Short-Term Action for America’s Health: Health Care, Public Health, and Community Collaboration to Reduce the Burden of Respiratory Infections, Opioid Use Disorder, and Other Public Health Threats

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Introduction: Collaborative Short-Term Action to Advance America’s Health

Progress on America’s health has been challenging despite better tools and capabilities to improve health than ever before (The Commonwealth Fund, 2022). The United States has world-leading diagnostic tests, treatments, and vaccines; increasingly rich and interoperable electronic health data to help patients stay healthier; and many innovative efforts by health care organizations to strengthen primary and preventive care, including care provided at home. Yet American life expectancy has declined, and many health disparities have widened in recent years, alongside rising health care spending with growing challenges in affordability and access (CMS, 2023; Hill et al., 2023; Arias et al., 2022). Health care workers are also reporting more burnout and attrition than ever before (Popowitz, 2023; Prasad et al., 2021).

It is time for a more collaborative path forward in improving the nation’s health. Here, the authors propose a set of short-term steps to leverage public and private efforts to improve the public health of the nation based on the increasing opportunities for collaboration across health care, public health, and community supports. This approach reflects growing opportunities for public-private collaborations to enable health care systems to be more prepared and resilient to address health risks in local communities. In particular, the authors identify short-term opportunities to leverage non-public health supports to advance goals shared across public health, health care, and social service programs—for example, steps that build on policies at the Centers for Medicare and Medicaid Services (CMS) to advance “value-based” care, that is, payment and care reforms that help health care organizations advance population health.

The nation’s federal, state, and local public health agencies play a critical role in bringing evidence, expertise, and best practices to help guide community responses to detecting and addressing these challenges to the health and well-being of Americans. But public health agencies have limited and tightening resources. According to National Health Expenditures for 2024, national funding for public health amounts to roughly $489 per person, a fraction of spending on health care and social and community services (Keehan et al., 2023). CDC is currently awarding over $5 billion in grants to state, local, and territorial health departments to bolster public health infrastructure across fiscal years 2023 to 2027, but consistent infrastructure funding at that level is not expected to persist (CDC, 2024a). With this level of support, significant shortfalls remain for state and local health departments to provide adequate public health services (Keeler et al., 2023). CDC is currently awarding over $5 billion in grants to state, local, and territorial health departments to bolster public health infrastructure across fiscal years 2023 to 2027, but consistent infrastructure funding at that level is not expected to persist (CDC, 2024a). With this level of support, significant shortfalls remain for state and local health departments to provide adequate public health services (McKillop and Lieberman, 2023). Many of these public health services increasingly involve medical services for disease prevention and control, with a focus on uninsured and vulnerable populations. These include programs that protect against infectious and non-infectious threats—including vaccination programs and maternal health pro-
grams; drug treatment programs to prevent, manage, or cure infectious diseases like HIV and hepatitis C; and partnerships with state and local public health in addressing the overdose epidemic. The Agency for Strategic Preparedness and Response (ASPR), in collaboration with CDC and a range of other HHS and federal agencies, including the Federal Emergency Management Agency, supports preventing and minimizing the damage from public health emergencies (PHEs) like new infectious disease outbreaks, natural disasters, and bioterrorist attacks.

Population health outcomes also depend substantially on social and community factors, which influence both health risks and people’s health-related choices. Recognizing this, social service organizations, businesses, and health care organizations are taking new steps to engage communities in identifying and addressing critical gaps in these social needs (Whitman et al., 2022). Yet despite these efforts and some increases in public spending on social services—through smaller funding levels and increases than for health care services—widespread evidence of unmet social needs and inequalities persist, contributing to the concerning trends in population health (Abedi, 2021).

A range of recent reports, including from the National Academy of Medicine, have called for additional federal and state resources to address these challenges in health care, public health, and initiatives to address social drivers of poor health in communities (The Commonwealth Fund, n.d.; DeSalvo, 2021). But tight budgets and concerns about increased federal authorities suggest that substantial new resources or authorities may not be available in the near future.

Amid these challenges, there are growing opportunities for and successful examples of federally supported, local cross-sector collaboration to advance the nation’s health. These collaborations show how public and private organizations across public health, health care, and social and community services can take steps now to achieve measurable improvements in the nation’s health and health disparities. One key driver of these activities is value-based health care reforms, implemented through CMS pilot programs to improve community-based care and population health, and increasingly through payment reforms in Traditional Medicare, Medicare Advantage, and innovative state Medicaid reforms. These reforms complement and enable community collaborations to form state-led and locally led “health hubs” and networks to address social drivers of poor health, coordinate social services around individuals and families, and use emerging electronic data supports for tracking and acting on health risks at the local level. Together, these efforts increase the ability of health care, social service, public health, and community initiatives to leverage their limited resources to achieve measurable improvements in population health and health equity. But despite the common goals, these efforts remain uneven, with limited data sharing, uncoordinated and sometimes duplicative activities, and thus limited impact on moving the needle in improving the health of Americans.

In this new initiative on Collaborative Action for America’s Health, supported by the National Academy of Medicine (NAM) and the Duke-Margolis Institute for Health Policy in collaboration with the CDC, the authors describe a set of feasible, meaningful collaborative action steps across health care, public health, and community supports to improve the nation’s capacity to help Americans stay healthy. These action steps advance the longer-term goal of bringing together public, private, and community-based organizations with health care systems and public health agencies to strengthen the nation’s public health capabilities.

The authors focus on two specific areas of short-term action: (1) strengthening protections for individuals and communities from the complications and disruptions of respiratory infections and (2) preventing overdose deaths and other complications of opioid use disorder (OUD). They describe how federal agencies can collaborate to support evidence-based, short-term actions by health care, public health, and community organizations across the nation, largely with existing authorities. Their goal is measurable progress toward improving the nation’s health within the next 18 months and providing a foundation for further progress.

The authors’ approach aims to leverage and strengthen a range of timely initiatives to support public-private collaborations at the local level to improve public health. Examples include CMS’s accountable care strategy to support health care systems in delivering coordinated, longitudinal care that improves outcomes for beneficiaries; CDC’s data modernization initiative to make it easier and less burdensome for public health and health care programs to share data; and the Department of Health and Human Services’ initiative to support community care hubs to increase local capacity to identify and address social needs, and others (CDC, n.d., CMS, n.d., HHS, 2023). Together, these efforts can build a foundation for more effective local initiatives to support better informed, coordinated, and effective action to improve America’s health.

In the next section, the authors illustrate how these existing cross-cutting federal initiatives can provide foundational elements to support voluntary, local collaborative action on various public health threats. These cross-cutting elements include the adoption of standard data-sharing approaches across health care and public health to inform action and accountability; health care reforms to better support health care capabilities that advance public health goals; aligned resources for public-private collaboration to achieve measurable progress at the community level; and increased sup-
port for timely and accurate communication to help individuals, families, and businesses make informed decisions. The authors then illustrate short-term actions to apply these approaches to progress in reducing the population health impact of respiratory infections and OUD.

**Cross-Cutting Foundational Elements for Enabling Progress on Population Health**

The actions described below can be applied to improve collaborative responses to existing and emerging infectious diseases, chronic diseases and their underlying risk factors, and other important contributors to gaps in population health and health equity.

**Improve the use of electronic data to inform public health threat awareness and action through systems standards and integration.**

Electronic data standards and supporting data infrastructure are enabling enhanced electronic data sharing and analysis to improve care, with the opportunity to provide increased situational awareness and coordinated public health and health care responses to local public health threats. Federal data standards and standard data-sharing arrangements, supported by aligned regulatory incentives, can result in bidirectional exchange and more complete and reliable “community dashboards” to inform local and national responses. CMS, CDC, and the Office of the National Coordinator for Health Information Technology (ONC) have multiple cross-agency efforts focused on improving data standards and exchange underway, with uniform standards for electronic case reports and a growing range of health care and community organizations participating in the Trusted Exchange Framework Common Agreement (TEFCA) for secure, governed local and regional sharing of key health-related data (ONC, n.d.). Adoption of national standards for the health information technology infrastructure used to address public health threats can strengthen existing processes for engaging health care, community, and public health stakeholders, through more timely and accurate shared information to inform responses. The resulting capabilities would reduce reporting burdens on stretched health care providers as well as provide an ongoing information base to inform public-private responses to existing public health threats and a warm foundation for timely and accurate data sharing in PHEs.

**Leverage health care payment and delivery reforms to increase health care capabilities to improve population health.**

With unprecedented biomedical capabilities to prevent, detect, and manage disease threats through better diagnostic tests, treatments, and vaccines, health care organizations can do more than ever to help address these threats. CMS’s strategy to make coordinated, longitudinal “whole person” care widely available to Medicare and Medicaid beneficiaries provides a pathway to help health care organizations strengthen their abilities to improve the health of the population they serve, especially those at higher risk of health threats, in collaboration with public health and community organizations. In particular, CMS can expand payment flexibilities and performance measures tied to improved access to preventive care, diagnostics, and treatment for important public health risks, including serious respiratory infections and OUD, to make it easier for stretched health care organizations, their community, and public health partners to support and sustain delivery system reforms that support prevention, harm reduction, and health promotion.

**Strengthen effective and accountable community health collaborations across public health, health systems, social services, and community organizations.**

A wide range of federal programs and requirements help support local community efforts to plan for and address public health threats. Federal public health, social service, and health care programs can take further action to align supports for such programs as community care hubs, community health needs assessments, public-private coordination in preparedness and response planning, modernized information sharing, and technical guidance and information on best practices for these collaborations to address public health threats, such as high-burden respiratory conditions and OUD (McClellan et al., n.d.; ONC, n.d.; CDC, 2022). These steps should be linked to explicit measures of local community public health burdens, including measures related to respiratory infection and OUD, as described above. This would enhance public and private capacity to work together on specific actions to achieve measurable improvements in health risks in their community.

**Help trusted health care and community organizations provide timely and accurate information that individuals, families, businesses, and community organizations can use to make decisions about their health.**

Diverse population groups within a community rely on different trusted sources of information to guide their own decisions that affect their health and the health of those around them. Helping all population groups get the information they need about health risks and how they choose to address these risks (or not) requires an inclusive approach to
public health communications. While different communicators are relevant to different groups, clinicians remain widely trusted by their patients, and many Americans look to business and community leaders for insights about how to respond to health risks as well (SteelFisher et al., 2023). As such, states and other entities are implementing strategies to help inform and empower these public health communicators (CTHS, n.d.). In collaboration with public and private partners, CDC can support these efforts by identifying best practices and by providing timely information updates targeted to these communicators.

**Collaborative Action to Reduce the Burden of Respiratory Infections for Families and Communities**

Respiratory infections in the fall and winter of 2023–24 have led to substantial work and school disruptions, hospitalizations, and deaths from major respiratory infection threats, including seasonal flu, RSV, and new COVID-19 variants (CDC, 2024b). At the same time, there are now better tools than ever to address these threats. Better diagnostic tests, treatments, and vaccines can help those who use them avoid complications and reduce the likelihood of infections spreading in their families, coworkers, and communities. New CDC and public health analytic capabilities have the potential to lead to more timely and localized information on the spread and risk of respiratory infections to inform the decisions that people make.

However, uptake of some of these new biomedical tools has been limited, and timely and complete electronic data on cases and community burdens in times of stress are not consistently available. As the authors look ahead to the next fall and winter, their proposed action steps can accelerate and strengthen the ability of state and local public health, health care, and community organizations to protect Americans and avoid stresses on health care organizations, schools, and workplaces.

**Short-Term Action Steps**

Provide nonburdensome, timely ways for health care organizations, state immunization registries, and other non-health care–based data sources to contribute electronic health data and other timely information toward more accurate forecasts of respiratory infection case surges and health system burden for local communities. This should include health care and public health responders, and use routinely collected health data on positive tests, emergency department (ED) visits, urgent care visits, hospitalizations, and rates of use of important treatments and vaccines.

- Provide a clear pathway for easing and accelerating the adoption of national electronic data standards, building on existing collaborations across CMS, CDC, and ONC, including aligned financial incentives for standard electronic case reports and a path toward the adoption of the Fast Healthcare Interoperability Resources (FHIR) standard, for health care and public health organizations to share key non-identifiable data for local situational awareness—supported by a public engagement and comment process for CMS and ONC to advance health data sharing, and financial incentives and guidance in CDC supports for state and local public health data infrastructure to align with these standards.
- Leverage these same electronic health data standards and capabilities through existing CDC and ASPR support for disease detection and tracking programs, like the National Syndromic Surveillance Program, to improve local information on new outbreaks, including the use of add-on genomic testing and integration of innovative data sources, such as wastewater surveillance (CDC, 2024c).
- Provide support through CDC forecasting and outbreak analysis resources to use these improving data to develop “heat maps” and forecasts provided to both the community and public health authorities on key respiratory infection metrics, including vaccination and treatment uptake, new cases and treatment use via laboratory reports, and ED visits and hospital admissions by local area and demographic groups (age groups, gender, race/ethnicity) based on aggregated deidentified data from hospitals, laboratories, and clinics.
- Develop aligned guidance and a pathway supported by CMS and CDC incentives and ONC standards and requirements toward the adoption of standard data use agreements and TEFCA for timely sharing of patient data for clear public health objectives to reduce respiratory infection threats, e.g., to help distribute patients and treatments to available beds in times of health system stress, and to facilitate follow up on high-risk cases (ONC, n.d.).
- Identify best practices and improve methods for timely and efficient use of increasingly reliable and consistent data on respiratory infection burden and care, both to inform the public and to enable better public-private response planning at the local and regional level.

Expand promising care models for primary care and other community providers to help their at-risk patients access and use preventive treatments supported by Medicare...
and Medicaid payment reforms—with Medicaid reforms particularly important for at-risk families and children (e.g., RSV-related reforms).

- Implement a clear pathway and timeline for the further development and adoption of Medicare and Medicaid performance measures and accountable care reforms for awareness and access for high-risk groups of respiratory immunizations (e.g., flu vaccines, RSV vaccines, +/- COVID boosters for older patients; RSV for pregnant women; and monoclonal antibodies for RSV protection in newborns), with voluntary pilot programs in the near term to guide national implementation.

- Provide incentives and support through CMS payments and CDC technical assistance for health care and public health organizations to expand successful “test-to-treat” models for high-risk patients who develop such respiratory infections, through quality improvement supports that build on better data exchange, and through standard performance measures supported by CMS, state Medicaid programs, CDC, and other agencies.

- Develop CMS guidance and incentives for Medicare Advantage plans and templates for state Medicaid plans (e.g., model state plan amendments) to adopt alternative coverage and payment arrangements for new respiratory vaccines and treatments that are intended for use on a broad population basis, for example through “subscription” models (as have been adopted by some states for hepatitis C curative therapies) linked to the steps described above to support greater screening and treatment capacity in primary care.

Provide more aligned federal guidance and financial support for community collaborations involving state and local governments, businesses, health care, and community organizations, linked to measurable steps for reducing the risk and managing the threat of respiratory infections (likely helping to address other health threats).

- Support expansion of successful local models of health care-public health collaboration to address social barriers to preventing respiratory complications for those at high risk through supports for community health collaborations (e.g., through the Administration for Community Living) and supports through Medicare payment reforms and CMS Medicaid guidance to states for health care screening and referral to address key social needs (Medicaid.gov, n.d.; CMS, 2023; ACL, 2022; Chappel et al., 2022).

- Identify best practices for effective public-private local collaboration for effective information sharing and local governance for addressing infectious disease surges and support their adoption through further alignment across CDC, ASPR, and CMS programs and requirements—better awareness and capacity for managing respiratory infection surges is a “warm base” for sharing data and coordinating action in the event of a PHE.

- Identify best practices to encourage and support local collaboration on community health needs assessments that set shared measurable goals and action steps for reducing the burden of respiratory infections, particularly in high-risk populations, building on the initiatives described herein.

- Aligned with collaborations above, establish more routing tests to treat partnerships that reduce reimbursement lag time for key vaccines and treatments and improve vaccine assessment programs.

Extend CDC collaborations to develop and share timely information on public health risks to support national and local networks that aim to provide accurate information and answers to key questions that individuals may have about respiratory infections to inform their decisions related to their own health risks and the potential for spread in their community.

- Support efforts to develop timely, accurate, and actionable information sharing with trusted sources, including clinicians, business and community organizations, and local news, in conveying accurate messages around respiratory infection risks and how to address them that are effective in reaching different populations (e.g., through sharing research insights, aligning on effective ways to convey uncertainty, and coordinating to assure that support is available to reach distinct populations in each community).

- Track key measures of whether different segments of the population have accurate information to inform their decisions related to respiratory infection risk and protective actions, and increase evaluations (local and national) to identify more effective approaches.

These approaches can be extended to opportunities to prevent and mitigate other infectious and chronic diseases in the future, as well as preparedness and response capabilities for PHEs.

Collaborative Action to Reduce Overdose Deaths and the Burden of OUD

Over the past two decades, Americans have faced major, evolving public health threats related to the OUD epidemic and rising rates of other substance use disorders (SUDs),
with persistently high deaths from overdoses. Many diverse efforts are underway across the nation to address these challenges, including new models for preventing addiction while managing pain, initiatives aiming to increase the availability of overdose treatments like naloxone, and innovative community- and telehealth-based treatment models involving medication-assisted therapy (MAT). These efforts are supported by new resources from the federal government as well as recent opioid-related legal settlements. Coordinated federal action can enable coordinated, effective approaches across health care organizations, community-based public health programs, and other local programs to expand, accelerating national progress on reducing deaths and burdens from OUD, with opportunities to leverage this progress to reduce other SUD threats.

The National Academy of Medicine’s Action Collaborative on Combating the U.S. Opioid Epidemic has produced a set of leading reports and recommendations on combating the opioid crisis based on a comprehensive framework for addressing the crisis that includes mechanisms for effective pain management and OUD prevention; approaches to reduce OUD-related stigma; telehealth-based and other models for improving access to OUD/SUD care with MAT; tools to close gaps in health professional capabilities to effectively manage OUD; and other public and private strategies to sustain an effective OUD/SUD prevention and care infrastructure (NAM, n.d.). This initiative reflects guidance from the NAM Action Collaborative to identify short-term action recommendations for stronger health care-public health partnerships to combat OUD overdose deaths and complications.

**Short-Term Action Steps**

These steps build on the NAM OUD Collaborative’s framework and ongoing activities by CMS, CDC, Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA), and other agencies to improve access to effective OUD prevention and treatment, to enable both short-term progress toward comprehensive, coordinated capabilities for reducing the burden of OUD across the country. These efforts can also produce practical guidance and incentives for state and local government use of opioid settlement funds in a manner that maximizes their impact (Johns Hopkins, n.d.).

Advance standards to connect and strengthen public health and health care data to provide timely and actionable information for understanding overdose risk within communities and target best practices to address overdose risk.

- Build on collaboration between CMS, CDC, and ONC to provide aligned financial incentives and aligned regulatory requirements to implement standard electronic case reporting and FHIR standards for health care and public health organizations to share key data related to OUD and other overdose trends.
- Encourage adoption through CDC-supported analytic tools to support community-based heat maps based on more timely and reliable aggregated data to track overdose hospitalizations and deaths, naloxone use, and other key indicators of OUD/SUD burden across neighborhoods and demographic groups. This should include exploring linkages to alternative data sources (e.g., school attendance, homelessness, and EMS responses to non-fatal overdoses) that could further inform heat maps and move them further upstream from acute periods of community response efforts.
- Expand community OUD management support through SAMHSA, CDC, and other funds to help communities use these aggregated data and other innovative data sources to improve signal detection for identifying and understanding OUD trends, and provide a feasible path for implementing key metrics for tracking and addressing OUD within and across geographic areas.
- Implement standard measures of availability and access to evidence-based, effective longitudinal OUD treatment by region, using data from the initiatives described below.

Improve evidence-based resources related to key “use cases” for OUD burden reduction that could be accelerated through the collaborative action of public health, health care, and private sector organizations—including preventive measures, harm reduction, and longitudinal treatment to prevent recurrence.

- Potential areas for development identified by the NAM OUD Collaborative and others: effective screening and action to address key social drivers of OUD and complications; effective pain management strategies; emergency management, including initiation of MAT therapy and primary care referral; coordination with departments of corrections for initiating MAT before release, with referral to community-based providers for ongoing maintenance; effective longitudinal OUD care models that can be integrated into primary care settings, with use of MAT, telehealth, and supports for primary care providers and community clinics; availability and use of naloxone; and syringe service programs integrated with access to primary care and treatment programs for related harms (e.g., HIV, HCV) (Waller et al., 2021).
Propose tools and incentives for states to adopt effective payment reforms in Medicaid, HRSA, and SAMHSA programs to increase the use of evidence-based care models for effective pain management (including pharmaceutical and non-pharmaceutical interventions, incorporating opioid prescribing guidelines), sustainable community-based longitudinal OUD management in outpatient or primary care and community settings, increased access to naloxone availability and use in communities, and effective social risk factor screening for those at high risk of OUD complications, to reduce the risk of overdose.

- Support further steps through CMS to advance the use of standard Medicaid performance measures, care models, aligned payments for MAT access, and incentives for hospitals and clinics to distribute naloxone—with collaborations to extend to employer insurance coverage.
- Advance the implementation of alternative payment models to support health care delivery reforms that reduce the risk of OUD and OUD complications—in Medicaid through CMS guidance on model state plan amendments and Medicaid waivers, and in Medicare through a path to incorporate accountability for screening for and addressing OUD and reducing risk factors for OUD (e.g., adoption of evidence-based care managing lower back pain).
- Expand innovative Medicaid payment reforms targeted to at-risk women and children by building on insights from the CMMI Maternal Opioid Misuse model.
- Identify incentives and activities that can support the coordinated use of federal grant funds (e.g., SAMHSA funding) and state and local opioid settlement funds to support better prevention and care models and longitudinal primary care for uninsured individuals with OUD.

Provide aligned guidance and support for community collaborations involving state and local governments, businesses, health care, and community organizations to help reduce the rate of OUD and overdoses in the community, building on promising local examples and relevant federal supports.

- Identify promising examples and accelerate the adoption of community health needs assessments that include explicit measures of OUD risk and action steps to reduce risk, in conjunction with the use of federal OUD-related funding from SAMHSA, CDC, HRSA, and other public health agencies, and new opioid settlement funds to drive adoption of sustainable reforms in OUD.
- Encourage the inclusion of screening for OUD risk factors and improving access to effective OUD prevention and treatment in existing community health collaborations and public-private community planning to address local health risks by identifying successful models and supports for sustaining them.
- Identify best practices for community partnerships to use federal supports and local resources to address pharmacy shortages, office or clinic closures, rural hospital closures, and other potential disruptions.
- Identify and support networks for developing and sharing accurate evidence-based information that clinicians, businesses, and community leaders can inform communities about resources and supports to reduce OUD risks to enable more informed decisions to reduce those risks.
- Create a set of resources supported by federal public health agencies that enables more accurate and effective public and personal messaging around OUD and individual or community risks.

**Time for Action**

We have focused on two public health challenges—viral respiratory infections and OUD—that have ongoing, serious consequences for the nation’s health, health equity, and stresses on health care systems. In both cases, there are unprecedented opportunities to bring together health care capabilities, social and community resources, and public health supports to better understand and address these threats. Similarly, there is unprecedented interest in ways in which health care and public health organizations can use new technologies and innovative collaborations to take action (Common Health Coalition, n.d.). The specific action steps identified here reflect themes that are more widely applicable to strengthening public health and health care—improving electronic data sharing to inform and support community action; leveraging CMS, state, and employer actions to implement value-based, longitudinal care models; expanding successful local collaborations that engage and support community organizations and social service programs; and helping trusted health care and community organizations provide timely and accurate information to help individuals and families reduce their risk. They build on steps already underway in the public and private sectors. It’s time for action.

**References**


6. CDC. 2024b. 2023–2024 Respiratory virus season is likely past peak but far from over. Available at: https://www.cdc.gov/publichealthgateway/cha/plan.html.


14. CTHS (Coalition for Trust in Health & Science). n.d. Coalition for Trust in Health & Science celebrates first anniversary. Available at: https://trustinhealthandscience.org/?adobe_mc=MCMID%3D485840665548866529292251226689914413%7CMCORID%3D242647254119970A4C98A6%2540AdobeOrg%7CTS%3D1700430731.


19. Johns Hopkins. n.d. The principles to guide jurisdiction in the use of opioid litigation funds, we encourage the adoption of five guiding principles. Available at: https://opioidprinciples.jhsph.edu/the-principles/.


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