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Scaling and Sustaining Better Health Outcomes Through Prevention

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Introduction

Since May 2024, the Milken Institute has assessed and evaluated the landscape of successful evidence-based models and platforms for preventive service delivery in the US. As a think tank, we aim to leverage our expertise and network of leaders and policymakers to identify effective community-based preventive service delivery models and scale them nationally by developing and disseminating policy recommendations to shift toward prevention-first health care.

Preventable illnesses remain a leading cause of death worldwide. Non-communicable diseases, such as cardiovascular disease, diabetes, and obesity, now account for most premature deaths driven by lack of access to healthy foods, inactivity, and inadequate screening. Socioeconomic inequities further restrict access to preventive services, especially in low- and middle-income countries. Yet evidence shows that early detection, vaccination, and community interventions can significantly lower morbidity, mortality, and health-care costs.

Most Americans are eligible for recommended evidence-based preventive health services. Yet only 8 percent of Americans older than 35 receive such care. One in four middle-aged and older adults (50–64 years) and one in two seniors (65 years and older) also receive such services. Access to and utilization of preventive care also differ across racial and ethnic groups and sociodemographic status.[1]

By not taking up preventive care services, millions of Americans fall ill needlessly, incurring personal pain and suffering and causing substantial economic losses in the form of medical care and lost productivity.[2] The reasons so few take up preventive care range from social determinants of health to lack of awareness and education, distrust, and human behaviors disregarding long-term health threats.[3] Focusing predominantly on sick care and treatment is no longer sustainable and effective in maintaining the population's health.

Over the past 10 months, the Milken Institute conducted in-depth literature reviews and met with public, private, and nonprofit stakeholders to identify successful evidence-based models for increasing the uptake and delivery of preventive services. To build further on this research and outreach, the Institute convened a roundtable and two workshops where we identified principles, models, and partners to scale promising evidence-based models for preventive services delivery to broader populations in the US.

Key Findings

Community partnership approaches to designing and delivering preventive services have increasing significance in the US health-care landscape, particularly in efforts to improve outcomes among communities in rural America and with low socioeconomic status.[4] Rather than imposing standardized programs from external organizations, a community partnership model engages local stakeholders—such as grassroots nonprofits, faith-based institutions, and local community groups—to cocreate interventions tailored to specific cultural values, linguistic needs, and prevalent health concerns. This collaborative method has been praised for helping bridge gaps in access to health care while also building trust between health-care providers and the communities they aim to serve.[5]

Community representatives often serve as "cultural brokers," translating not just language but also social norms, religious beliefs, and historical contexts that shape community attitudes and behaviors toward certain issues.[6] Codeveloped interventions—such as faith-based health screenings or neighborhood-led health fairs—garner greater trust and participation.[7] These events provide safe spaces where attendees can openly discuss health concerns and learn about preventive strategies in a format that resonates with their cultural or spiritual background, thus increasing the uptake of screenings and immunizations.[8] Many studies—Evaluation of the North Carolina Health Opportunities Pilots and cancer screening initiatives—confirm the efficacy of community partnership and multisectoral preventive services delivery, and they warrant our focus on designing effective and efficient preventive services delivery.[9]

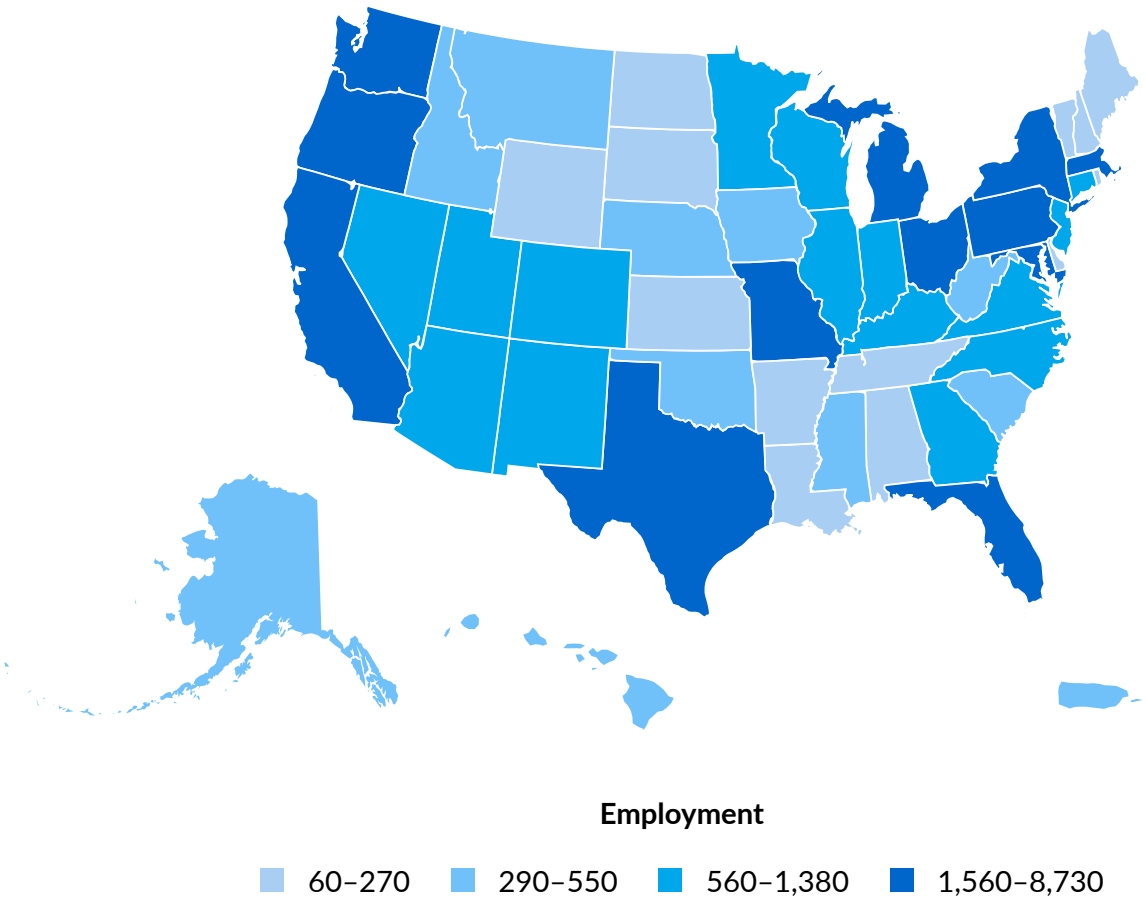
The role of shared decision-making and culturally informed conversations cannot be overstated.[10] Health-care providers learn strategies to communicate with empathy and humility, and community leaders become well versed in medical guidelines, which equip them to explain evidence-based preventive measures in terms familiar to their community members. This reciprocity of knowledge fosters an environment where patients feel respected and heard, thus boosting adherence to preventive measures such as well-child visits, screening and care for diabetes, or cancer. These types of engagement increase knowledge about diseases and conditions, particularly on accurate risk perceptions, along with the pros and cons of treatment and screening options.[11] A sustained commitment to community engagement will be necessary to create broader benefits for people most vulnerable to systemic barriers, ensuring that preventive care is culturally attuned, accessible, and ultimately more effective at improving population health.

Community health workers (CHWs) and other nonphysician providers are increasingly recognized as critical partners in preventive services education and delivery across the US.[12] Often drawn from the very neighborhoods they serve, these dedicated individuals bring a level of cultural fluency and familiarity that can foster trust, improve communication, and ultimately increase participation in preventive health measures. By meeting people where they live—whether through home visits, church gatherings, or local health fairs—CHWs and navigators can shape educational messages to resonate with the specific language, beliefs, and daily realities of each community.

One of the most significant ways CHWs and patient navigators contribute to preventive service education is by guiding individuals through the importance and logistics of recommended screenings and immunizations.[13] Rather than relying solely on formal medical settings, these frontline workers convey crucial information in accessible ways. While a primary care provider may have limited time in the clinic to discuss routine screenings for blood pressure, diabetes, and cholesterol, a CHW can spend additional time explaining why these tests matter, how to access them, and what to expect from each procedure.[14] Many people hesitate to engage in preventive screenings due to uncertainty, lack of motivation, or past negative experiences with medical systems.[15] However, skepticism often decreases when the message about early detection and healthy lifestyles comes from a familiar face within the community.

CHWs are employed across the US (Figure 1), no longer employed solely by community-based organizations (CBOs). The workforce has shifted to hospitals and health systems, including payers,[16] requiring CHWs with diverse skill sets beyond those required based on CBO settings.[17] Grounded in a randomized controlled trial of an evidence-based CHW model, a return on investment (ROI) analysis revealed that every dollar invested yields a $2.47 return to the average Medicaid payer within one fiscal year for addressing unmet social needs among disadvantaged populations.[18]

Figure 1: Employment of Community Health Workers by State, May 2023



Source: Milken Institute (2025), adapted from the US Bureau of Labor Statistics

In essence, integrating CHWs and patient navigators into preventive service education and delivery represents a more holistic approach to health care, one that recognizes that medical knowledge alone is not enough to drive behavior change. By linking scientific guidelines powered by local knowledge, these trusted community liaisons help close gaps in the use of preventive care. As the US health-care system shifts toward a focus on wellness and early detection and intervention, the role of CHWs in elevating public health education, fostering community trust, and guiding patients to essential screenings and immunizations becomes increasingly indispensable.

Data-driven and risk-based health-care delivery has gained considerable traction in the US health-care system with the rising prominence of electronic health records (EHRs) and adaptation of artificial intelligence, informing how clinicians identify at-risk populations and provide appropriate care and interventions.[19] Risk-based stratification significantly enhances adherence to preventive screening recommendations among high-risk populations.[20] Studies have illustrated the advantages of leveraging large-scale health datasets—drawn from EHRs, claims data, and demographic information—to stratify patients more accurately according to

their susceptibility to chronic diseases.[21] These efforts can further be bolstered through the incorporation of standardized, evidence-based protocols by providers who can apply tailored screening frequencies, vaccination schedules, or laboratory tests in line with best-practice guidelines established by entities such as the US Preventive Services Task Force.[22] It will ensure that the right interventions reach the right individuals at the right time.

Telehealth and digital health technologies have also played a vital role in enhancing the uptake of preventive services.[23] Telehealth consultations and remote patient monitoring expand access to care for individuals in rural or underserved communities, who otherwise might encounter barriers such as limited transportation or long waiting times. Through virtual follow-ups, care teams can promptly identify emerging risk factors—like rising blood pressure or worsening blood glucose levels—and adjust preventive care plans accordingly. Moreover, automated reminders delivered through patient portals and mobile applications have been shown to improve patient engagement.[24]

Taken together, the convergence of data-driven analysis, risk-based stratification, and digital engagement tools suggests a promising new era for preventive medicine in the United States. By identifying persons at the highest risk and ensuring they receive proactive, personalized care, the health-care system can not only enhance clinical outcomes but also achieve a more cost-effective distribution of resources. Research continues to evolve, but the consensus among recent peer-reviewed findings points in a clear direction: harnessing the power of data and technology leads to more efficient and patient-centered preventive service delivery.

Emerging Principles, Platforms, and Components for Effective and Scalable Preventive Service Delivery

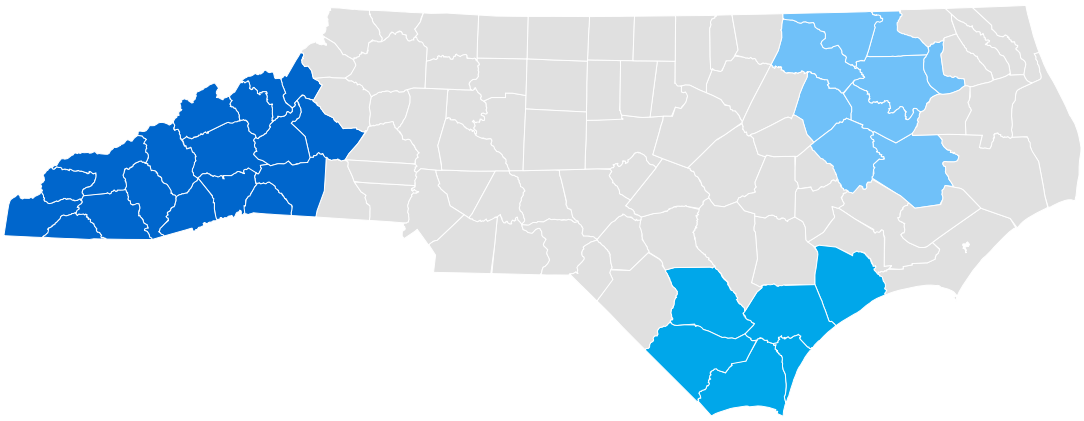
Our in-depth research and stakeholder engagements identified community partnership as a fundamental principle of preventive services delivery models based on sustaining trust as the bedrock for success. Rather than viewing trust as a peripheral element, stakeholders positioned it as a critical requirement for forging meaningful collaborations, whether through faith-based coalitions, advisory boards, or CHW programs. The community partnership approach should also shift away from one-size-fits-all, top-down initiatives toward models that acknowledge the expertise of community members and foster genuine participation by listening to community priorities.

Stakeholders highlighted the relevance of broader social factors and basic needs that might supersede the urgency of preventive services.[25] They urged designers of preventive services delivery models to view health as part of an interconnected tapestry. Program implementers could better align preventive measures with real-world circumstances by responding to pressing challenges like food insecurity or inadequate housing. This tied into the repeated call for

cocreation strategies, where messaging, outreach materials, and even navigational resources for health care were designed in tandem with local community groups.

Successful models are already in effect, with foundational platforms that could be expanded to prevention by integrating resources and referrals relevant to preventive care for the communities. One such example is North Carolina's Healthy Opportunities Pilot (HOP), which was approved in October 2018 under the first Trump administration. It is a Medicaid 1115 waiver program that channels state and federal health-care dollars toward nonmedical drivers of health, including food, transportation, and housing. HOP has focused on three largely rural regions (Figure 2), connecting people to social services via a statewide platform called NCCARE360, which links providers, CBOs, and social service agencies with health-care resources. The pilot was launched in 2022 to bridge the gap between clinical care and essential social support. Under HOP, North Carolina has authorized Medicaid payments for 28 evidence-based interventions—ranging from home-delivered meals to transportation for preventive checkups—to reduce emergency department use, lower hospital admissions, and improve overall health.

Figure 2: Health Opportunity Network Leads and Regions



Awarded Healthy Opportunities Network Leads

Access East, Inc.
Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt

Community Care of the Lower Cape Fear
Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender

Impact Health
Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

Source: Milken Institute (2025), adapted from North Carolina Department of Health and Human Services

Evaluations so far indicate that participants enrolled in HOP show lower ER visits, fewer hospitalizations, and an average monthly Medicaid saving of $85 per beneficiary (after factoring in the cost of the services). Beyond improving individual outcomes, HOP has helped investment in local community-based organizations, especially in rural areas.

United Way Worldwide (UWW)'s nationwide networks of local affiliates and the UWW-supported "211" system—a free, confidential 24/7 referral hotline for health and human services—form a powerful infrastructure for health and social services coordination. The 211 system supports around 20 million callers annually across all 50 states and Canada for issues including medical insurance enrollment, transportation for health appointments, and nutrition support. The hidden power of the 211 system lies in the data it collects on community needs: it can identify "hot spots" (where calls suggest urgent unmet needs) and "cold spots" (where no resources may exist), giving partners a near real-time view of service gaps. The 211 system is leveraged in various preventive health collaborations with organizations including Prevent Cancer Foundation, AARP, and other national and local partners. All evidence from those partnerships points to the platform's potential for increasing preventive services referrals, access to necessary health-care and coverage, and behavioral changes aimed toward prevention.

United Way 211: 2023 Impact

Across the US, 211 responded to 15.4 million requests for help and provided 19 million referrals to local services and programs.

- 5.3 million referrals for housing assistance
- 2.8 million referrals for utility assistance
- 2.4 million referrals for food assistance
- 1.2 million referrals for legal, consumer, or public safety assistance
- 1.1 million referrals for mental health and substance use disorders assistance

Source: United Way

In some workplaces, CHW-like roles (often called "navigators") help employees with high health-care utilization or chronic conditions to connect with external services. The Office of Intergovernmental and External Affairs at the Department of Health and Human Services (HHS) hosts 10 Regional Offices. HHS Region 2 Office serves New Jersey, New York, Puerto Rico, and the US Virgin Islands, home to nearly 33 million individuals with complex racial and ethnic communities, biomes, and living environments. In particular, the Region 2 Office is designated to focus on prevention by the Office of Assistant Secretary of Health at the HHS. Region 2's interest lies in defining those CHW responsibilities, exploring how to pay for them, and mapping best practices for large companies. If properly tracked and incentivized, such workforce-oriented programs might replicate the successes seen in models like IMPaCT Care. Blending in-person training, ongoing mentorship, and user-friendly technology, IMPaCT Care has expanded to 22 states. Leaders in clinical or employer

settings often worry about administrative burdens, so any large-scale CHW deployment must demonstrate cost savings and reduce operational burden. Evidence supports the clear ROI of CHW models, and such ROI can also be reinvested and may still generate cost-savings, which has a great potential to end a perpetual cycle of underfunding of CHW programs.[26]

Long-term sustainability underpinned all our engagements. Though preventive health could offer significant benefits, its effectiveness hinges on consistent funding models that do not evaporate when grant cycles end or institutional priorities shift. Participants from the design workshop repeatedly emphasized that effectively scaling preventive care delivery models requires a broad ecosystem of partners.

Actions to Scale the Progress

Incentivize Value-Based Models

Medicaid managed care organizations emerged as key enablers because they can formalize value-based contracts and fund community-based interventions to reduce high-cost health-care use. CBOs and nonprofits can serve as trusted points of contact, especially in rural or low-income settings, and rely on support from philanthropic groups and private funders for start-up or bridging funds. Health systems and providers bring clinical services but often have limited capacity to address social determinants of health, which makes well-structured referral processes with groups like the YMCA or the 211 system essential.

Large employers can incorporate navigator or CHW models within their workforces to reduce absenteeism and claims costs. At the same time, state legislators can craft regulatory waivers and budgetary commitments—such as North Carolina's 1115 waiver for HOP—that allow nonclinical supports to be reimbursed. Finally, technology and data partners can also help unify referrals, track outcomes, and illustrate hot spots of need, as seen in NCCARE360 and the 211 National Data Platform.

These partnerships aim for common outcomes to sustain and expand preventive models. Core among them are measurable cost savings (such as the $85 per-beneficiary monthly saving that North Carolina's pilot produced)[27] and concrete health improvements like higher screening rates or reduced complications of chronic disease.

Establish Reliable Community-Based Infrastructure

Equally critical is reliable infrastructure for community services—organizational capacity and real-time referral systems—that can accommodate a substantial volume of new enrollees. Participants underscored the importance of "closed-loop" technology enabling agencies, health-care providers, and payers to follow each client's progress, share updates, and verify completed referrals. Often anchored by Medicaid or other public payers, long-term investment models are needed to ensure that these interventions do not revert to short-lived pilots.

Share Best Practices and Stories with Concrete Evaluation

Stakeholders agreed that telling a cohesive story—one that blends narratives from successful implementation and credible data—remains vital for getting legislators, health systems, large employers, and health plans on board. Ultimately, each program's success will hinge on demonstrating tangible financial and health impacts, scalable technology, and the ability to integrate seamlessly into mainstream practice so that prevention becomes a routine part of America's health-care system.

Next Steps

Preventive health will flourish when communities are empowered rather than resorting to temporary or externally imposed solutions. Existing models with proven success do not need to be reinvented. However, we need to rethink how we buy and pay for health by installing community and multisectoral networks of partners, relatable outcome measures, appropriate reimbursement mechanisms, and a powerful messaging strategy. Harnessing these strengths and translating them into national policy goals could be the key to a stronger, more prevention-centered health-care system in the US.

Milken Institute Health is launching the "**Project Prevent Collaborative**," inviting stakeholders to participate in both small- and large-group forums to finalize plans for statewide or national expansions. In these sessions, Milken Institute Health will serve both as a facilitator—connecting potential funders, CBOs, and policymakers—and as a champion, developing and promoting policies that incentivize proactive health care. The Institute will also collaborate with members on thought-leadership pieces, share best practices broadly, and highlight success stories through the Milken Institute's platforms, all in an effort to expand preventive care and strengthen a sustainable health-care system.

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Milken Institute Health bridges innovation gaps across the health-care continuum to advance whole-person health throughout the life span by improving healthy aging, public health, biomedical science, and food systems.

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