharing should always be voluntary and under individual control.

Pillar 8

Prevention-First Leadership and Implementation

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Section 1 — Introduction

Prevention-first transformation requires sustained national leadership and coordinated implementation. The changes outlined in Prevention First — spanning payment reform, workforce development, delivery systems, community prevention, private-sector engagement and data infrastructure — represent a long-term national effort that must be guided by clear goals and consistent oversight.

Transformation cannot succeed through fragmented initiatives alone. While many federal agencies, state governments, healthcare systems and private-sector organizations contribute to prevention, no single entity currently holds responsibility for coordinating prevention-oriented transformation across the healthcare system.

Without sustained leadership and coordination, preventive initiatives risk becoming disconnected efforts that fail to produce lasting improvements in population health. A prevention-first healthcare system requires a durable leadership structure capable of guiding implementation across sectors and maintaining long-term accountability.

Section 2 — Problem: Fragmented Leadership for Prevention

Responsibility for prevention is currently distributed across multiple federal agencies and programs. Healthcare programs, public-health agencies, workforce programs, and community initiatives all contribute to prevention, but these activities are rarely coordinated around shared national goals.

This fragmentation makes it difficult to align policy decisions, measure progress consistently, or sustain long-term prevention investments. Individual programs may make important contributions to prevention, but without coordinated leadership the overall system cannot move consistently toward prevention-first goals. As a result, prevention remains an important objective but not an organizing principle for the healthcare system.

Prevention First Transformation Requires Sustained Oversight

The transformation described in this strategy involves coordinated progress across multiple domains, including the following:

- Prevention-oriented delivery systems
- Payment reform and financing
- Workforce development
- Community prevention systems
- Private-sector engagement
- Data infrastructure and measurement

These efforts must evolve together over time in order to produce meaningful improvements in population health. No existing organization is responsible for coordinating this work across federal programs and sectors. Without sustained oversight and coordination, prevention-first transformation is unlikely to be implemented consistently or maintained over time.

Prevention First Transformation is too Important to Leave Fragmented

Prevention-first transformation represents a fundamental shift in how the healthcare system defines success — from treating disease after it occurs to addressing the root causes of disease and improving long-term health outcomes. This transformation is too large and too important to rely on disconnected initiatives or temporary programs.

A Prevention First healthcare system requires a clear focal point for leadership and accountability. Without a dedicated structure responsible for coordinating prevention-first transformation, responsibility will remain fragmented and progress will be uneven and therefore less effective. A durable leadership structure is therefore essential to ensure that prevention-first transformation is implemented consistently and sustained over time.

Section 3 — Solution Framework

A Prevention First Transformation Office

The federal government should establish a Prevention First Transformation Office responsible for coordinating national prevention-first strategy and implementation. This office would provide sustained leadership for prevention-first transformation across federal programs while supporting coordination with states, healthcare organizations, and the private sector.

The Prevention First Transformation Office would not replace existing agencies or programs. Instead, it would provide strategic coordination and oversight to ensure that prevention-first goals are consistently integrated into federal health policy. The office would serve as the central coordinating body responsible for the following:

- Maintaining a national prevention-first strategy
- Aligning federal prevention initiatives
- Coordinating implementation across agencies
- Supporting state prevention-first efforts
- Monitoring progress toward prevention-first goals
- Reporting on national prevention-first performance

This structure would provide a durable focal point for prevention-first leadership while allowing implementation to remain distributed across existing institutions.

Section 4 — Policy Recommendations

Establish a Prevention First Transformation Office

The federal government should establish a Prevention First Transformation Office to provide sustained leadership and coordination for prevention-oriented transformation. The office should be positioned to coordinate across the Department of Health and Human Services while maintaining strong connections with state governments and private-sector organizations.

Key responsibilities should include the following:

- **National Strategy Development**
The office should maintain a national Prevention First strategy aligned with the pillars described in this framework and updated periodically to reflect evolving knowledge and priorities.
- **Cross-Agency Coordination**
The office should coordinate activities across federal programs, including healthcare financing programs, workforce initiatives, community programs and data infrastructure efforts. This coordination would help ensure that federal programs operate toward shared prevention-first goals rather than as independent initiatives.
- **Support for State-Led Prevention First Transformation**
The office should support prevention-oriented initiatives across states, including Prevention First transformation grants and technical assistance for implementation. States would remain responsible for designing and implementing prevention-first strategies within their own healthcare systems.
- **National Prevention-First Measurement**
The office should coordinate development of prevention-first measurement systems that allow consistent tracking of prevention outcomes across populations and over time. Measurement should support continuous improvement and public accountability while maintaining strong protections for privacy.
- **Workforce Leadership Development**
The office should support national leadership development initiatives such as the Prevention Leadership Corps to prepare professionals capable of implementing prevention-first transformation across sectors.

Conclusion

A Prevention First healthcare system is not only possible, but also necessary to achieve the future we must build.

The United States stands at a critical inflection point. The convergence of rising chronic disease rates, persistent health inequities, escalating healthcare costs, risks of epidemics of infectious diseases, burden of injuries and the residual impacts of public health crises has made clear that our current model of care — centered on episodic treatment rather than sustained wellness — is no longer tenable. Prevention is no longer optional, it is imperative. The Prevention First framework offers a blueprint for transformation that shifts the center of gravity in U.S. healthcare toward prevention, equity and sustainability. It is grounded in a clear vision: that health should be strengthened and preserved, not merely repaired. It rests on the expertise of preventive medicine physicians; whose clinical and population health training makes them uniquely qualified to lead this shift across sectors.

To succeed, this transformation must be systemic. It requires reorienting medical education and GME funding, restructuring health systems and reimbursement methodology, elevating community partnerships and equity, integrating new technologies and data systems and enacting bold policy reforms. This not only will prevent illness and extend life, but also will strengthen our economy, workforce and collective resilience as a nation. The goals set forth in Prevention First are ambitious but achievable. Within five years, the United States can double the preventive medicine workforce, embed prevention into every medical school and build the foundations for equity-driven payment models. Within ten years, the U.S. can move from a reactive system that treats disease to one actively protecting and promoting health.

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