

HEALTHY RHODE ISLANDERS 2010

Evidence-Based Strategies and Best Practices for Leading Health Indicators

Rhode Island Department of Health
Center for Health Information and Communication

May 2004



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Acknowledgement: This report was developed by Policy Studies Inc. (www.Policy-Studies.com) with research assistance from Peter Quon.

INTRODUCTION

Healthy People 2010 is a nationwide health promotion and disease prevention agenda for improving the health of all people in the United States during the first decade of the 21st century. Healthy People 2010 builds on similar initiatives from the last two decades, the most recent being Healthy People 2000, which identified health improvement goals to be reached by the year 2000.

Healthy People 2010 represents ideas and expertise from a diverse group of individuals and organizations concerned about the Nation's health. These groups include:

- Over 350 National organizations;
- Over 250 State public health, mental health, substance abuse, and environmental agencies; and
- Members of the general public from every State, the District of Columbia, and Puerto Rico.

GOALS AND OBJECTIVES OF HEALTHY PEOPLE 2010

The Healthy People 2010 agenda has two overarching goals:

- Increase quality and years of healthy life; and
- Eliminate health disparities.

These two goals are supported by specific objectives in 28 focus areas. Each objective was developed with a target to be achieved by the year 2010. The Healthy People 2010 team adopted ten Leading Health Indicators (LHIs) as a way to measure progress towards objectives. For each of the following LHIs, specific objectives derived from Healthy People 2010 will be used to track progress and provide a snapshot of the nation's health:

- Physical Activity
- Overweight and Obesity
- Tobacco Use
- Substance Abuse
- Responsible Sexual Behavior
- Mental Health
- Injury and Violence
- Environmental Quality
- Immunization
- Access to Health Care

The development of strategies and action plans to address one or more of these indicators can profoundly increase the quality of life and the years of healthy life of people nationwide, and can help eliminate health disparities.

HEALTHY PEOPLE 2010 IN RHODE ISLAND

Rhode Island, like many other states, has adopted the Healthy People 2010 agenda using the ten Leading Health Indicators and corresponding objectives as a roadmap toward a healthier Rhode Island by 2010.

The Rhode Island Department of Health (HEALTH) embarked on the development of its Healthy Rhode Islanders 2010 (HRI 2010) plan by:

1. Conducting a progress review of Healthy Rhode Island 2000 efforts;
2. Adopting the Healthy People 2010 ten Leading Health Indicators and a subset of 27 objectives;
3. Identifying state-level data sources, establishing baselines, and setting targets for each of the 27 objectives;
4. Charting baseline data by race and ethnicity, gender, household income, education level, geographic location, age group, and disability status; and
5. Documenting evidence-based strategies and best practices addressing each Leading Health Indicator and objective.

A note on objectives: As part of the HRI 2010 agenda, HEALTH is tracking the state's progress on 27 objectives associated with the ten Leading Health Indicators. The national agenda is tracking a larger set of objectives. For more information on objectives on the national agenda, visit the Healthy People 2010 website at www.healthypeople.gov/.

HEALTH developed a series of public reports addressing each of these topic areas. See Table 1 for a full list of HRI 2010 reports available from HEALTH.

Table 1. HRI 2010 Reports Available from HEALTH*

Report Title	Content
<i>Healthy Rhode Islanders 2000 Progress Review</i>	Review of progress towards state-level objectives for 2000
<i>Healthy Rhode Islanders 2010: Draft Objectives and Targets</i>	State-level data sources, baselines, and targets for each of 27 objectives
<i>Healthy Rhode Islanders 2010: Leading Health Indicators by Race and Ethnicity –</i>	Baseline data for the state by Race and Ethnicity
<i>Healthy Rhode Islanders 2010: A Baseline</i>	Baseline data for the state by

<i>Report. Leading Health Indicators by Gender, Household Income, Education Level, Geographic Location, Age Group, and Disability Status</i>	Gender, Household Income, Education Level, Geographic Location, Age Group, and Disability Status
<i>Evidence-Based Strategies and Best Practices for Leading Health Indicators</i>	National Best Practices addressing each Leading Health Indicator

***All HRI 2010 reports are available at:**
www.health.ri.gov/chic/healthypeople/home.htm.

ABOUT THIS REPORT

HEALTH is continuing with the next step in the Healthy Rhode Islanders 2010 process by presenting this report on evidence-based strategies and best practices related to the 27 objectives under each Leading Health Indicator (LHI). This report contains information on local, state and national programs, initiatives and campaigns that have proven successful in meeting one or more Healthy People 2010 objective(s).

This report is part of a series of reports, described above. Ultimately, HEALTH will develop a single document summarizing baseline data, health disparities, and best practices for intervention. Taken together, the HRI 2010 reports are intended to guide programming decisions, fundraising, advocacy, policy-making, and a range of other activities that impact the health of Rhode Island residents. The information made available through HRI 2010 efforts will equip our state to meet HRI 2010 goals.

HOW THIS REPORT IS ORGANIZED

The recommended interventions under each Leading Health Indicator (LHI) are organized differently, depending on the number of sources used to gather recommended strategies for that LHI, the number of sub-topics that are covered under each LHI, and how the source(s) rate the recommendations (strongly recommended, etc.). The major headings and subheadings are organized in this order:

1. If an LHI has sub-topics, the sub-topics are presented as the first major heading;

2. Under each sub-topic, the sources are the next set of major headings. If a topic does not have sub-topics, the sources are the first major heading for that LHI.
3. Some sources that were used to write this report present the interventions with recommendation ratings: “strongly recommended,” “recommend,” and “insufficient evidence to recommend.” If these ratings were used to categorize the intervention strategies presented here, the strategies are organized by those ratings.
4. Because the issue of workplace interventions crosses a number of different indicators, recommendations for employers can be found at the end of each corresponding LHI.

MODEL INTERVENTIONS: EVALUATING THE STANDARDS

This report details **evidence-based strategies** and **best practices** related to the specific objectives under each Leading Health Indicator (LHI). Although the terms “evidence-based strategies” and “best practices” are often used interchangeably, they are applied using a wide variety of criteria, depending on the person or organization making the determination. As a result, it is important to understand the level of scrutiny given to each suggested policy, approach, and program in order to compare the value of potential interventions.

Two of the sources cited as examples of evidence-based strategies, *The Community Guide to Preventive Services (The Community Guide)* and the Substance Abuse and Mental Health Services Administration’s (SAMHSA): *Science-Based Prevention Programs and Principles* use detailed evaluation procedures to identify successful interventions. These two comprehensive approaches, however, differ in the type of evidence they evaluate. *The Community Guide* looks at published, quantitative literature while the SAMSHA guide uses meta-analysis, and includes the “full range of primary research, including published and unpublished, experimental and quasi-experimental studies of programs that succeeded and programs that failed.”¹

In contrast, the term “best practices” does not necessarily indicate a rigorous evaluation of the available evidence. For example, while one of the documents cited under the Tobacco Use LHI (the CDC’s “Best Practices for Comprehensive Tobacco Control Programs”) conducted an in-depth, scientific analysis of state interventions, many other publications use the term much more loosely. While one document’s “best practice” may be a rigorously evaluated program, such as

those listed in the tobacco guide, another source may list a series of projects with self-reported results. For example, a number of obesity publications recommend strategies to decrease the amount of time children spend watching television and playing video games, but *The Community Guide*'s evaluation found that while programs that use these strategies met their initial objectives of reduced TV/game use, they did not result in increased physical activity.² Consequently, when comparing different interventions, it is important to understand the level of scrutiny with which they were evaluated in order to judge the weight of evidence recommending each one.

Conversely, there is a danger in relying solely on interventions that have passed the most stringent tests in order to become an “evidence-based strategy” or “best practice.” For example, as *The Community Guide* points out, the determination that an approach demonstrates “Insufficient Evidence to Determine Effectiveness,” does not mean that the strategy would never work. It means that the available research has not yet met the necessary criteria for the strategy to be considered “evidence-based.” Because many grassroots projects do not evaluate and/or publish their results, an effective strategy can be overlooked because it has not made its way into the literature or because it has not been studied extensively.

Finally, even after choosing a rigorously evaluated “evidence-based practice,” implementation challenges remain. The SAMHSA guide cautions that:

“...Increasing the number of principles used in a program does not necessarily increase its effectiveness. It is important to select scientifically defensible principles that best meet the needs of program participants, support program objectives, and complement one another... Combining a series of substance abuse prevention principles does not necessarily make for an effective prevention program. Principles are best used to modify and enhance existing prevention programs and efforts, rather than create new programs from scratch.”³

The first part of this report provides a summary of the suggested interventions for each of the 10 LHIs. The next section has detailed descriptions of each recommendation, excerpted from the original document in order to preserve the context in which the recommendation was made.

INTERVENTIONS: HIGHLIGHTS

The following is a summary of interventions for the 10 LHIs and 27 objectives, described in more detail throughout the rest of the document.

LHI 1: PHYSICAL ACTIVITY

Objective 1-1: Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes a day.

Objective 1-2: Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion.

Interventions at a Glance:

1. Community-wide campaigns to promote physical activity
2. School-based physical education
3. Non-family social support
4. Individually adapted health behavior change
5. Creation and/or enhanced access to places for physical activity combined with informational outreach activities
6. Point of decision prompts (encouraging use of stairs)
7. Worksite efforts such as company fitness challenges

Physical Activity Intervention Summary

Recommended interventions to meet the Physical Activity objectives fall into three categories: 1) Community-wide approaches; 2) School-based programs; and 3) Programs directed at individuals.

Community-wide approaches involve wide-spread public education and media campaigns, increased opportunities for risk factor screening and counseling, promotion of opportunities for individuals to join physical activity groups, and community and political organization to change environmental barriers that limit physical activity. School-based programs focus on increasing the intensity level of activity performed by students during physical education class time by changing the curriculum to include more vigorous games and exercises. Individually based programs develop networks that bring together people who are interested in increasing their levels of physical activity, and they teach participants to monitor and change their personal behavior related to exercise and activity.

LHI 2: OVERWEIGHT AND OBESITY

Objective 2-1: Reduce the proportion of adults who are obese.

Objective 2-2: Reduce the proportion of children and adolescents who are overweight or obese.

Objective 2-3: Increase the proportion of persons aged 2 years and older who consume at least five daily servings of fruit and vegetables.

Interventions at a Glance:

1. Promote increases in physical activity
2. Promote breastfeeding
3. Increase fruit and vegetable consumption
4. Reduce television viewing time
5. Worksite efforts such as providing healthy snacks in vending machines

Overweight and Obesity Intervention Summary

Recommended interventions to meet the Overweight and Obesity objectives focus on four key issues: 1) Physical Activity; 2) Breast Feeding; 3) Fruit and Vegetable Consumption; and 4) Television Viewing Time. In order to affect changes across these four categories, recommendations include focusing on working at the community, school, health plan, state health department, worksite, and state public policy levels to improve physical activity and encourage good eating choices.

LHI 3: TOBACCO USE

Objective 3-1: Reduce cigarette smoking by adults.

Objective 3-2: Reduce cigarette smoking by adolescents.

Interventions at a Glance:

1. Smoking bans and restrictions
2. Increasing the unit price of tobacco products
3. Mass media education (campaigns) combined with other interventions
4. Provider reminder + provider education
5. Reducing out-of-pocket costs for effective treatment
6. Patient telephone support (quit lines)
7. Community programs to reduce tobacco use (including involving youth coalitions, promoting smoke free policies, and coverage of treatment)
8. Chronic disease programs to reduce the burden of tobacco-related diseases (such as cardiovascular disease and asthma prevention, oral health programs and cancer registries)
9. School programs (including tobacco-free policies, anti-tobacco curricula, parent and teacher involvement, and linking school-based efforts to community wide programs)
10. Enforcement of smoking bans in public places and laws prohibiting the sale of tobacco to minors
11. Statewide programs (such as statewide media campaigns, media advocacy, grants to local entities)
12. Counter-marketing
13. Cessation programs
14. Surveillance and evaluation
15. Administration and management requirements (for an effective statewide tobacco prevention effort)
16. Worksite policies and programs

Tobacco Use Intervention Summary

Recommended interventions to meet the Tobacco Use objectives focus on efforts in four key areas: 1) Local community initiatives; 2) Health care system innovations; 3) Schools-based programs; and 4) Statewide action and policy. Community-based strategies include smoking bans, enforcement of laws regulating the sale of tobacco products to minors, and media/public relations/grassroots counter-marketing campaigns. Health care interventions include provider education, decreasing patient cost for treatment, and telephone “quit lines.” School-based programs focus on implementing anti-tobacco curricula, tobacco-free campus policies, cessation assistance, and teacher and parent involvement and training. Finally, statewide action and policy can enhance and coordinate the efforts of local coalitions, implement legal and programmatic innovations on a statewide basis, and provide comprehensive surveillance of tobacco use and its consequences.

LHI 4: SUBSTANCE ABUSE

Objective 4-1: Increase the proportion of adolescents not using alcohol or any illicit drugs during the past 30 days.

Objective 4-2: Reduce the proportion of adults using any illicit drug during the past 30 days.

Objective 4-3: Reduce binge drinking by adults in the past 30 days.

Interventions at a Glance:

1. Focus on following six domains in programs designed to decrease substance abuse:
 - A. Individual domain
 - B. Family domain
 - C. Peer domain
 - D. School domain
 - E. Community domain
 - F. Society/Environmental domain
2. Core competencies of successful programs
 - A. Content requirements
 - B. Community building
 - C. Delivery mechanisms
 - D. Context (use of multiple channels)
 - E. Duration of intervention
 - F. Relationships (between program participants and staff/volunteers)
 - G. Integration and adaptation
 - H. Strengths focus
 - I. Continuity
 - J. Facilitators (training, experience)
3. Policies to decrease negative health outcomes from alcohol use
 - A. Multi-faceted programs that discourage underage and binge drinking
 - B. Motivate and train health professionals to boost screening and counseling for alcohol problems
 - C. Adopt and enforce 0.08 blood alcohol laws
 - D. Develop Responsible Beverage Service (RBS) programs
 - E. Alert women to avoid drinking during pregnancy
 - F. Implement worksite policies that discourage alcohol misuse and offer confidential assistance with problems
 - G. Increase Federal Excise Tax on alcoholic beverages
 - H. Invest in research about alcohol use and prevention of misuse

Substance Use Intervention Summary

Recommended interventions to meet the Substance Abuse objectives center on efforts in four key areas: 1) Individually tailored strategies and programs; 2) Family-based approaches; 3) School-based approaches; and 4) Community-wide efforts. In each of these categories, strategies directed specifically at young people should focus on a comprehensive approach that goes beyond one-time activities, helps participants build social skills, involves and improves their relationship with their families, focuses on individual and family strengths instead of weaknesses, provides positive alternatives for substance use for high risk youth and their peers, and addresses community norms, policies, and laws that affect substance use.

LHI 5: RESPONSIBLE SEXUAL BEHAVIOR

Objective 5-1: Increase the proportion of adolescents who have never had sexual intercourse, have abstained from sexual intercourse in the past 3 months, or used condoms at last sexual intercourse.

Objective 5-2: Increase the proportion of unmarried, sexually active persons who use condoms.

Interventions at a Glance:

1. Implement community-based programs (youth development programs not directly related to sexual health that improve young people's life prospects)
2. Implement school-based programs (sexuality education programs)
3. Implement clinic-based programs (counseling and education; condom or contraceptive distribution; and STD/HIV screening)
4. Implement religion-based programs (needs additional research)
5. Focus on youth development
6. Involve family and other caring adults with youth
7. Involve men in teenage pregnancy prevention
8. Use culturally relevant messages for teen pregnancy prevention
9. Implement service learning programs for youth at risk for teenage pregnancy
10. Increase employment opportunities for at-risk youth for teen pregnancy prevention
11. Provide sexuality and AIDS education for teen pregnancy prevention
12. Provide outreach in teen pregnancy prevention programs
13. Provide access to reproductive health services for sexually active teens

Responsible Sexual Behavior Intervention Summary

Recommended interventions to meet the Responsible Sexual Behavior objectives focus on four key areas: 1) Effective sexual education programs; 2) Increased public awareness and discussion of the issue; 3) Community-wide programs that involve young people of both sexes and their families; and 4) Access to reproductive health services. In addition to strategies targeted specifically at responsible sexual behavior, initiatives that improve educational, employment, and leadership opportunities for young people can reduce teen pregnancy rates.

LHI 6: MENTAL HEALTH

Objective 6-1: Increase the proportion of adults aged 18 years and older with recognized depression who receive treatment.

Objective 6-2: Reduce the suicide rate.

Interventions at a Glance:

1. Continue to build the science base
2. Overcome stigma
3. Improve public awareness of effective treatment for depression and of suicide as a preventable public health issue
4. Ensure the supply of mental health services and providers
5. Ensure the delivery of state-of-the art treatments
6. Tailor treatment to age, gender, race, and culture
7. Facilitate entry into treatment
8. Reduce financial barriers to treatment
9. Enhance opportunities for professional training
10. Improve coordination among service providers
11. Improve ability of people with mental disorders to become integrated into the community
12. Increase active engagement of primary care physicians
13. Increase public investment in mental health services
14. Promote efforts to reduce access to lethal means and methods of self-harm
15. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media

Mental Health Intervention Summary

Recommended interventions to meet the Mental Health objectives focused on four key issues: 1) Reducing the stigma surrounding mental illness; 2) Reducing disparities in access to mental health services among different population groups and increasing the supply of providers in underserved areas; 3) Delivering state-of-the art treatments that focus on recovery; and 4) Creating a cultural change that equates the importance of treating mental health issues with the importance of physical health treatment.

LHI 7: INJURY AND VIOLENCE

Objective 7-1: Reduce deaths caused by motor vehicle crashes.

Objective 7-2: Reduce homicides.

Interventions at a Glance:***Motor Vehicle Injuries***

1. Increase the proper use of child safety seats
 - A. Implement child safety seat use laws
 - B. Distribution and education programs
 - C. Community wide information and enhanced enforcement campaigns
 - D. Incentive and education programs
2. Increase the use of safety belts
 - A. Implement safety belt use laws
 - B. Pass primary enforcement laws
 - C. Develop enhanced enforcement programs
3. Reduce alcohol impaired driving
 - A. Use sobriety checkpoints
 - B. Implement 0.08% blood alcohol concentration laws (BAC)
 - C. Minimum legal drinking age laws
 - D. Lower BAC laws for young or inexperienced drivers
 - E. Server intervention programs

Youth Violence Prevention Strategies

1. Parent and family-based
2. Home visitation
3. Social cognitive
4. Mentoring

Community Crime Prevention Strategies

1. Gang violence prevention (focusing on decreasing gang cohesion)
2. Family therapy for delinquent and pre-delinquent youth
3. School-based crime prevention (programs to communicate norms of behavior and efforts to help students improve social competency skills)
4. Substance abuse prevention programs
5. Short term vocational programs for older male ex-offenders

6. Intensive, residential training programs for at-risk youth
7. Prison-based vocational education programs for adults
8. Housing dispersion programs
9. Enterprise Zones (to improve employment prospects for people in low-income areas)
10. Increased directed patrols in street-corner hotspots of crime
11. Proactive arrests of serious repeat offenders
12. Proactive drunk driving arrests
13. Arrests of employed suspects for domestic assault
14. Police traffic enforcement patrols against illegally carried handguns
15. Community policing with community participation in priority setting
16. Community policing focused on improving police legitimacy
17. Zero tolerance of disorder, if legitimacy issues can be addressed
18. Problem-oriented policing
19. Addition of extra police to cities, regardless of assignments
20. Warrants for arrest of suspect absent when police respond to domestic violence

Injury and Violence Intervention Summary

Recommended interventions to meet the Injury and Violence objectives focus on five key areas: 1) Legal and educational measures to encourage use of child safety seats and safety belts and to decrease the incidence of alcohol impaired driving; 2) Individually-based approaches to youth crime prevention that build social cognitive skills and include strategies such as mentoring; 3) Family-based crime prevention, including home visitation; 4) School-based crime prevention that helps students improve social skills and develop community norms of positive behavior; and 5) Law enforcement strategies that focus police resources on proven techniques of decreasing crime.

LHI 8: ENVIRONMENTAL QUALITY

Objective 8-1: Reduce the proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health-based standards for ozone.

Objective 8-2: Reduce the proportion of nonsmokers exposed to environmental tobacco smoke.

Objective 8-3: Eliminate elevated blood lead levels in children.

Objective 8-4: Increase the proportion of persons served by community water systems who receive a supply of drinking water that meets the regulations of the Safe Drinking Water Act.

Objective 8-5: Increase the proportion of persons who live in homes tested for Radon concentrations.

Objective 8-6a: Reduce infections caused by key foodborne pathogens: *Campylobacter* species.

Objective 8-6b: Reduce infections caused by key foodborne pathogens: *Salmonella* species.

Interventions at a Glance:***Air Quality (indoor and outdoor)***

1. Source reduction
 - A. Cleaner electric generation at utilities
 - B. Cleaner electric generation sources
 - C. Increased energy efficiency for commercial and residential customers
 - D. Transportation-based programs to reduce emissions
 - E. Industrial-based programs to reduce emissions
2. Public education about air quality levels
3. Public education (including employers) about the health effects of environmental tobacco smoke and the need for restrictions
4. Telephone hotlines for reporting violations of clean indoor air ordinances and laws and investigating reports received
5. Public and private policies that reduce or eliminate exposure to environmental tobacco smoke
6. Public outreach and education to promote increased radon testing and mitigation of existing housing and during residential real estate transactions

Lead Exposure

1. Pediatricians should provide anticipatory guidance and screen children at risk
2. Third party payer and managed care organizations should cover lead screening and follow-up
3. Government should pursue environmental investigation, transitional lead-safe housing assistance, and follow-up for individual cases
4. Research effectiveness of strategies to prevent and treat lead poisoning
5. Implement prevention strategies through code enforcement

Water Quality

1. Delineate protection areas for all public drinking water sources
2. Create an inventory of existing and potential sources of contamination
3. Communicate the results of the inventory to the general public
4. Prepare and implement a source protection plan

Food Safety

1. Improve the management and effectiveness of regulatory programs
2. Improve the coordination of food safety activities with other public health agencies
3. Protect meat, poultry and egg products against intentional contamination

Environmental Quality Intervention Summary

Recommended interventions to meet the Environmental Quality objectives focus on six distinct areas: Ozone levels in outdoor air, reductions in lead exposure, decreased exposure to environmental tobacco smoke (also discussed in LHI 3), providing safe drinking water, encouraging radon testing and mitigation, and reducing foodborne diseases.

Strategies to improve **air quality** include 1) Source reduction; 2) Cleaner electric generation at utilities and other sources; 3) Increased energy efficiency; 4) Reduced emissions; and 5) Public education to help people reduce their exposure to dangerous ozone levels in outdoor air. Strategies to address the issue of **lead exposure** focus on two key areas: 1) Improved screening and follow up by health care providers and health insurance systems, and 2) Governmental efforts to use code enforcement and other legal avenues to require abatement of lead in housing units.

Safe drinking water interventions involve state development of a Source Water Assessment Program, described by the 1996 amendments to the federal Safe Drinking Water Act. The EPA's suggested **radon strategy** includes adoption of a "risk trading" method that encourages states to develop a Multimedia Mitigation (MMM) program. The MMM approach focuses on "trading" higher allowable concentrations of radon in public drinking water systems for more intensive efforts in statewide radon testing and mitigation of existing buildings and encouragement of radon-resistant construction techniques.

Interventions to reduce the incidence of **foodborne diseases** include improving regulatory program effectiveness, coordinating food safety with federal, state, and public health entities, and improving public education efforts.

LHI 9: IMMUNIZATION

Objective 9-1: Increase the proportion of young children who receive all vaccines that have been recommended for universal administration for at least 5 years.

Objective 9-2: Increase the proportion of adults aged 65 and older who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease.

Interventions at a Glance:

1. Client reminder/recall systems
2. Multi-component interventions (media and educational campaigns conducted in conjunction with providers)
3. Multi-component intervention for expanding access (increasing availability and frequency of opportunities for people to access vaccinations)
4. Reducing out-of-pocket costs
5. Requirements for child care or school attendance
6. Home visits (by providers to people in populations with low vaccine coverage)
7. Provider reminder/recall systems
8. Assessment and feedback for providers (of their practice's vaccination rate)
9. Standing orders for adults (allowing non-physician medical personnel to prescribe or deliver vaccinations to clients without direct physician involvement in provider's office)
10. Immunization registries

Immunization Intervention Summary

Recommended interventions to meet the Immunization objectives focus on three key areas: 1) Improve providers' and health care systems' ability to record, track, and promote appropriate vaccinations; 2) Educate the public about the importance of vaccinations; and 3) Improve access to vaccines for people at risk of not being immunized.

LHI 10: ACCESS TO HEALTH CARE

Objective 10-1: Increase the proportion of persons with health insurance.

Objective 10-2: Increase the proportion of persons who have a specific source of ongoing care.

Objective 10-3: Increase the proportion of pregnant women who receive early and adequate prenatal care.

Interventions at a Glance:***Health Insurance***

1. Help different groups of uninsured find coverage
2. Enhance employer-based coverage
3. Expand existing state programs through creative approaches
4. Improve quality of care as a way to improve access

Access to Care

1. Strengthening the safety net (increasing number of providers who can care for the uninsured)
2. Expanding the systems of care to additional needy areas
3. Improving and expanding the work force and its diversity
4. Increasing excellence in medical practice

Prenatal Care

1. Streamlined application process for public insurance coverage
2. Reimbursement policies (to encourage provider participation)
3. Toll free hotlines (to enroll pregnant women in prenatal care)
4. Outreach campaigns (to encourage women to participate in public insurance prenatal care program)
5. Free pregnancy testing
6. Extending coverage to undocumented foreign-born women
7. Raising income eligibility from 110% to 185% of poverty
8. 'Outstationing' eligibility workers at prenatal clinics
9. Increasing reimbursement to providers
10. Increasing income eligibility to 200% of poverty
11. Eliminating assets test for women with incomes 185-200% of poverty

12. Presumptive eligibility (automatic enrollment in program, followed by verification of eligibility at a later date)
13. Shortened application form for public insurance program
14. Eliminating assets test for women under 200% of poverty level

Access to Health Care Intervention Summary

Recommended interventions to meet the Access to Health Care objectives focus on four key areas: 1) Improve coverage of the uninsured by expanding public programs; 2) Develop policies to encourage more people to use employer-based insurance; 3) Improve access to care by increasing the number of providers available in underserved areas, and 4) Loosen income and other eligibility requirements that limit access to prenatal care.

**INTERVENTIONS
BY
LEADING HEALTH INDICATORS**

PHYSICAL ACTIVITY

Objective 1-1: Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes a day.

Objective 1-2: Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion.

SUMMARY

Recommended interventions to meet the Physical Activity objectives fall into three categories: 1) Community-wide approaches; 2) School-based programs; and 3) Programs directed at individuals. Community-wide approaches involve wide-spread public education and media campaigns, increased opportunities for risk factor screening and counseling, promotion of opportunities for individuals to join physical activity groups, and community and political organizing to change environmental barriers that limit physical activity. School-based programs focus on increasing the intensity level of activity performed by students during physical education class time by changing the curriculum to include more vigorous games and exercises. Individually-based programs develop networks that bring together people who are interested in increasing their levels of physical activity, and they teach participants to monitor and change their personal behavior related to exercise and activity.

SPECIFIC INTERVENTIONS

Strongly Recommended Strategies

The Community Guide reviewed studies related to promoting physical activity in the areas of informational, behavioral, and environmental and policy approaches.⁴ It found “Strong Evidence” to classify the following interventions as “Strongly Recommended Strategies:”

1. *Community-wide Campaigns to Promote Physical Activity*

These interventions were large-scale, intense, and highly visible community-wide campaigns with messages directed to large audiences through different

types of media, including television, radio, newspapers, movie theaters, billboards, and mailings. Community-wide campaigns were typically conducted as part of a multi-component effort that also included strategies such as support or self-help groups, physical activity counseling, risk factor screening and education, community health fairs and other community events, and environmental or policy changes such as the creation of walking trails. Interventions were evaluated as a “combined package” because the relative contributions of each individual component could not be assessed separately.

2. School-based Physical Education

To increase the amount of time students spend doing moderate or vigorous activity in PE class, these programs seek to change PE curricula by making classes longer or having students be more active during class. Interventions reviewed include changing the activities taught (e.g., substituting soccer for softball) or modifying the rules of the game so that students are more active (e.g., in softball, have the entire team run the bases together when the batter makes a base hit). Many interventions also include health education.

3. Non-family Social Support

These interventions focus on changing physical activity behavior through building, strengthening, and maintaining social networks that provide supportive relationships for behavior change (e.g., setting up a buddy system, making contracts with others to complete specified levels of physical activity, or setting up walking groups or other groups to provide friendship and support). Interventions included in the review involve either creating new social networks or working within existing networks in a social setting outside the family, such as in the workplace.

4. Individually Adapted Health Behavior Change

Individually adapted health behavior change programs teach behavioral skills to help participants incorporate physical activity into their daily routines. The programs are tailored to each individual’s specific interests, preferences, and readiness for change. These programs teach behavioral skills such as 1) goal-setting and self-monitoring of progress toward those goals, 2) building social support for new behaviors, 3) behavioral reinforcement through self-reward and positive self-talk, 4) structured problem solving to maintain the behavior change, and 5) prevention of relapse into sedentary behavior. All of the

evaluated interventions were delivered to people either in group settings or by mail, telephone, or directed media.

5. Creation and/or enhanced access to places for physical activity combined with informational outreach activities

These interventions involve the efforts of worksites, coalitions, agencies, and communities in attempts to change the local environment to create opportunities for physical activity. Such changes include creating walking trails, building exercise facilities, or providing access to existing nearby facilities. Many of these programs also train participants to use the equipment and offer health behavior education, risk factor screening, referrals to physicians or additional services, health and fitness programs, and support or buddy systems. These multi-component programs were evaluated as a “combined package” because it was not possible to separate out the effects of each individual component.

Recommended Strategies

The Community Guide categorized “*Point of Decision Prompts*” as having “Sufficient Evidence” to be considered a “Recommended Strategy.”

Point-of-decision prompts are signs placed by elevators and escalators that encourage people to use nearby stairs for health benefits or weight loss. These signs tell people about health benefits of taking the stairs and/or remind people who already want to be more active that an opportunity to do so is at hand.

Strategies with Insufficient Evidence to Determine Effectiveness

1. Classroom-based health education focused on information provision
2. Mass media campaigns
3. Health education with TV/Video game turnoff component
4. College-age physical education/health education
5. Family-based social support

Strategies in Process of Being Evaluated

1. Transportation policy and infrastructure changes to promote non-motorized transit
2. Urban planning approaches - zoning and land use

Worksite Recommendations

In *HEALTHY WORKFORCE 2010, An Essential Health Promotion, Sourcebook for Employers, Large and Small*, the Partnership for Prevention recommends the following physical activity interventions for employers:⁵

1. Sponsor company fitness challenges
2. Support lunchtime walking/running clubs or company sports team
3. Create accessible walking trails and/or bike routes
4. Provide periodic incentive programs to promote physical activity
5. Offer a health risk appraisal (HRA) to all employees and follow-up with sedentary employees
6. Contract with health plans that offer free or reduced-cost memberships to health clubs
7. Provide clean and safe stairwells and promote their use
8. Provide facilities for workers to keep bikes secure and provide worksite showers and lockers
9. Allow flexible work schedules so employees can exercise
10. Discount health insurance premiums and/or reduce copayments and deductibles in return for an employee's participation in specified health promotion or disease prevention program

OVERWEIGHT AND OBESITY

Objective 2-1: Reduce the proportion of adults who are obese.

Objective 2-2: Reduce the proportion of children and adolescents who are overweight or obese.

Objective 2-3: Increase the proportion of persons aged 2 years and older who consume at least five daily servings of fruit and vegetables.

SUMMARY

Recommended interventions to meet the Overweight and Obesity objectives focused on four key issues: 1) Physical Activity; 2) Breast Feeding; 3) Fruit and Vegetable Consumption; and 4) Television Viewing Time. In order to affect changes across these four categories, recommendations include focusing on working at the community, school, health plan, state health department, and state public policy levels to improve physical activity and encourage good eating choices.

SPECIFIC INTERVENTIONS

Recommended Objectives

In *Promising Practices in Chronic Disease Prevention and Control: a Public Health Framework for Action*, the CDC recommends focusing on the following four objectives related to obesity:⁶

1. Promote Increases in Physical Activity
2. Promote Breastfeeding (breastfed children have a reduced risk of becoming obese)
3. Increase Fruit and Vegetable Consumption
4. Reduce Television Viewing Time*

* Admitting that this issue needs more research, *Promising Practices* argued that school-based programs have “shown promise” by helping parents and children “monitor and budget” television viewing. *The Community Guide*, however, did find a link between reductions in television viewing and increased physical activity.

More specific recommendations for each of these categories include:

1. Physical Activity

(See evidence-based strategies under “Physical Activity” starting on page 16)

2. Breast Feeding

The following recommendations to promote breastfeeding come from the U.S. Department of Health and Human Services’ *Blueprint for Action on Breastfeeding*⁷:

- A. Develop social support resources for breastfeeding women
- B. Train health care professionals to promote breastfeeding among their patients
- C. Establish maternity care practices and policies that promote breastfeeding
- D. Establish workplace programs and policies that promote breastfeeding

3. Increase Fruit and Vegetable Consumption

The national model to increase fruit and vegetable consumption is the National Cancer Institute’s (NCI) “5-A-Day for Better Health” initiative. While a recent evaluation included a number of recommendations at the national level to improve the program, the suggestions could also be adapted at the state and local levels to communicate the nutritional message more effectively⁸. The recommendations include:

- A. The Media and Message Delivery: That the 5-A-Day Program seek to prevent the further growth of "dietary helplessness," to help the public differentiate between good and poor information, to provide a larger context for personal dietary decisions, and to help clarify the confusion engendered in the message environment.
- B. Message Design: That the NCI reconsider the design and emphasis of the 5-A-Day message. Specifically, media process-evaluation data suggest the need to "reinvent" the 5-A-Day message on a regular basis to prevent "wear-out" and to enhance its continuing attractiveness to the mass media. In addition, the current strategy seems less successful in reaching minorities and low-income groups, which suggests that any change in message emphasis should take these groups into consideration.

- C. Media Strategies: That the 5-A-Day Program devote additional resources to a variety of media strategies, including a systematic media relations effort to educate reporters, editors, and producers about diet and nutrition issues. As part of this approach, program planners should consider pursuing partnerships with the media to develop a long-term community emphasis on the 5-A-Day message. The 5-A-Day Program (should) rethink its channel-use strategy, with a particular focus on new media, tailored communications, and how media channels may be used as part of a collective approach to reaching lower socio-economic groups and the disadvantaged.
- D. States: Increase the resources, staffing, and expertise made available to the states for the dissemination, monitoring, and evaluation of the 5-A-Day Program.

Recommended Strategies

The *Promising Practices* document also suggests the following interventions, which cut across the four obesity objectives, at the community, school, state, health care provider, and public policy levels.

1. Community-Based Interventions

- A. Conduct community assessments to determine the dietary and exercise habits of residents, identify interventions that might help improve these habits, and identify community resources and potential partners that could help establish these interventions.
- B. Coordinate efforts to achieve *Healthy People 2010* objectives among various groups and agencies.
- C. Encourage representatives of the intended population to participate in program planning, design, implementation, and evaluation.
- D. Identify relevant population subgroups, attempt to understand physical activity, nutrition, and obesity from their point of view, and develop community based strategies and programs that are relevant and acceptable to them.
- E. Educate the public and policy makers about the importance of supportive environments.
- F. Promote broad social and environmental changes that complement individual change efforts. Examples of such activities include:
 - i. Promoting healthy food choices in away-from-home sites such as restaurants, fast-food outlets, school and worksite cafeterias, vending machines, and sports, arts, and recreation venues.

- ii. Encouraging restaurants to label heart-healthy foods on menus and encouraging vending machine operators to include a certain percentage of choices low in fat, sodium, and sugar.
- G. Coordinating community resources and identifying consistent, convincing, culturally appropriate, and scientifically sound nutrition and physical activity messages delivered through health professionals, grocery stores, places of worship, schools, the media, parks and recreational facilities and programs, food service operations, and other pertinent channels.
- H. Improving lighting and security in public exercise areas such as walking paths (sidewalks, trails) and bike paths.
- I. Involving the Department of Agriculture as a key partner through programs such as WIC.
- J. Recruiting nontraditional partners such as food producers and retailers, bicycle-pedestrian coordinators, transportation planners, local land/urban planners, trail coordinators, violence-prevention advocates, and neighborhood associations.
- K. Encouraging employers to adopt policies that support physical activity and good nutrition, such as offering flex-time and providing healthy food options at worksite cafeterias.
- L. Demonstrating model physical activity and healthy nutrition policies, procedures, and practices at the worksites of state agencies.
- M. Ensuring that the public health benefits of both leisure-time and transportation-related physical activity are conveyed to state transportation agencies, urban planners, building designers, and officials responsible for zoning and transportation-investment decisions.

2. School-Based Recommendations for Children and Adolescents

- A. Use state funding to employ a full-time school health coordinator to work collaboratively with the state education department on school health issues related to nutrition and physical activity.
- B. Collaborate with the state department of education to employ a physical education/activity coordinator at the state department of education.
- C. Educate policy makers, health advocates, and the general public about the importance of requiring daily physical education classes and state-of-the-art nutrition education in the core curriculum for kindergarten through 12th grade.
- D. Collaborate with the state department of education to provide support, training, and technical assistance to help schools implement CDC school health guidelines for promoting healthy eating and physical activity and

- use the tools that support the implementation of these guidelines (e.g., the *School Health Index* and *Fit, Healthy, and Ready to Learn*).
- E. Provide schools with the resources necessary to educate faculty and students about healthy eating and physical activity and implement curricula to promote healthy eating and physical activity.
 - F. Encourage communities and businesses to support physical activity and nutrition programs for young people.
 - G. Provide support, training, and technical assistance to help schools and community organizations achieve the following:
 - i. Create food service programs that are consistent with USDA school meal program regulations and physical education programs that are consistent with the National Standards for Physical Education.
 - ii. Create a healthy school nutrition environment in which appealing, healthy, and nutritious choices are available whenever and wherever food and beverages are offered to students.
 - iii. Provide before- and after-school extracurricular physical activity opportunities such as physical activity clubs, intramural activities, and interscholastic sports.
 - iv. Integrate physical activity and healthy eating into before- and after-school childcare programs (e.g., extended-day programs).
 - v. Develop effective programs to increase the number of students walking to and from school.
 - vi. Develop and implement school health councils, which include community representation, to guide school health programs.
 - vii. Develop and implement effective employee health promotion programs and services.
 - viii. Evaluate school programs in healthy eating and physical activity and make improvements where needed.

3. Health Care Programs

- A. Work with health care plans to develop and use evidence-based standards of practice for delivering preventive services. At a minimum, health care plans should have standards of practice for assessing physical activity and nutrition and for assessing the effectiveness of clinical interventions.
- B. All children and adults enrolled in health care plans should have access to appropriate primary and secondary prevention care services related to physical activity and nutrition.
- C. Work with health care systems to ensure that their health care professionals are qualified to deliver preventive services related to physical activity and nutrition.

- D. Work with plans to develop and evaluate prompts for counseling patients about nutrition, physical activity, and body weight regulation.
- E. Promote policies that either require or provide incentives for health care systems to include preventive services related to nutrition and physical activity as part of their benefit packages. Examples of policies that provide such incentives include reimbursing providers for preventive care and basing a health care system's quality-of-care rating at least in part on the quality of the preventive care it provides.
- F. Help health care plans coordinate their preventive care activities with community efforts to promote physical activity and healthy nutrition. The collaboration of the North Carolina Prevention Partners (www.ncpreventionpartners.org) illustrates how such a coordinated effort might function.
- G. Work with health care systems to include nutrition and physical activity indicators in the surveillance data they collect. These indicators can be used to evaluate the effectiveness of interventions to increase physical activity or improve nutrition among patients in the system.

4. *State and Local Infrastructure*

- A. Program Management and Administration:
State health departments are uniquely positioned to lead efforts to integrate disparate programs related to nutrition, physical activity, and obesity prevention and control. The minimum staff requirements for this effort include a full-time, high-level person to coordinate the crosscutting nutrition and physical activity functions of the health department and its partners, a full-time physical activity coordinator, and a full-time nutrition coordinator. If necessary, in states with a small population, two people may perform these three roles.
- B. Surveillance and Education:
A state plan for promoting healthy diets and physical activity should describe how the comprehensive state program will coordinate multiple categorical programs that in any significant way address nutrition, physical activity, or obesity prevention. Key elements should include a surveillance system for monitoring progress; a public communication and education program focusing on all segments of the population; coordination with other programs and services (e.g., cardiovascular health, diabetes, cancer control, minority health, and aging/social services); and strategic partnerships with state and local government entities, CDC Prevention Research Centers, academic institutions, and private organizations.

5. *Policy*

In addition to convincing people to be more physically active and eat a healthier diet, public health organizations should work to create environments, systems, and policies that:

- A. Serve as passive inducements to being physically active and eating a healthy diet.
- B. Eliminate barriers to being active and eating a healthy diet.
- C. Provide explicit support, reinforcement, and inducements to making healthy choices such as taking stairs rather than riding elevators or eating fruits or vegetables instead of less healthy foods.
- D. Change cultural and organizational norms for physical activity and body weight.
- E. Establish themselves as partners in planning and decision-making on environmental and policy issues that affect people's eating and physical activity habits.

Worksite Recommendations

In *HEALTHY WORKFORCE 2010, An Essential Health Promotion, Sourcebook for Employers, Large and Small*, the Partnership for Prevention recommends the following obesity-related interventions for employers:⁹

1. Provide healthy snacks in vending machines, in break rooms, and at company events.
2. Provide healthy meal choices in cafeterias and at company events.
3. Disseminate nutrition information to employees. For example, work with a weight management vendor to provide information about the nutritional content of cafeteria foods.
4. Subsidize healthy foods in the cafeteria or vending machines. (10¢ apples may be more appealing than \$1.00 candy bars.)
5. Choose health plans that cover programs to help enrollees with weight management.
6. Institute flexible work schedules so employees can participate in weight-loss programs.
7. Offer a health risk appraisal (HRA) to all employees, and follow-up with those at risk.
8. Ask voluntary health associations, health care providers, and/or public health agencies to offer onsite nutrition education classes.

9. If a group of employees are interested in losing weight, offer onsite fitness and weight-management programs. (Ask a dietician at your local health department or hospital about high quality vendors who offer worksite programs.)
10. Locate dietetics professionals near your worksite as a resource for employees who want information on healthy eating/meal planning or weight control. (Use the “find a dietician” service on the American Dietetic Association website: <http://www.eatright.org/finddiet.html>.)
11. Assign a fitness center “trainer” to each participant in weight management classes to help overweight employees meet health and fitness goals.
12. Offer financial incentives for employee participation in weight management programs. For example, offer full or partial reimbursement for the cost of the program or discount health insurance premiums and/or reduce copayments and deductibles after successful program completion.
13. Form a support group to help employees who are trying to lose weight.
14. Offer individual and group counseling to those struggling with weight loss.

TOBACCO USE

Objective 3-1: Reduce cigarette smoking by adults.

Objective 3-2: Reduce cigarette smoking by adolescents.

SUMMARY

Recommended interventions to meet the Tobacco Use objectives focus on efforts in four key areas: 1) Local community initiatives; 2) Health care system innovations; 3) Schools-based programs; and 4) Statewide action and policy. Community-based strategies include smoking bans, enforcement of laws regulating the sale of tobacco products to minors, and media/public relations/grassroots counter-marketing campaigns. Health care interventions include provider education, decreasing patient cost for treatment, and telephone “quit lines.” School-based programs focus on implementing anti-tobacco curricula, tobacco-free campus policies, cessation assistance, and teacher and parent involvement and training. Finally, statewide action and policy can enhance and coordinate the efforts of local coalitions, implement legal and programmatic innovations on a statewide basis, and provide comprehensive surveillance of tobacco use and its consequences.

SPECIFIC INTERVENTIONS

Strongly Recommended Strategies

The Community Guide found “Strong Evidence” to classify the following interventions as “Strongly Recommended Strategies.”¹⁰

1. Smoking bans and restrictions

Smoking bans and restrictions are policies, regulations, and laws that limit smoking in workplaces and other public areas. Smoking bans prohibit smoking entirely; smoking restrictions limit smoking to designated areas.

2. Increasing the unit price for tobacco products

The unit price for tobacco products can be increased by raising the product excise tax through legislation at the state or national level. In several states, excise tax increases have provided revenue for comprehensive tobacco use prevention and control programs.

3. Mass media education (campaigns) combined with other interventions

Messages are developed through formative research, and use broadcast messages on television and radio, although other formats, such as billboards, print media, and movies have been used. Campaigns are conducted over long periods of time and employ brief, recurring messages to inform and motivate individuals to quit or remain tobacco-free.

4. Provider reminder + Provider education (with or without patient education)

Efforts to increase the number of people who stop using tobacco include prompting healthcare providers to identify tobacco-using patients and to discuss with them the importance of quitting (“provider reminder”), an education program for providers, so that they can help their patients quit tobacco use (“provider education”), and self-help materials for patients interested in quitting (“patient education”).

5. Patient telephone support (quit lines) when combined with other interventions

These programs are organized efforts to help tobacco users quit and not start using tobacco again. They provide one or more sessions of counseling or assistance, usually delivered by trained counselors or healthcare providers. Help is delivered in one of two ways: either the tobacco user places a call requesting help, or the professional guiding the effort to quit calls the user to offer help or returns a call from a user who requested help. These telephone sessions, which usually follow a standardized approach to providing advice and counseling, are often combined with other efforts, such as distribution of materials about quitting, formal individual or group counseling, or nicotine replacement therapies (including patches or gum).

Recommended Strategies

The Community Guide categorized the following as having “Sufficient Evidence” to be considered a “Recommended Strategy.”

1. Provider reminder systems (alone)

Provider reminders involve efforts to identify patients who use tobacco products and to prompt healthcare providers to discuss with these patients the importance of quitting. Providers receive these reminders through stickers on patients’ charts, vital sign stamps, medical record flow sheets, checklists, and by computer. Provider reminders are often combined with other approaches. In the seven qualifying studies, the evaluated techniques for prompting providers were chart prompts or stickers, “expanded vital signs” that include status of tobacco use, and flow sheets.

2. Reducing patient out-of-pocket costs for effective treatments for tobacco use and dependence.

These programs include efforts to reduce the financial barriers that may stop patients from using cessation therapies. Techniques include providing the services within the healthcare system, or providing coverage for or reimbursement of patients for expenditures on (1) cessation groups or (2) nicotine replacement or other pharmacological therapies.

Strategies with Insufficient Evidence to Determine Effectiveness

1. Community education to reduce ETS exposure in the home environment
2. Smoking cessation (short-term media broadcast) series
3. Smoking cessation contests
4. Provider education programs (alone)
5. Provider feedback system

Other Recommendations from the CDC

In addition to *The Community Guide’s* recommendations, in 1999, the CDC published a guide to *Best Practices for Comprehensive Tobacco Control Programs*, which listed interventions “determined by evidence-based analyses of comprehensive State tobacco control programs.”¹¹ While listing nine separate

categories, the report emphasized the importance of developing a comprehensive set of interventions that work together to reduce tobacco use.

They include:

1. Community Programs to Reduce Tobacco Use
2. Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases
3. School Programs
4. Enforcement
5. Statewide Programs
6. Counter-Marketing
7. Cessation Programs
8. Surveillance and Evaluation
9. Administration and Management

The report listed the following interventions for each category (also listing the cost for each, which can be found at <http://www.cdc.gov/tobacco/bestprac.htm>):

1. Community Programs to Reduce Tobacco Use

Local community programs cover a wide range of prevention activities including engaging youth in developing and implementing tobacco control interventions; developing partnerships with local organizations; conducting educational programs for young people, parents, enforcement officials, community and business leaders, health care providers, school personnel, and others; and promoting governmental and voluntary policies to promote clean indoor air, restrict access to tobacco products, provide coverage for treatment, and achieve other policy objectives. In California and Massachusetts, local coalitions and programs have been instrumental in achieving policy and program objectives.

2. Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases

Even if current tobacco use were to stop, the residual burden of disease among past users would cause disease for decades to come. As part of a comprehensive tobacco control program, communities can focus attention directly on tobacco-related diseases both to prevent them and to detect them early. The following are examples of such disease programs:

- A. Cardiovascular disease prevention
- B. Asthma prevention

- C. Oral health programs
- D. Cancer registries

Examples of activities to reduce the burden of these diseases include:

- A. Implementing community interventions that link tobacco control interventions with cardiovascular disease prevention
- B. Developing counter-marketing to increase awareness of environmental tobacco smoke (ETS) as a trigger for asthma
- C. Training dental providers to counsel their patients on the role of tobacco use in the development of oral cancer
- D. Expanding cancer registries to monitor tobacco related cancers

3. School Programs

School program activities include implementing CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*, which call for tobacco-free policies, evidence-based curricula, teacher training, parental involvement, and cessation services; implementing evidence-based curricula identified through CDC's Research to Classroom Project; and linking school-based efforts with local community coalitions and statewide media and educational campaigns.

4. Enforcement

Enforcement of tobacco control policies enhances their efficacy by deterring violators and by sending a message to the public that community leaders believe these policies are important. The two primary policy areas that require enforcement activity are restrictions on minors' access to tobacco and on smoking in public places. State efforts should be coordinated with Food and Drug Administration (FDA) and Substance Abuse and Mental Health Services Administration (SAMHSA) Federal programs.

Examples of enforcement activities include:

- A. Conducting frequent retailer compliance checks (four per outlet per year, funds permitting) to identify retailers who sell tobacco to minors.
- B. Imposing a graduated series of civil penalties on the retailer, including license revocation if possible.
- C. Eliminating tobacco vending machines and self-service displays in stores accessible to young people.

- D. Providing comprehensive merchant education, including information on health effects, can deter retailer violators.

5. *Clean Indoor Air*

The health of nonsmokers is protected by the enforcement of public and private policies that reduce or eliminate exposure to environmental tobacco smoke (ETS). Studies have shown that enforcement of worksite smoking bans protects nonsmokers and decreases the number of cigarettes that employees smoke during the workday. Enforcement of clean indoor air laws is generally passive: complaints by the public are investigated by State or local officials who base enforcement on a graduated series of civil warnings and penalties. Before smoking restrictions are implemented, educating the public, employers, and employees about the health effects of ETS and the need for these restrictions can build support for the restrictions and increase compliance. Examples of enforcement activities include:

- A. Establishing and publicizing telephone hotlines for reporting violations of clean indoor air ordinances and laws and investigating reports received.
- B. Reporting violations noted by State officials performing health, environmental, and other routine inspections.

6. Statewide Programs

Statewide projects can increase the capacity of local programs by providing technical assistance on evaluating programs, promoting media advocacy, implementing smoke-free policies, and reducing minors' access to tobacco. Supporting organizations that have statewide access to racial, ethnic, and diverse communities can help eliminate the disparities in tobacco use among the State's various population groups. Statewide and regional grants to organizations representing cities, business and professional groups, law enforcement, and youth groups inform their members about tobacco control issues and encourage their participation in local efforts.

Statewide programs in California, Massachusetts, and Oregon have included the following elements:

- A. Funding multicultural organizations and networks to collect data and develop and implement culturally appropriate interventions.
- B. Sponsoring local, regional, and statewide training, conferences, and technical assistance on best practices for effective tobacco use prevention and cessation programs.

- C. Supporting innovative demonstration and research projects to prevent youth tobacco use, promote cessation and the implementation of tobacco use counseling and treatment for young people and adults, and promote smoke-free communities.
- D. Direct funding provided to statewide organizations can mobilize their organizational assets to strengthen community resources. For example, nongovernmental partners may be better equipped than state governments to reach specific populations, including women, racial/ethnic minority populations, and blue-collar workers. Involving culturally diverse communities in the planning and implementation of tobacco control efforts has been shown to be effective.

7. Counter-Marketing

Counter-marketing attempts to counter pro-tobacco influences and increase pro-health messages and influences throughout a state, region, or community. Counter-marketing consists of a wide range of efforts including paid television, radio, billboard, and print counter-advertising at the State and local level; media advocacy and other public relations techniques using such tactics as press releases, local events, and health promotion activities; and efforts to reduce or replace tobacco industry sponsorship and promotions. Counter-marketing activities can promote smoking cessation and decrease the likelihood of initiation. They also can have a powerful influence on public support for tobacco control interventions, and can create a supportive climate for school and community efforts. Counter-marketing campaigns are a primary activity in all states with comprehensive tobacco control programs.

8. Cessation Programs

Strategies to help people quit smoking can yield significant health and economic benefits. Effective cessation strategies include brief advice by medical providers, counseling, and pharmacotherapy. In addition, system changes (e.g., tobacco-use screening systems, clinician training, and insurance coverage for proven treatments) are critical to the success of cessation interventions. State action should include establishing population-based treatment programs such as telephone cessation helplines; covering treatment of tobacco use under both public and private insurance; and eliminating cost barriers to treatment for underserved populations, particularly the uninsured.

9. Surveillance and Evaluation

A surveillance and evaluation system monitors program accountability for state policymakers and others responsible for fiscal oversight. Surveillance is the monitoring of tobacco-related behaviors, attitudes, and health outcomes at regular intervals of time. Program evaluation efforts build upon surveillance systems by linking statewide and local program efforts to progress in achieving intermediate and primary outcome objectives.

10. Administration and Management

An effective tobacco control program requires a strong management structure to facilitate coordination of program components, involvement of multiple state agencies (e.g., health, education, and law enforcement) and levels of local government, and partnerships with statewide voluntary health organizations and community groups. In addition, administration and management systems are required to prepare and implement contracts and to provide fiscal and program monitoring.

Clinical Recommendations

In *Treating Tobacco Use and Dependence*, a Public Health Service-sponsored Clinical Practice Guideline, a panel of government and nonprofit authorities on the subject conducted a comprehensive review of existing literature and solicited expert opinions, resulting in the following recommendations for health care providers and health care systems:¹²

1. Tobacco dependence is a chronic condition that often requires repeated intervention. However, effective treatments exist that can produce long-term or even permanent abstinence.
2. Because effective tobacco dependence treatments are available, every patient who uses tobacco should be offered at least one of these treatments:
 - A. Patients *willing* to try to quit tobacco use should be provided treatments identified as effective in this guideline.
 - B. Patients *unwilling* to try to quit tobacco use should be provided a brief intervention designed to increase their motivation to quit.
3. It is essential that clinicians and health care delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of every tobacco user seen in a health care setting.

4. Brief tobacco dependence treatment is effective, and every patient who uses tobacco should be offered at least brief treatment.
5. There is a strong dose-response relationship between the intensity of tobacco dependence counseling and its effectiveness. Treatments involving person-to-person contact (via individual, group, or proactive telephone counseling) are consistently effective, and their effectiveness increases with treatment intensity (e.g., minutes of contact).
6. Three types of counseling and behavioral therapies were found to be especially effective and should be used with all patients attempting tobacco cessation:
 - A. Provision of practical counseling (problem-solving/skills training);
 - B. Provision of social support as part of treatment (intra-treatment social support); and
 - C. Help in securing social support outside of treatment (extra-treatment social support).
7. Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all patients attempting to quit smoking.
 - A. Five *first-line* pharmacotherapies were identified that reliably increase long-term smoking abstinence rates:
 - i. Bupropion SR
 - ii. Nicotine gum
 - iii. Nicotine inhaler
 - iv. Nicotine nasal spray
 - v. Nicotine patch
 - B. Two *second-line* pharmacotherapies were identified as efficacious and may be considered by clinicians if first-line pharmacotherapies are not effective:
 - i. Clonidine
 - ii. Nortriptyline

- iii. Over-the-counter nicotine patches are effective relative to placebo, and their use should be encouraged.
8. Tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions. As such, insurers and purchasers should ensure that:
 - A. All insurance plans include the counseling and pharmacotherapeutic treatments identified as effective in this guideline as a reimbursed benefit; and
 - B. Clinicians are reimbursed for providing tobacco dependence treatment just as they are reimbursed for treating other chronic conditions.

Worksite Recommendations

In *HEALTHY WORKFORCE 2010, An Essential Health Promotion, Sourcebook for Employers, Large and Small*, the Partnership for Prevention recommends the following tobacco-related interventions for employers:¹³

1. Prohibit smoking at the workplace.
2. Offer employees and their spouses smoking cessation classes to help them quit.
3. Offer a health risk appraisal (HRA) to all employees, and follow up with tobacco users.
4. Work with your health plan to ensure coverage for all tobacco use cessation services recommended by the U.S. Public Health Service (USPHS)—including primary care visits for smoking cessation with no co-payment and all cessation pharmaceuticals approved by the U.S. Food and Drug Administration with usual pharmacy co-pays. (Guidelines entitled “Treating Tobacco Use and Dependence” can be found at www.surgeongeneral.gov/tobacco/default.htm)

SUBSTANCE ABUSE

Objective 4-1: Increase the proportion of adolescents not using alcohol or any illicit drugs during the past 30 days.

Objective 4-2: Reduce the proportion of adults using any illicit drug during the past 30 days.

Objective 4-3: Reduce binge drinking by adults in the past 30 days.

INTERVENTION SUMMARY

Recommended interventions to meet the Substance Abuse objectives center on efforts in four key areas: 1) Individually tailored strategies and programs; 2) Family-based approaches; 3) School-based approaches; and 4) Community-wide efforts. In each of these categories, strategies directed specifically at young people should focus on a comprehensive approach that goes beyond one-time activities, helps participants build social skills, involves and improves their relationship with their families, focuses on individual and family strengths instead of weaknesses, provides positive alternatives for substance use for high risk youth and their peers, and addresses community norms, policies, and laws that affect substance use.

SPECIFIC INTERVENTIONS

SAMHSA: Domains of Recommended Strategies

The Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration (SAMHSA) has identified six critical domains related to effective substance abuse prevention programs in the document *Principles of Substance Abuse Prevention*.¹⁴

Individual Domain

1. Build social and personal skills.
2. Design culturally sensitive interventions.
3. Cite immediate consequences.
4. Combine information dissemination and media campaigns with other interventions.

5. Provide positive alternatives to help youth in high-risk environments develop personal and social skills in a natural and effective way.
6. Recognize that relationships exist between substance use and a variety of other adolescent health problems.
7. Incorporate problem identification and referral into prevention programs.
8. Provide transportation to prevention and treatment programs.

Family Domain

1. Target the entire family.
2. Help develop bonds among parents in programs; provide meals, transportation, and small gifts; sponsor family outings; and ensure cultural sensitivity.
3. Help minority families respond to cultural and racial issues.
4. Develop parenting skills.
5. Emphasize family bonding.
6. Offer sessions where parents and youth learn and practice skills.
7. Train parents to both listen and interact.
8. Train parents to use positive and consistent discipline techniques.
9. Promote new skills in family communication through interactive techniques.
10. Employ strategies to overcome parental resistance to family-based programs.
11. Improve parenting skills and child behavior with intensive support.
12. Improve family functioning through family therapy when indicated.
13. Explore alternative community sponsors and sites for schools.
14. Videotape training and education.

Peer Domain

1. Structure alternative activities and supervise alternative events.
2. Incorporate social and personal skills-building opportunities.
3. Design intensive alternative programs that include a variety of approaches and a substantial time commitment.
4. Communicate peer norms against use of alcohol and illicit drugs.
5. Involve youth in the development of alternative programs.
6. Involve youth in peer-led interventions or interventions with peer-led components.
7. Counter the effects of deviant norms and behaviors by creating an environment for youth with behavior problems to interact with other nonproblematic youth.

School Domain

1. Avoid relying solely on knowledge-oriented interventions designed to supply information about negative consequences.
2. Correct misconceptions about the prevalence of use in conjunction with other educational approaches.
3. Involve youth in peer-led interventions or interventions with peer-led components.
4. Give students opportunities to practice newly acquired skills through interactive approaches.
5. Help youth retain skills through booster sessions.
6. Involve parents in school-based approaches.
7. Communicate a commitment to substance abuse prevention in school policies.

Community Domain

1. Develop integrated, comprehensive prevention strategies rather than one-time community-based events.
2. Control the environment around schools and other areas where youth gather.
3. Provide structured time with adults through mentoring.
4. Increase positive attitudes through community service.
5. Achieve greater results with highly involved mentors.
6. Emphasize the costs to employers of workers' substance use and abuse.
7. Communicate a clear company policy on substance abuse.
8. Include representatives from every organization that plays a role in fulfilling coalition objectives.
9. Retain active coalition members by providing meaningful rewards.
10. Define specific goals and assign specific responsibility for their achievement to subcommittees and task forces.
11. Ensure planning and clear understanding for coalition effectiveness.
12. Set outcome-based objectives.
13. Support a large number of prevention activities.
14. Organize at the neighborhood level.
15. Assess progress from an outcome-based perspective and make adjustments to the plan of action to meet goals.
16. Involve paid coalition staff as resource providers and facilitators rather than as direct community organizers.

Society/Environmental Domain

1. Develop community awareness and media efforts.
2. Use mass media appropriately.
3. Set objectives for each media message delivered.
4. Avoid the use of authority figures.
5. Broadcast messages frequently over an extended period of time.
6. Broadcast messages through multiple channels when the target audience is likely to be viewing or listening.
7. Disseminate information about the hazards of a product or industry that promotes it.
8. Promote placement of more conspicuous labels.
9. Promote restrictions on tobacco use in public places and private workplaces.
10. Support clean indoor air laws.
11. Combine beverage server training with law enforcement.
12. Increase beverage servers' legal liability.
13. Increase the price of alcohol and tobacco through excise taxes.
14. Increase minimum purchase age for alcohol to 21.
15. Limit the location and density of retail alcohol outlets.
16. Employ neighborhood anti-drug strategies.
17. Enforce minimum purchase age laws using undercover buying operations.
18. Use community groups to provide positive and negative feedback to merchants.
19. Employ more frequent enforcement operations.
20. Implement "use and lose" laws.
21. Enact deterrence laws and policies for impaired driving.
22. Enforce impaired-driving laws.
23. Combine sobriety checkpoints with positive passive breath sensors.
24. Revoke licenses for impaired driving.
25. Immobilize or impound the vehicles of those convicted of impaired driving.
26. Target underage drivers with impaired-driving policies.

SAMHSA: Defining the Core Competencies of Model Programs

In *Science-Based Prevention Programs and Principles, 2002*, SAMHSA identified a number of "core competencies" derived from its model programs. They include:

1. Content

- A. Program content may address generic life skills or knowledge and skills related to alcohol, tobacco, and illicit drugs (ATID), but ATID related content alone is insufficient.
 - i. None of the programs reviewed focus exclusively on ATID-related knowledge and skills. Half of the programs emphasize the acquisition of generic life skills. The remaining half incorporate both generic and ATID specific content.
- B. Besides imparting new knowledge and skills, effective prevention programs offer participants opportunities to use this information.
 - i. Among programs reviewed, opportunities for practice were incorporated into curriculum-based activities or through the addition of intervention components intended to reinforce curriculum content. Commonly employed curriculum-based strategies include:
 - a. Modeling and behavioral rehearsal (facilitator demonstrates a new skill; participants then perform the skill within session)
 - b. Assigning out-of-session activities intended to reinforce concepts (journaling, identification of issues to be raised in subsequent sessions, practice of skills at home with parents or others)
 - c. Cueing (teachers cue students to use new behaviors in specific situations)
 - d. Placing participants in the role of expert and having them demonstrate new knowledge and skills (e.g., participants create an anti-drug advertising campaign that would be effective with their peer group)
 - e. Use of self-monitoring techniques to enhance awareness and enactment of desired behaviors

2. Community Building

Effective programs move beyond change at the individual level. Emphasis is placed on creating lasting changes within individual, family, and school domains in an effort to create “caring communities” that share accountability for change.

3. Delivery

- A. The most commonly used method to deliver program content is through written, session-by-session curricula, largely because many of the

programs reviewed for this analysis were school-based. Across programs, curricula were implemented over relatively short intervals (9–12 weeks); the periodicity of sessions was at least weekly in three-fourths of reviewed programs.

- B. While the degree of structure found in curriculum implementation materials varies (from highly to loosely structured), effective programs use materials that are clear and easy to follow. Persons with minimal or no training can understand and implement curricula with relative ease.

4. Context

- A. Successful programs promote a consistent message sent through multiple channels (e.g., parents, teachers, peers).
 - i. For example, *Incredible Years*, *Child Development Project*, and *Project ACHIEVE* employ a “whole school reform” approach. A consistent message is sent to parents, teachers, and students, and students consistently hear this message in settings where they spend most of their time—at home and school.
- B. Effective programs tend to characteristics of the target population that place them at risk for alcohol, tobacco, and illicit drugs use. Intervention components ancillary to curricula are often used to tend to these characteristics.
 - i. Mentoring, for example, was an effective strategy to provide youth with social support that is absent from their lives and to expose them to peers and adults who model positive, drug-free behavior.
 - ii. Experientially based activities, such as volunteering, help youth experience self-efficacy, serve others, and share what they have learned. This strategy also lessens the sense that their personal struggles are unique.
 - iii. Recreational, cultural, and social events were used to strengthen family bonds, or, when carried out in the school setting, school bonds.

5. Relationships

- A. Successful programs emphasize relationship building as a precursor to the delivery of program content. Although the number of sessions provided and the activities that comprise the intervention vary, a common first step is gaining influence.
 - i. For example, *Family Effectiveness Training*, *Leadership and Resiliency*, and *Communities Mobilizing for Change on Alcohol* stress

the importance of relationship building across individual and agency levels. Effective programs establish relationships with agencies in which services will be offered, and nurture these relationships throughout the life of the program.

- ii. Teachers, coaches, and other individuals who deliver program content receive on-going support and direction.
- iii. Initial sessions focus on joining participants together, before introducing program content.
- iv. Critical to the success of *Project ACHIEVE* was “buy-in” on the school and district levels prior to program implementation.
- v. The positive effects of relationship were observed among participants in the *Across Ages* program:
 - a. The greatest gains were observed among participants in the mentoring component of the program who engaged in consistent and ongoing contact with caring adult mentors.

6. Integration and Adaptation

- A. Successful programs work through naturally occurring social networks. Services are delivered via the school, community-based agencies, or other networks already in place (e.g., the sports team setting).
- B. Effective programs stress the importance of entering into the world of the client and integrating services into it. For example:
 - i. Programs serving disadvantaged adults provide daycare, meals, transportation, and other services to address barriers that would otherwise prevent them from participating in the program.
 - ii. Programs serving racially and ethnically diverse groups discourage the use of a “one size fits all” approach.
- C. Effective programs tailor materials for specific groups and use bicultural facilitators to deliver program content.
- D. The use of language-translated materials is discouraged because the content of translated materials may not be culturally meaningful to the targeted group. Yet, materials carefully adapted for a particular population in a language other than the one in which the program was originally developed can be effective. Consequently, translating materials alone may be necessary but insufficient.

7. Strengths Focus

- A. Effective prevention programs view individuals and families in relation to their strengths and assets rather than focusing on deficits:

- i. The *Incredible Years* program, for example, employs a collaborative group method that seeks to remove the perception that group leaders are experts and relies on the strengths and knowledge of group participants.
- ii. The *Leadership and Resiliency Program* uses a “whole person” approach that acknowledges individual deficits but does not give priority to those deficits over positive attributes.
- iii. *Family Effectiveness Training* shifts focus from the “identified patient,” instead highlighting functional interactions within the family unit.
- iv. Didactic instruction and skills-building training for participants in the *Positive Action* program focus on their strengths in relation to their developing self-concepts and self-esteem.
- v. The message of the *LifeSkills Training* program is promoted within the context of self-improvement and the acquisition of general life skills.

8. Continuity

- A. Process evaluation data reveal that successful programs enjoy high fidelity to the curriculum, dosage adequacy, and dosage consistency.
 - i. Ongoing support is provided to facilitators implementing program components to ensure uniform delivery.
 - ii. Program activities are structured to create a sense of safety and continuity for participants.
 - a. The *Leadership and Resiliency Program* for example, uses a small-group modality to deliver the intervention. Groups are composed of six to nine students, are closed to new members during the year, and continue for the duration of students’ high school careers.
 - iii. Outcome evaluation data reveal the efficacy of booster sessions in maintaining gains over longer periods.

9. Facilitators

- A. Educational attainments and experience levels of persons delivering interventions vary widely, yet programs consistently require the training of delivery agents (self-instructional, curriculum-based, or in-person) before program implementation.
 - i. One-half of reviewed programs do not require delivery agents to have specific educational attainments; two-fifths require agents to hold a

- bachelor's degree in a relevant field. Two-thirds require facilitators to have prior employment experience in an area relevant to the target population and/or target problems/issues to be addressed.
- ii. Four-fifths of facilitators received advance training to acclimate them to the goals and philosophy of their respective programs and to standardize practices employed over the duration of intervention.
 - iii. Remote site training is the most common type of training participants receive prior to implementing the intervention.
- B. Effective prevention programs use known (versus outside) authorities to deliver program content.
- i. Head Start teachers, athletic coaches, parents, and others with whom participants have an ongoing relationship deliver the content.
 - ii. Over three-fourths of known authorities delivering content are teachers.
- C. Effective programs targeting adolescents acknowledge the developmental importance of the peer group and its influence on adolescent beliefs and perceptions.
- i. Programs targeting adolescents rely on peers to deliver some or all of the content.
- D. Trainer attributes are critical to program success.
- i. Process evaluation data reveal that participants perceive effective trainers as having the following characteristics: they are knowledgeable about local resources available to participants, believe in the program and are committed to its success, and share the same ethnic-racial heritage as participants.
 - ii. Training and certification of facilitators are consistently emphasized in program-related documentation as a way of maintaining integrity of process and consistency of results.

10. *Program Facilitators Parental Involvement*

- A. Program developers consider parental involvement to be a critical factor for success. Efforts to include parents focus on two interrelated goals: enhancing parenting skills and self-efficacy, and increasing parents' involvement in the lives of their children.
- i. Close to half (48 percent) of reviewed programs incorporate a parenting component.
 - ii. Sixty percent of programs with a parenting component use structured activities and experiential activities (social, cultural, recreational events) to foster more interaction between parents and youth.

- iii. The remaining 40 percent of programs with a parenting component provide one or more forms of parenting skills training.

Priorities in Prevention: Recommended Strategies for Alcohol Abuse

In its January 2002 issue brief, *Alcohol and Health, When Risky Use Means Costly Problems*, Priorities in Prevention recommends the following six interventions to prevent negative outcomes related to alcohol use:¹⁵

1. Adopt and sustain multifaceted programs that discourage underage drinking and binge drinking.
 - A. Curb youth access to alcohol with local keg registration and social host liability laws and through higher taxes on alcoholic beverages.
 - B. Consistently enforce existing laws via compliance checks to ensure that minimum legal drinking age laws are obeyed and use roadside sobriety checks to discourage driving while intoxicated (DWI). All 50 states have zero-tolerance laws for drivers under the age of 21.
 - C. Change social norms and youth behavior through public and school based education, community activism, and effective use of the news media. Publicizing existing laws and penalties for offenders can be helpful.
2. Motivate and train health professionals to boost screening and counseling for alcohol problems.
 - A. Health plans should offer alcohol screening/counseling as covered benefits and take steps to improve the delivery of these highly valuable services.
 - B. Employers can choose health plans that cover alcohol screening/counseling and are committed to delivering the services (preferably with data to demonstrate success).
 - C. Doctors and other health professionals can participate in continuing education programs to hone screening and counseling skills.
3. Adopt and enforce laws that make it illegal to drive with 0.08 or greater blood alcohol concentration and revoke licenses of drivers who fail or refuse to take a breath test.

- A. Establish a strict, nationwide, minimum period of one year for administrative license revocation (ALR) for drivers who fail or refuse to take a breath test.
- B. Provide federal funds to states to enforce alcohol-impaired driving laws via sobriety checkpoints.

The following recommendations come from *The Community Guide*:

- C. Lowering the BAC legal limit for young and inexperienced drivers.
- D. Training servers of alcoholic beverages in skills to reduce customers' intoxication.

Responsible beverage service (RBS) programs can result in fewer alcohol related motor vehicle crashes. Typical RBS programs include efforts to:

- i. Preclude alcohol sales to minors at restaurants and bars.
- ii. Prevent intoxication among legal age patrons.
- iii. Keep drunken patrons from driving by promoting the use of taxi services and/or designated drivers.

4. Alert women to avoid drinking during pregnancy.

Women of childbearing age in all socioeconomic groups need accurate information about the dangers of drinking during pregnancy, particularly binge drinking and alcohol abuse. About 80,000 U.S. women report binge drinking while pregnant (3% of all pregnant women). Because many women do not receive adequate health care before or during pregnancy, broader community education and health care provider outreach are vital. Health professionals need better preparation in substance abuse issues for pregnant women.

5. Implement worksite policies that discourage alcohol misuse and offer confidential assistance with problems.

To stem the cost of lost productivity, worksite accidents, and excess health care due to alcohol and drug use, employers can:

- A. Offer health plans that cover the cost of screening, counseling, and treatment for substance misuse.
- B. Participate in community programs to prevent alcohol and drug misuse.
- C. Integrate alcohol prevention into existing worksite health promotion programs.
- D. Educate supervisors about alcohol and drugs so they are better equipped to make caring and effective interventions and referrals.
- E. Sponsor confidential employee assistance programs (EAPs) with onsite or external counselors to help workers resolve substance abuse problems

and link them with treatment services (especially those in safety sensitive positions).

- F. Educate employees about health problems associated with drinking and stress.

6. *Increase the Federal Excise Tax on Alcoholic Beverages.*

Past tax increases in some states resulted in fewer deaths from liver disease, homicide, suicide, and industrial injuries related to alcohol use. After Congress raised the federal excise tax in 1991, overall per capita alcohol consumption dropped 6%.

7. *Invest in Research About Alcohol Use and Ways to Prevent Misuse.*

More data is needed to assess community wide patterns of alcohol use and related problems. The Council of State and Territorial Epidemiologists recommends strengthening systems that collect data (via surveys, accident reports, etc.) on alcohol use. These systems can provide data essential to designing, implementing, and evaluating programs to reduce risky drinking.

Institute of Medicine “Reducing Underage Drinking” Recommendations

In its 2003 report, *REDUCING UNDERAGE DRINKING: A Collective Responsibility*, the Institute of Medicine’s Committee on Developing a Strategy to Reduce and Prevent Underage Drinking suggested a comprehensive approach that looks beyond youth-oriented strategies and works “to create and sustain a broad society commitment” that involves “parents and other adults, alcohol producers, wholesalers and retail outlets, restaurants and bars, entertainment media, schools, colleges and universities, the military, landlords, community organizations and youths themselves¹⁶.” The report’s recommendations include:

1. *National Adult-Oriented Media Campaign*

(Recommendation 6-1):

The federal government should fund and actively support the development of a national media effort, as a major component of an adult-oriented campaign to reduce underage drinking.

2. *Partnership to Prevent Underage Drinking*

(Recommendation 7-1):

All segments of the alcohol industry that profit from underage drinking, inadvertently or otherwise, should join other private and public partners to establish and fund an independent nonprofit foundation with the sole mission of preventing and reducing underage drinking.

3. Alcohol Advertising

A. (Recommendation 7-2):

Alcohol companies, advertising companies, and commercial media should refrain from marketing practices (including product design, advertising, and promotional techniques) that have substantial underage appeal and should take reasonable precautions in the time, place, and manner of placement and promotion to reduce youthful exposure to other alcohol advertising and marketing activity.

B. (Recommendation 7-3):

The alcohol industry trade associations, as well as individual companies, should strengthen their advertising codes to preclude placement of commercial messages in venues where a significant proportion of the expected audience is underage, to prohibit the use of commercial messages that have substantial underage appeal, and to establish independent external review boards to investigate complaints and enforce the codes.

C. (Recommendation 7-4):

Congress should appropriate the necessary funding for the U.S. Department of Health and Human Services to monitor underage exposure to alcohol advertising on a continuing basis and to report periodically to Congress and the public. The report should include information on the underage percentage of the exposed audience and estimated number of underage viewers of print and broadcasting alcohol advertising in national markets and, for television and radio broadcasting, in a selection of large local or regional markets.

4. Entertainment Media

A. (Recommendation 8-1):

The entertainment industries should use rating systems and marketing codes to reduce the likelihood that underage audiences will be exposed to movies, recordings, or television programs with unsuitable alcohol content, even if adults are expected to predominate in the viewing or listening audiences.

B. (Recommendation 8-2):

The film rating board of the Motion Picture Association of America should consider alcohol content in rating films, avoiding G or PG ratings for films with unsuitable alcohol content, and assigning mature ratings for films that portray underage drinking in a favorable light.

C. (Recommendation 8-3):

The music recording industry should not market recordings that promote or glamorize alcohol use to young people; should include alcohol content in a comprehensive rating system, similar to those used by the television, film, and video game industries; and should establish an independent body to assign ratings and oversee the industry code.

D. (Recommendation 8-4):

Television broadcasters and producers should take appropriate precautions to ensure that programs do not portray underage drinking in a favorable light, and that unsuitable alcohol content is included in the category of mature content for purposes of parental warnings.

E. (Recommendation 8-5):

Congress should appropriate the necessary funds to enable the U.S. Department of Health and Human Services to conduct a periodic review of a representative sample of movies, television programs, and music recordings and videos that are offered at times or in venues likely to have a significant youth audience (e.g., 15 percent) to ascertain the nature and frequency of lyrics or images pertaining to alcohol. The results of these reviews should be reported to Congress and the public.

5. Limiting Access

A. (Recommendation 9-1):

The minimum drinking age laws of each state should prohibit:

- i. Purchase or attempted purchase, possession, and consumption of alcoholic beverages by persons under age 21;
- ii. Possession of and use of falsified or fraudulent identification to purchase or attempt to purchase alcoholic beverages;
- iii. Provision of any alcohol to minors by adults, except to their own children in their own residences; and underage drinking in private clubs and establishments.

B. (Recommendation 9-2):

States should strengthen their compliance check programs in retail outlets, using media campaigns and license revocation to increase deterrence.

- i. Communities and states should undertake regular and comprehensive compliance check programs, including notification of

- retailers concerning the program and follow-up communication to them about the outcome (sale/no sale) for their outlet.
- ii. Enforcement agencies should issue citations for violations of underage sales laws, with substantial fines and temporary suspension of license for first offenses and increasingly stronger penalties thereafter, leading to permanent revocation of license after three offenses.
 - iii. Communities and states should implement media campaigns in conjunction with compliance check programs detailing the program, its purpose, and outcomes.
- C. (Recommendation 9-3):
The federal government should require states to achieve designated rates of retailer compliance with youth access prohibitions as a condition of receiving relevant block grant funding, similar to the Synar Amendment's requirements for youth tobacco sales.
- D. (Recommendation 9-4):
States should require all sellers and servers of alcohol to complete state-approved training as a condition of employment.
- E. (Recommendation 9-5):
States should enact or strengthen dram shop liability statutes to authorize negligence-based civil actions against commercial providers of alcohol for serving or selling alcohol to a minor who subsequently causes injury to others, while allowing a defense for sellers who have demonstrated compliance with responsible business practices. States should include in their dram shop statutes key portions of the Model Alcoholic Beverage Retail Licensee Liability Act of 1985, including the responsible business practices defense.
- F. (Recommendation 9-6):
States that allow Internet sales and home delivery of alcohol should regulate these activities to reduce the likelihood of sales to underage purchasers. States should:
- i. Require all packages for delivery containing alcohol to be clearly labeled as such;
 - ii. Require persons who deliver alcohol to record the recipient's age identification information from a valid government-issued document (such as a driver license or ID card); and
 - iii. Require recipients of home delivery of alcohol to sign a statement verifying receipt of alcohol and attesting that he or she is of legal age to purchase alcohol.
- G. (Recommendation 9-7):

States and localities should implement enforcement programs to deter adults from purchasing alcohol for minors. States and communities should:

- i. Routinely undertake shoulder tap or other prevention programs targeting adults who purchase alcohol for minors, using warnings, rather than citations, for the first offense;
- ii. Enact and enforce laws to hold retailers responsible, as a condition of licensing, for allowing minors to loiter and solicit adults to purchase alcohol for them on outlet property; and
- iii. Use nuisance and loitering ordinances as a means of discouraging youth from congregating outside of alcohol outlets in order to solicit adults to purchase alcohol.

H. (Recommendation 9-8):

States and communities should establish and implement a system requiring registration of beer kegs that records information on the identity of purchasers.

I. (Recommendation 9-9):

States should facilitate enforcement of zero tolerance laws in order to increase their deterrent effect. States should:

- i. Modify existing laws to allow passive breath testing, streamlined administrative procedures, and administrative penalties; and
- ii. Implement media campaigns to increase young peoples' awareness of reduced BAC limits and of enforcement efforts.

J. (Recommendation 9-10):

States should enact and enforce graduated driver licensing laws.

K. (Recommendation 9-11):

States and localities should routinely implement sobriety checkpoints.

L. (Recommendation 9-12):

Local police, working with community leaders, should adopt and announce policies for detecting and terminating underage drinking parties, including:

- i. Routinely responding to complaints from the public about noisy teenage parties and entering the premises when there is probable cause to suspect underage drinking is taking place;
- ii. Routinely checking, as a part of regular weekend patrols, open areas where teenage drinking parties are known to occur; and
- iii. Routinely citing underage drinkers and, if possible, the person who supplied the alcohol when underage drinking is observed at parties.

M. (Recommendation 9-13):

States should strengthen efforts to prevent and detect use of false identification by minors to make alcohol purchases. States should:

- i. Prohibit the production, sale, distribution, possession, and use of false identification for attempted alcohol purchase;
- ii. Issue driver licenses and state identification cards that can be electronically scanned;
- iii. Allow retailers to confiscate apparently false identification for law enforcement inspection; and
- iv. Implement administrative penalties (e.g., immediate confiscation of a driver's license and issuance of a citation resulting in a substantial fine) for attempted use of false identification by minors for alcohol purchases.

N. (Recommendation 9-14):

States should establish administrative procedures and non-criminal penalties, such as fines or community service, for alcohol infractions by minors.

6. Youth-Oriented Interventions

A. (Recommendation 10-1):

Intensive research and development for a youth-focused national media campaign relating to underage drinking should be initiated. If this work yields promising results, the inclusion of a youth-focused campaign in the strategy should be reconsidered.

B. (Recommendation 10-2):

The U.S. Department of Health and Human Services and the U.S. Department of Education should fund only evidence-based education interventions, with priority given both to those that incorporate elements known to be effective and those that are part of comprehensive community programs.

C. (Recommendation 10-3):

Residential colleges and universities should adopt comprehensive prevention approaches, including evidence-based screening, brief intervention strategies, consistent policy enforcement, and environmental changes that limit underage access to alcohol. They should use universal education interventions, as well as selective and indicated approaches with relevant populations.

D. (Recommendation 10-4):

The National Institute on Alcohol Abuse and Alcoholism and the Substance Abuse and Mental Health Services Administration should continue to fund evaluations of college-based interventions, with a

particular emphasis on targeting of interventions to specific college characteristics, and should maintain a list of evidence-based programs.

E. (Recommendation 10-5):

The U.S. Department of Health and Human Services and states should expand the availability of effective clinical services for treating alcohol abuse among underage populations and for following up on treatment. The U.S. Department of Education, the U.S. Department of Health and Human Services, and the U.S. Department of Justice should establish policies that facilitate diagnosing and referring underage alcohol abusers and those who are alcohol dependent for clinical treatment.

7. Community Interventions

A. (Recommendation 11-1):

Community leaders should assess the underage drinking problem in their communities and consider effective approaches-such as community organizing, coalition building, and the strategic use of the mass media to reduce drinking among underage youth.

B. (Recommendation 11-2):

Public and private funders should support community mobilization to reduce underage drinking. Federal funding for reducing and preventing underage drinking should be available under a national program dedicated to community-level approaches to reducing underage drinking, similar to the Drug Free Communities Act, which supports communities in addressing substance abuse with targeted, evidence-based prevention strategies.

8. Government Assistance and Coordination

A. (Recommendation 12-1):

A federal interagency coordinating committee on prevention of underage drinking should be established, chaired by the secretary of the U.S. Department of Health and Human Services.

B. (Recommendation 12-2):

A National Training and Research Center on Underage Drinking should be established in the U.S. Department of Health and Human Services. This body would provide technical assistance, training, and evaluation support and would monitor progress in implementing national goals.

C. (Recommendation 12-3):

The secretary of the U.S. Department of Health and Human Services should issue an annual report on underage drinking to Congress

summarizing all federal agency activities, progress in reducing underage drinking, and key surveillance data.

D. (Recommendation 12-4):

Each state should designate a lead agency to coordinate and spearhead its activities and programs to reduce and prevent underage drinking.

E. (Recommendation 12-5):

The annual report of the secretary of the U.S. Department of Health and Human Services on underage drinking should include key indicators of underage drinking.

F. (Recommendation 12-6):

The Monitoring the Future Survey and the National Survey on Drug Use and Health should be revised to elicit more precise information on the quantity of alcohol consumed and to ascertain brand preferences of underage drinkers.

9. Alcohol Excise Taxes

(Recommendation 12-7):

Congress and state legislatures should raise excise taxes to reduce underage consumption and to raise additional revenues for this purpose. Top priority should be given to raising beer taxes, and excise tax rates for all alcoholic beverages should be indexed to the consumer price index so that they keep pace with inflation without the necessity of further legislative action.

10. Research and Evaluation

A. (Recommendation 12-8):

All interventions, including media messages and education programs, whether funded by public or private sources, should be rigorously evaluated, and a portion of all federal grant funds for alcohol-related programs should be designated for evaluation.

B. (Recommendation 12-9):

States and the federal government-particularly the U.S. Department of Health and Human Services and the U.S. Department of Education-should fund the development and evaluation of programs to cover all underage populations.

Worksite Recommendations

In *HEALTHY WORKFORCE 2010, An Essential Health Promotion, Sourcebook for Employers, Large and Small*, the Partnership for Prevention recommends the following substance abuse interventions for employers:¹⁷

1. Provide employees access to counseling and referrals to treat substance abuse.
2. Participate in community efforts to prevent substance abuse.
3. Offer a health risk appraisal (HRA) to all employees, and follow up with those at risk.
4. Establish an employee assistance program (EAP) and/or link EAP to health promotion initiatives.
5. Provide drug and alcohol education to supervisors to counteract “enabling” behaviors.
6. Establish worksite alcohol and drug policies.

RESPONSIBLE SEXUAL BEHAVIOR

Objective 5-1: Increase the proportion of adolescents who have never had sexual intercourse, have abstained from sexual intercourse in the past three months, or used condoms at last sexual intercourse.

Objective 5-2: Increase the proportion of unmarried, sexually active persons who use condoms.

SUMMARY

Recommended interventions to meet the Responsible Sexual Behavior objectives focus on four key areas: 1) Effective sexual education programs; 2) Increased public awareness and discussion of the issue; 3) Community-wide programs that involve young people of both sexes and their families; and 4) Access to reproductive health services. In addition to strategies targeted specifically at responsible sexual behavior, initiatives that improve educational, employment, and leadership opportunities for young people can reduce teen pregnancy rates.

SPECIFIC INTERVENTIONS

In 2001, *The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior* identified "evidence-based intervention models" in the following areas (literature citations omitted)¹⁸:

- 4.1 Community based programs (not typically addressed to sexuality)
- 4.1 School based programs (abstinence-only requires more study)
- 4.1 Clinic based programs
- 4.1 Religion based programs (needs more study)

The Call to Action: Recommended Strategies

The Call to Action recommended the following strategies:

1. *Increasing Public Awareness of Issues Relating to Sexual Health and Responsible Sexual Behavior*
 - A. Begin a national dialogue on sexual health and responsible sexual behavior that is honest, mature and respectful, and has the ultimate goal of developing a national strategy that recognizes the need for common ground.
 - B. Encourage opinion leaders to address issues related to sexual health and responsible sexual behavior in ways that are informed by the best available science and that respect diversity.
 - C. Provide access to thorough and wide-ranging education about sexual health and responsible sexual behavior that begins early and continues throughout the lifespan. Such education should:
 - i. Recognize the special place that sexuality has in our lives;
 - ii. Stress the value and benefits of remaining abstinent until involved in a committed, enduring, and mutually monogamous relationship; but
 - iii. Assure awareness of optimal protection from sexually transmitted diseases and unintended pregnancy, for those who are sexually active, while also stressing that there are no infallible methods of protection, except abstinence, and that condoms cannot protect against some forms of STDs.
 - D. Recognize that sexuality education can be provided in a number of venues-homes, schools, churches, other community settings-but must always be developmentally and culturally appropriate.
 - E. Recognize that parents are the child's first educators and should help guide other sexuality education efforts so that they are consistent with their values and beliefs.
 - F. Recognize that families differ in their level of knowledge, as well as their emotional capability to discuss sexuality issues. In moving toward equity of access to information for promoting sexual health and responsible sexual behavior, school sexuality education is a vital component of community responsibility.

2. *Providing the Health and Social Interventions Necessary to Promote and Enhance Sexual Health and Responsible Sexual Behavior*
 - A. Eliminate disparities in sexual health status that arise from social and economic disadvantage, diminished access to information and health care services, and stereotyping and discrimination.
 - B. Target interventions to the most socioeconomically vulnerable communities where community members have less access to health education and services and, thus, are likely to suffer most from sexual health problems.
 - C. Improve access to sexual health and reproductive health care services for all persons in all communities.
 - D. Provide adequate training in sexual health to all professionals who deal with sexual issues in their work, encourage them to use this training, and ensure that they are reflective of the populations they serve.
 - E. Encourage the implementation of health and social interventions to improve sexual health that have been adequately evaluated and shown to be effective.
 - F. Ensure the availability of programs that promote both awareness and prevention of sexual abuse and coercion.
 - G. Strengthen families, whatever their structure, by encouraging stable, committed, and enduring adult relationships, particularly marriage. Recognize, though, that there are times when the health interests of adults and children can be hurt within relationships with sexual health problems, and that sexual health problems within a family can be a concern in and of themselves.

Journal of Prevention: Recommended Strategies

In April 2003, the *Journal of Prevention* identified the following suggestions from an article entitled *Best Practices in Teen Pregnancy Prevention Practitioner Handbook*:¹⁹

1. *Youth Development* focuses on providing young people with skills that will help them succeed as adults. One of the most promising approaches to reducing teenage pregnancy is to improve educational and career opportunities for teens and to instill a belief in a successful future.
2. *Involvement of Family and Other Caring Adults* matters when it comes to affecting a teenager's sexual behavior and the risk of early pregnancy.

Family involvement maximizes the effectiveness of pregnancy prevention programs.

3. *Male Involvement* acknowledges the critical role males play in unintended and early pregnancies among teenagers, and involves them in pregnancy prevention efforts.
4. *Cultural Relevant* interventions will increase the effectiveness of efforts to reduce teenage pregnancy because culture plays a major role in influencing values and attitudes about sex, child bearing, and parenting.
5. *Community-Wide Campaigns* to discourage adolescent pregnancy and childbearing are needed because practitioners work with complex social issues such as teenage pregnancy, violence, alcohol, and substance abuse. Single solutions are inadequate.
6. *Service Learning* connects meaningful community service with academic learning, civic responsibility, and personal growth. It enables young people to study community issues in-depth, plan and initiate community action, and make a difference in their community.
7. *Increasing Employment Opportunities* for adolescents is necessary to assure economic self-sufficiency, generate self-esteem, and create the motivation to delay early childbearing.
8. *Sexuality and AIDS Education* plays an important role in providing youth with the knowledge and skills necessary to make healthy decisions about their intimate relationships.
9. *Outreach in Teen Pregnancy Prevention Programs* that focuses on sexual health is critical. The risks of pregnancy and sexually transmitted infections are high in the early months of sexual activity, and teens have the tendency to not seek help before a crisis occurs.
10. *Access to Reproductive Health Services* is important for sexually active teenagers since they need support and encouragement to use contraception effectively and consistently.

MENTAL HEALTH

Objective 6-1: Increase the proportion of adults aged 18 years and older with recognized depression who receive treatment.

Objective 6-2: Reduce the suicide rate.

SUMMARY

Recommended interventions to meet the Mental Health objectives focused on four key issues: 1) Reducing the stigma surrounding mental illness; 2) Reducing disparities in access to mental health services among different population groups and increasing the supply of providers in underserved areas; 3) Delivering state-of-the art treatments that focus on recovery; and 4) Creating a cultural change that equates the importance of treating mental health issues with the importance of physical health treatment.

SPECIFIC INTERVENTIONS

National Reports: Recommended Strategies

In 1999, *Mental Health: A Report of the Surgeon General* recommended the following strategies to improve treatment and access:²⁰

1. Continue to Build the Science Base:

Today, integrative neuroscience and molecular genetics present some of the most exciting basic research opportunities in medical science. A plethora of new pharmacologic agents and psychotherapies for mental disorders afford new treatment opportunities but also challenge the scientific community to develop new approaches to clinical and health services interventions research. Special effort is required to address pronounced gaps in the mental health knowledge base. Key among these are the urgent need for evidence which supports strategies for mental health promotion and illness prevention. Additionally, research that explores approaches for reducing risk factors and strengthening protective factors for the prevention of mental illness should be encouraged.

2. Overcome Stigma:

Powerful and pervasive, stigma prevents people from acknowledging their own mental health problems, and from disclosing them to others. For our Nation to reduce the burden of mental illness, to improve access to care, and to acquire urgently needed knowledge about the brain, mind, and behavior, stigma must no longer be tolerated. Research on brain and behavior that continues to generate ever more effective treatments for mental illnesses is a potent antidote to stigma.

3. *Improve Public Awareness of Effective Treatment*

Americans are often unaware of the choices they have for effective mental health treatments. All human services professionals, not just health professionals, have an obligation to be better informed about mental health treatment resources in their communities and should encourage individuals to seek help from any source in which they have confidence.

4. *Ensure the Supply of Mental Health Services and Providers*

The fundamental components of effective service delivery, which include integrated community-based services, continuity of providers and treatments, family support services (including psychoeducation), and culturally sensitive services, are broadly agreed upon, yet certain of these and other mental health services are in consistently short supply, both regionally and, in some instances, nationally. Because the service system as a whole, as opposed to treatment services considered in isolation, dictates the outcome of recovery-oriented mental health care, it is imperative to expand the supply of effective, evidence-based services throughout the Nation.

5. *Ensure Delivery of State-of-the-Art Treatments*

A wide variety of effective, community-based services, carefully refined through years of research, exist for even the most severe mental illnesses yet are not being translated into community settings. Numerous explanations for the gap between what is known from research and what is practiced beg for innovative strategies to bridge it.

6. *Tailor Treatment to Age, Gender, Race, and Culture*

Mental illness, no less than mental health, is influenced by age, gender, race, and culture as well as additional facets of diversity that can be found within all of these population groups—for example, physical disability or a person's sexual orientation choices. To be effective, the diagnosis and

treatment of mental illness must be tailored to all characteristics that shape a person's image and identity.

7. *Facilitate Entry Into Treatment*

Public and private agencies have an obligation to facilitate entry into mental health care and treatment through the multiple “portals of entry” that exist: primary health care, schools, and the child welfare system. To enhance adherence to treatment, agencies should offer services that are responsive to the needs and preferences of service users and their families. At the same time, some agencies receive inappropriate referrals. For example, an alarming number of children and adults with mental illness are in the criminal justice system inappropriately.

8. *Reduce Financial Barriers to Treatment*

Concerns about the cost of care—concerns made worse by the disparity in insurance coverage for mental disorders in contrast to other illnesses—are among the foremost reasons why people do not seek needed mental health care. While both access to and use of mental health services increase when benefits for those services are enhanced, preliminary data show that the effectiveness—and, thus, the value—of mental health care also has increased in recent years, while expenditures for services, under managed care, have fallen.

In July 2003, the **President's New Freedom Commission on Mental Health** released its final report, advocating for “The Goal of a Transformed System: Recovery.”²¹ The commission identified the following two key principles necessary to transform the existing mental health system:

- Services and treatments must be consumer and family centered, geared to give consumers real and meaningful choices for treatment options and providers — not oriented to the requirements of bureaucracies.
- Care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, not just on managing symptoms.

Based on these principles, the Commission enunciated the following six goals and objectives.

GOAL 1: Americans Understand that Mental Health is Essential to Overall Health.

- 1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.
- 1.2 Address mental health with the same urgency as physical health.

GOAL 2: Mental Health Care is Consumer and Family Driven.

- 1.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 1.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 1.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 1.4 Create a Comprehensive State Mental Health Plan.
- 1.5 Protect and enhance the rights of people with mental illnesses.

GOAL 3: Disparities in Mental Health Services are Eliminated.

- 3.1 Improve access to quality care that is culturally competent.
- 3.2 Improve access to quality care in rural and geographically remote areas.

GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice.

- 4.1 Promote the mental health of young children.
- 4.2 Improve and expand school mental health programs.
- 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
- 4.4 Screen for mental disorders in primary health care, across the lifespan, and connect to treatment and support.

GOAL 5: Excellent Mental Health Care is Delivered and Research is Accelerated.

- 5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.
- 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
- 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.

- 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

GOAL 6: Technology is Used to Access Mental Health Care and Information.

- 6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
- 6.2 Develop and implement integrated electronic health record and personal health information.

In testimony before the commission, Diane T. Marsh, Ph.D., **President of the American Psychological Association** made the following specific policy recommendations (her remarks addressed three areas for which Commission had asked for the Association's views, so they are not necessarily a comprehensive list, but do apply to the federal, state, and local levels).²²

1. Encourage the Use of Effective Treatments and Services

- A. *Support Basic and Applied Research.* Increase federal funding for basic research to shed light on critical processes underlying mental disorders and for applied research to develop and evaluate the full range of prevention, early intervention, and treatment strategies, including psychotherapeutic and psychopharmacological approaches.
- B. *Promote Information Dissemination.* Embark on outreach efforts to inform mental health providers about the latest effective interventions, with increased emphasis on community-based treatment; cultural competence and related approaches for reducing racial/ethnic disparities in access, treatment, and outcomes; recovery; and administration of multiple, integrated, and interdisciplinary services, including primary health and mental health care. This could be accomplished in part through on-line journals, Web sites, curriculum renewal in graduate programs, professional meetings, and continuing education programs.
- C. *Further Interagency Collaboration.* Continue to promote collaboration between research and service agencies in the federal government, most notably the National Institutes of Health and the Substance Abuse and Mental Health Services Administration.

2. Enhance Opportunities for Professional Training

- A. *Invest in Human Resource Development.* Increase the nation's mental health workforce through federal support for graduate students to specialize in working with vulnerable populations (e.g., children, the elderly, racial and ethnic minorities, and individuals who have co-occurring conditions or chronic physical disorders, including HIV/AIDS and cancer). This could be accomplished by offering training grants to graduate programs, along with stipends, scholarships, and loan repayment programs for graduate students.
- B. *Promote Workforce Diversity.* Provide federal funding for such initiatives as the Minority Fellowship Program to encourage and support racial and ethnic minorities and multilingual individuals to pursue graduate education in the mental health field to help address the mental health needs of our increasingly diverse population.
- C. *Expand Interdisciplinary Training.* Opportunities should be made available in graduate, post-graduate, and continuing education programs to learn about other mental health disciplines and professions to better understand their respective training and differing perspectives. This would include increased training and encouragement for primary care providers to screen children, adolescents, and adults for mental health problems (including depression) on a routine basis and to refer individuals in need to treatment.

3. Improve Coordination Among Service Providers

- A. *Increase Cross-Systems Collaboration.* Develop linkages between and among the mental health system and the health, substance abuse, education, recreation, child welfare/social services, justice, housing, and vocational rehabilitation systems, among others. Interagency collaboration should include consumer and family involvement across community and inpatient/residential settings.
- B. *Implement Flexible Funding Mechanisms.* Intermingling of funds should occur within and across agencies at the federal, state, and local levels to promote collaboration among mental health and other professionals and offer a range of prevention initiatives and individualized, integrated treatment services.
- C. *Encourage Facilitative Policy Changes.* Establish cross-agency management teams at all key levels to identify and address conflicts and barriers to collaboration and ensure adequate staffing allocations for training, service delivery, and ongoing collaboration to decide upon goals and strategy, monitor client progress, and provide for consumer and family involvement. Develop interagency agreements at state and

local levels to address critical issues, such as confidentiality of client information and records, together with attention to respective agency/professional roles in initiating treatment, identifying alternative community resources, and obtaining/providing emergency care, when needed.

4. *Improve the Ability of Adults and Children with Mental Disorders to Integrate in the Community*

- A. *Improve Mental Health Outreach/Intervention.* Enhance early identification, referral, and treatment services for individuals with mental disorders through outreach to schools, primary care, senior centers, and other community settings. Targeted interventions should focus on promoting resilience, self-sufficiency, and quality of life, as well as symptom alleviation, with recovery as the goal.
- B. *Achieve Full Parity.* To ensure access to treatment for all people with mental disorders, there should be full parity for mental health services in both private and public (i.e., Medicare and Medicaid) health insurance coverage. Concerted efforts need to be undertaken to educate the public about mental disorders to eliminate stigma and discrimination and reduce barriers to access these services.
- C. *Implement Systems of Care.* The system of care model should drive the service delivery system to ensure that it is person-centered, family-focused, community-based, developmentally appropriate, linguistically and culturally competent, and geographically accessible. Networks of mental health and other community services need to be developed, which include provisions for children of parents in treatment and support for caregivers of older adults (e.g., on-site or community-based care).
- D. *Expand Federal Mental Health Programs.* Vital federal programs offering support to the states, such as the Community Mental Health Services Performance Partnership Block Grant and Medicaid, with its Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, and the Individuals with Disabilities Education Act, need to be fully implemented and expanded. Middle-income families should be able to "buy into" the Medicaid program to secure needed mental health treatment for their children with serious mental and/or physical disorders. Efforts should also be made to ensure the development of consistent Medicare local medical review policies for mental health services across insurance carriers.

The Community Guide: Recommended Strategies

The Community Guide has not completed its review of evidence-based strategies regarding mental health, but has determined that Prevention of Relapse and Recurrence has demonstrated insufficient evidence to determine effectiveness.²³

Regional Reports: Recommended Strategies*NECON Task Force on Mental Health Promotion*

In its August 2001 report, *The Time is Now: Report of the NECON Task Force on Mental Health Promotion, Mental Illness and Substance Abuse Prevention*, the New England Coalition for Health Promotion and Disease Prevention (NECON) argued, “Three giant steps are required in order to move mental health promotion and illness prevention into the mainstream of America.”²⁴ These include:

1. Increased public awareness and understanding.
2. Increased active engagement and participation of primary care physicians.
3. Increased public investment, especially under the Medicaid program, which provides coverage to populations with some of the highest rates of mental and emotional problems.

In order to meet these goals, the report recommended that New England states:

1. Establish working groups to assess service needs and resources in the region, and to develop reliable statistical indicators to measure performance of prevention and promotion programs.
2. Provide the required financial support to mental health programs and services by assuring mental health parity with physical health in public and private insurance coverage, and by applying Medicaid and a portion of state tobacco settlement funds to mental illness prevention and mental health promotion.
3. Establish and expand mental health promotion in schools and community settings, and to educate and involve primary care physicians in routine incorporation of mental health screening as part of a clinical prevention practice.

NECON recommended that governors in each state:

1. Ensure mental health parity in all insurance plans and extend state subsidized insurance to low income, working adults without health insurance coverage—insurance that includes screening and other demonstrated effective preventive services.
2. Assign personnel to collaborate with NECON to identify the existing programs, policies, and structures that fall within the areas of both substance abuse and mental health and determine how they might be addressed in an integrated way.
3. Identify a representative to work with NECON to form a regional working group to review public health data collection systems across the New England states. This group will be charged to identify several comparable indicators to measure improved outcomes, especially among diverse cultural groups.
4. Use proceeds of tobacco tax and settlement funds to establish or expand health promotion and illness prevention in the areas of mental health and dual disorders; to this end we can build on “common ground” with state Medicaid and other cross-agency funding, as well as public/private partnerships, to forge a broad mental health promotion and illness prevention base.
5. Establish and expand school and community based health programs that include comprehensive mental illness prevention and health education services across the lifespan. These programs require trained personnel that can identify points of intervention and can screen for early indications of depression in school and primary care settings across the lifespan; the programs also require referral linkages to services and alternative programs as follow-up screening. Improve coordination between the state departments of mental health and education.
6. Honor a significant community mental health promotion and illness prevention initiative in each of the six states with recognition from the annual New England Governors Conference.

The report also recommended the following “strategic approaches:”

1. *Create clarity and focus.* Developing an initiative that focuses on the prevention of depression and other mental disorders across the lifespan needs to be a well thought out process that involves multiple steps toward the goal of reducing the factors that contribute to the occurrence of symptoms. Such a process will involve the identification of a unique, at-risk population in communities and the development of a series of sequential

interventions that can reduce the risk factors prevalent in the lives of these populations.

2. *Create consensus across key stakeholders regarding a vision for a behavioral health wellness/prevention agenda.* Advocacy for mental health can include several action steps. The first and most important of these is to create partnerships with key constituencies. If we are to create “win-win” collaborative arrangements, we must learn to “walk in the shoes” of key partners—and vice-versa—to understand each other’s policy, regulatory, and funding worlds; and encourage all players (state, local, private, consumers) to understand each other’s underlying values. The list of possible partners is long and includes, at minimum:
 - A. Involving the substance abuse community in mental health promotion efforts. They are crucial to reaching a significant portion of people with mental illness who are at risk for substance abuse.
 - B. Creating a link between physical and mental health and enlisting the support and involvement of health care communities including the state entity responsible for health promotion and disease prevention.
 - C. Forging partnerships with early education and school based programs that include social and emotional learning. The literature support for some of these programs is extensive.
 - D. Developing linkages with the business community in the development of prevention programs and the promotion of “emotional competency in the workplace.”
 - E. Finding partners among grassroots community groups and organizations whose mission may be interpreted to include the promotion of mental health.
3. *Create win-win fiscal incentives.* Some would argue that there are ample resources in the public system to address several of the issues that the task force has been discussing. However, these funds are circumscribed in such a way that it is impossible to use them in a collaborative or “blended” manner. Mechanisms need to be developed that not only allow, but encourage, local input into funding decisions. A prevention budget should be developed across departmental lines, and states should allocate a reasonable percentage of Tobacco Settlement Funds toward prevention efforts.
4. *Create a common framework.* Identify the contributing “causes” of depression for each age group in order to understand the differences and similarities in risk/protective factors for children, adolescents, adults, the

elderly, the culturally diverse, and other special groups. Decide how best to utilize resources and provide prevention services based on this understanding.

Rhode Island Department of Health Primary Care Physician Advisory Committee: Recommended Strategies

The Mental Health Workgroup made the following recommendations to improve provider-to-provider communication:²⁵

1. Enhance mutual understanding of the respective roles of both primary care physicians and behavioral health providers.
2. Conduct a needs assessment of behavioral health services in Rhode Island to identify unmet needs and appropriately target resources.
3. Adapt the behavioral health infrastructure to ensure timely, open communication between primary care physicians and behavioral health providers.
4. Improve basic information exchange between providers.
5. Support intentional physician-to-physician communication.
6. Increase behavioral health access for underserved patient populations.
7. Strengthen state infrastructure to facilitate improved communication.
8. Advocate for insurance coverage changes.
9. Develop benchmarks and identify best practices.

Suicide Prevention Strategies

The National Strategy for Suicide Prevention established 11 goals to address key issues related to preventing suicide in the United States. Following are a list of each of the goals and accompanying objectives.²⁶

Goal 1: Promote Awareness that Suicide is a Public Health Problem that is Preventable

- A. Developing public education campaigns;
- B. Sponsoring national conferences on suicide and suicide prevention;
- C. Organizing special-issue forums; and
- D. Disseminating information through the Internet.

Goal 2: Develop Broad-based Support for Suicide Prevention

- A. Organizing a Federal interagency committee to improve coordination and to ensure implementation of the National Strategy;
- B. Establishing public/private partnerships dedicated to implementing the National Strategy;
- C. Increasing the number of professional, volunteer, and other groups that integrate suicide prevention activities into their ongoing activities; and
- D. Increasing the number of faith communities that adopt policies designed to prevent suicide.

Goal 3: Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse, and Suicide Prevention Services

- A. Increasing the number of suicidal persons with underlying mental disorders who receive appropriate mental health treatment; and
- B. Transforming public attitudes to view mental and substance use disorders as real illnesses, equal to physical illness, that respond to specific treatments and to view persons who obtain treatment as pursuing basic health care.

Goal 4: Develop and Implement Suicide Prevention Programs

- A. Increasing the proportion of states with comprehensive suicide prevention plans;
- B. Increasing the number of evidence-based suicide prevention programs in schools, colleges and universities, worksites, correctional institutions, aging programs, and family, youth, and community service programs; and
- C. Developing technical support centers to build the capacity across the States to implement and evaluate suicide prevention programs.

Goal 5: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm

- A. Educating health care providers and health and safety officials on the assessment of lethal means in the home and actions to reduce suicide risk;
- B. Implementing a public information campaign designed to reduce accessibility of lethal means'

- C. Improving firearm safety design, establishing safer methods for dispensing potentially lethal quantities of medications and seeking methods for reducing carbon monoxide poisoning from automobile exhaust systems; and
- D. Supporting the discovery of new technologies to prevent suicide.

Goal 6: Implement Training For Recognition of At-Risk Behavior and Delivery of Effective Treatment

- A. Improving education for nurses, physician assistants, physicians, social workers, psychologists, and other counselors;
- B. Providing training for clergy, teachers and other educational staff, correctional workers, and attorneys on how to identify and respond to persons at risk for suicide; and
- C. Providing educational programs for family members of persons at elevated risk.

Goal 7: Develop and Promote Effective Clinical and Professional Practices

- A. Changing procedures and/or policies in certain settings, including hospital emergency departments, substance abuse treatment centers, specialty mental health treatment centers, and various institutional treatment settings, designed to assess suicide risk;
- B. Incorporating suicide-risk screening in primary care;
- C. Ensuring that individuals who typically provide services to suicide survivors have been trained to understand and respond appropriately to their unique needs (e.g., emergency medical technicians, firefighters, police, funeral directors);
- D. Increasing the numbers of persons with mood disorders who receive and maintain treatment;
- E. Ensuring that persons treated for trauma, sexual assault, or physical abuse in emergency departments receive mental health services; and
- F. Fostering the education of family members and significant others of persons receiving care for mental health and substance abuse disorders with risk of suicide.

Goal 8: Improve Access to and Community Linkages with Mental Health and Substance Abuse Services

- A. Increasing the number of states that require health insurance plans to cover mental health and substance abuse care on par with coverage for physical health care;
- B. Implementing utilization management guidelines for suicidal risk in managed care and insurance plans;
- C. Integrating mental health and suicide prevention into health and social services outreach programs for at-risk populations;
- D. Defining and implementing screening guidelines for schools, colleges, and correctional institutions, along with guidelines on linkages with service providers; and
- E. Implementing support programs for persons who have survived the suicide of someone close.

Goal 9: Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media

- A. Establishing a public/private group to promote responsible representation of suicidal behaviors and mental illness on television and in movies;
- B. Increasing the number of television programs, movies, and news reports that observe recommended guidelines in the depiction of suicide and mental illness; and
- C. Increasing the number of journalism schools that adequately address reporting of mental illness and suicide in their curricula.

Goal 10: Promote and Support Research on Suicide and Suicide Prevention

- A. Developing a national suicide research agenda;
- B. Increasing funds for suicide prevention research;
- C. Evaluating preventive interventions; and
- D. Establishing a registry of interventions with demonstrated effectiveness for prevention of suicide or suicidal behavior.

Goal 11: Improve and Expand Surveillance Systems

- A. Developing and implementing standardized protocols for death scene investigations;

- B. Increasing the number of follow-back studies of suicides;
- C. Increasing the number of hospitals that code for external cause of injuries;
- D. Increasing the number of nationally representative surveys with questions on suicidal behavior;
- E. Implementing a national violent death reporting system that includes suicide;
- F. Increasing the number of states that produce annual reports on suicide; and
- G. Supporting pilot projects to link and analyze information on self-destructive behavior from various, distinct data systems.

In 1999, *The Surgeon General's Call To Action To Prevent Suicide* suggested 15 interventions under the framework of the acronym **AIM: Awareness, Intervention, and Methodology**. This report led to the development of the National Strategy for Suicide Prevention, referenced above. The recommendations for each component of the AIM strategy include:²⁷

1. ***Awareness: Appropriately broaden the public's awareness of suicide and its risk factors.***
 - A. Promote public awareness that suicide is a public health problem and, as such, many suicides are preventable. Use information technology appropriately to make facts about suicide and its risk factors and prevention approaches available to the public and to health care providers.
 - B. Expand awareness of and enhance resources in communities for suicide prevention programs and mental and substance abuse disorder assessment and treatment.
 - C. Develop and implement strategies to reduce the stigma associated with mental illness, substance abuse, and suicidal behavior and with seeking help for such problems.
2. ***Intervention: Enhance services and programs, both population-based and clinical care.***
 - A. Extend collaboration with and among public and private sectors to complete a National Strategy for Suicide Prevention.

- B. Improve the ability of primary care providers to recognize and treat depression, substance abuse, and other major mental illnesses associated with suicide risk. Increase the referral to specialty care when appropriate.
- C. Eliminate barriers in public and private insurance programs for provision of quality mental and substance abuse disorder treatments and create incentives to treat patients with coexisting mental and substance abuse disorders.
- D. Institute training for all health, mental health, substance abuse and human service professionals (including clergy, teachers, correctional workers, and social workers) concerning suicide risk assessment and recognition, treatment, management, and aftercare interventions.
- E. Develop and implement effective training programs for family members of those at risk and for natural community helpers on how to recognize, respond to, and refer people showing signs of suicide risk and associated mental and substance abuse disorders. Natural community helpers are people such as educators, coaches, hairdressers, and faith leaders, among others.
- F. Develop and implement safe and effective programs in educational settings for youth that address adolescent distress, provide crisis intervention and incorporate peer support for seeking help.
- G. Enhance community care resources by increasing the use of schools and workplaces as access and referral points for mental and physical health services and substance abuse treatment programs and provide support for persons who survive the suicide of someone close to them.
- H. Promote a public/private collaboration with the media to assure that entertainment and news coverage represent balanced and informed portrayals of suicide and its associated risk factors including mental illness and substance abuse disorders and approaches to prevention and treatment.

3. ***Methodology: Advance the science of suicide prevention.***

- A. Enhance research to understand risk and protective factors related to suicide, their interaction, and their effects on suicide and suicidal behaviors. Additionally, increase research on effective suicide prevention programs, clinical treatments for suicidal individuals, and culture-specific interventions.

- B. Develop additional scientific strategies for evaluating suicide prevention interventions and ensure that evaluation components are included in all suicide prevention programs.
- C. Establish mechanisms for federal, regional, and state interagency public health collaboration toward improving monitoring systems for suicide and suicidal behaviors and develop and promote standard terminology in these systems.
- D. Encourage the development and evaluation of new prevention technologies, including firearm safety measures, to reduce easy access to lethal means of suicide.

INJURY AND VIOLENCE

Objective 7-1: Reduce deaths caused by motor vehicle crashes.

Objective 7-2: Reduce homicides.

SUMMARY

Recommended interventions to meet the Injury and Violence objectives focus on five key areas: 1) Legal and educational measures to encourage use of child safety seats and safety belts and to decrease the incidence of alcohol impaired driving; 2) Individually-based approaches to youth crime prevention that build social cognitive skills and include strategies such as mentoring; 3) Family-based crime prevention, including home visitation; 4) School-based crime prevention that helps students improve social skills and develop community norms of positive behavior; and 5) Law enforcement strategies that focus police resources on proven techniques to decrease crime.

SPECIFIC INTERVENTIONS

While motor vehicle accident prevention is a distinct category that has been carefully studied for decades, the issue of homicide prevention crosses a number of different issues such as intimate partner violence, youth violence, and criminal behavior. As a result, the recommended interventions depend on the context in which the homicide was committed.

MOTOR VEHICLE OCCUPANT INJURY

The Community Guide looked at interventions in three strategic areas:

1. Increasing the proper use of child safety seats
2. Increasing the use of safety belts
3. Reducing alcohol impaired driving

Strongly Recommended Strategies

1. Child safety seat use laws

All 50 states currently have laws requiring children traveling in motor vehicles to be restrained in federally approved child restraint devices (e.g., infant or child safety seats) appropriate for the child's size and age. State laws vary widely in defining the age, weight, and/or height, of children affected by the law, as well as the enforcement provisions and penalties. Although enforcement provisions and penalties also vary widely from state to state, enforcement is primary. Drivers can be stopped solely for failing to restrain children as required under the law.

2. Distribution + education programs

Distribution programs provide free loaner child safety seats, low-cost rentals, or direct giveaways. The systematic review examined programs that combined safety seat distribution with education regarding the proper way to secure children in correctly installed seats. Child safety seat distribution and education programs increased both possession of and proper use of safety seats by a median of 23%. Distribution programs were effective when implemented in hospitals and clinics, as part of postnatal home visits, and when provided by an auto insurance company. Effectiveness of these programs was found among urban, suburban, and rural populations, and among affluent and poor populations.

3. Safety belt use laws

Every state but New Hampshire has laws in place requiring the use of seat belts by motor vehicle occupants. State laws vary widely in their specific requirements (e.g., age, seating position, exceptions) and their enforcement provisions (e.g., fines, penalties).

4. Primary enforcement laws (versus secondary enforcement laws)

As of July 2002, 18 states (AL, CA, CT, GA, HI, IN, IA, LA, MD, MI, NJ, NM, NY, NC, OK, OR, TX, WA), the District of Columbia, and Puerto Rico had implemented primary safety belt laws. These laws allow police to stop motorists solely for being unbelted. Secondary safety belt laws permit police to ticket unbelted motorists only if they are stopped for other reasons such as speeding.

5. Enhanced enforcement programs

Enhanced enforcement programs are conducted in addition to normal enforcement practices and are coupled with a publicity component. They fall into two general categories: (1) those that increase citations along with increasing the number of officers on patrol (supplemental), and (2) programs that encourage increased citations during an officer's normal patrol (targeted).

6. 0.08% blood alcohol concentration (BAC) laws

The systematic review included nine studies. Each study evaluated 0.08% BAC laws in one or more of the 16 states that implemented the laws before January 1, 1998. Following implementation of the laws, the median decrease in fatal alcohol-related motor vehicle crashes was 7%. Estimates (in three of the studies) of the number of lives that could be saved if all states enact 0.08% BAC laws ranged from 400 to 600 lives per year.

7. Sobriety checkpoints

At sobriety checkpoints, law enforcement officers systematically stop drivers to assess their level of alcohol impairment. The goal of these interventions is to deter alcohol-impaired driving by increasing drivers' perceived risk of arrest. Two types of sobriety checkpoints exist:

- A. Random breath testing (RBT) checkpoints, which test all drivers for blood alcohol levels and are used in Australia and several European countries.
- B. Selective breath testing (SBT) checkpoints, in which police must have reason to suspect the driver has been drinking. SBT is the only type of sobriety checkpoint used in the United States.

8. Minimum legal drinking age (MLDA) laws

MLDA laws specify an age below which the purchase or public consumption of alcoholic beverages is illegal. In the United States, the MLDA in all 50 states is currently 21 years.

Recommended Strategies (sufficient evidence)*1. Community-wide information + enhanced enforcement campaigns*

Community-wide information and enhanced enforcement campaigns target information about child safety seats and child automobile safety to an entire community, usually geographic in nature. Campaigns use mass media, mailings, safety seat displays in public sites to promote use, and include special enforcement strategies such as checkpoints, dedicated law enforcement officials, or alternative penalties (e.g., informational warnings instead of citations). Campaigns can enhance the benefits gained by passing child safety seat laws.

2. Incentive + education programs

Incentive and education programs reward parents (could include low or no-cost child safety seats for parents) for obtaining and correctly using child safety seats or directly reward children (with stickers, trinkets, coupons) for correctly using safety seats. Programs include educational components varying considerably in terms of information content, duration and intensity of education, methods used, and the number of methods employed.

3. Lower BAC laws for young or inexperienced drivers

In the United States, the lower BAC laws apply to all drivers under the age of 21. The illegal BAC level varies by state from any detectable BAC to 0.02%. In other countries, lower BAC laws apply to either newly licensed drivers or newly licensed drivers under a specified age.

4. Server intervention training programs (face-to-face instruction with management support)

As of January 1, 2000, 11 states had established mandatory server training programs for all licensed establishments, and 10 states provided liability protection to establishments that voluntarily implemented server training. Local governments can also mandate server training. The evidence reviewed primarily comes from small-scale studies in which the participants may have been unusually motivated and the researchers had a high degree of control over the implementation of the server training. The results may not generalize to server intervention training programs as they are typically implemented.

Strategies with Insufficient Evidence to Determine Effectiveness

Education-only programs

VIOLENCE**Youth Violence Prevention**

Best Practices of Youth Violence Prevention: A Sourcebook for Community Action has identified a number of successful strategies to use in youth violence prevention strategies, which include:²⁸

1. *Parent- and Family-Based Strategy*

Parents' interactions with each other, their behavior toward their children, and their emotional state have been shown to be important predictors of children's violent behavior. Hendrix and Molloy, for example, found that poor interactions between a mother and a child at age 1 predict behavioral problems and aggression at age 6. Having an emotionally distressed parent at age 4 has been found to contribute to a child's developing conduct disorders and antisocial behaviors.

Marital conflict and a lack of communication between parents have also been identified as risk factors for youth violence. Parent- and family-based interventions are designed to improve family relations. There is growing evidence that these interventions, especially those that start early and recognize all the factors that influence a family, can have substantial, long term effects in reducing violent behavior by children. Parent and family-based interventions combine training in parenting skills, education about child development and the factors that predispose children to violent behavior, and exercises to help parents develop skills for communicating with their children and for resolving conflict in nonviolent ways. This type of intervention is ideal for families with very young children and for at-risk parents with a child on the way.

2. *Home Visiting Strategy*

Violent and criminal behavior, poor mental health, drug use, and poor school performance have been linked to several childhood risk factors, including child abuse and neglect, poverty, a poor relationship with parent(s), poor physical

and mental health, parental drug or alcohol abuse, and child abuse and neglect. By eliminating these risk factors, we can help reduce the aggressive and violent behaviors we see in our schools and communities.

Home visiting is one effective strategy to address these factors. Home-visiting interventions bring community resources to at risk families in their homes. During home visits, intervention staff provides information, healthcare, psychological support, and other services that participants need to function more effectively as parents. These programs have helped improve maternal health and pregnancy outcomes, increase employment and education among young parents, reduce reliance on welfare, improve children's mental and physical health, reduce childhood injuries, and reduce criminal behavior by young people. This strategy is ideally implemented with families who are expecting or have recently had their first child.

3. *Social Cognitive Strategy*

Researchers have linked a lack of social problem-solving skills to youth violence. When children and adolescents are faced with social situations for which they are unprepared emotionally and cognitively, they may respond with aggression or violence. Many assert that we can improve children's ability to avoid violent situations and solve problems nonviolently by enhancing their social relationships with peers, teaching them how to interpret behavioral cues, and improving their conflict-resolution skills.

Social-cognitive interventions strive to equip children with the skills they need to deal effectively with difficult social situations, such as being teased or being the last one picked to join a team. They build on Bandura's social-cognitive theory, which posits that children learn social skills by observing and interacting with parents, adult relatives and friends, teachers, peers, and others in the environment, including media role models. Social-cognitive interventions incorporate didactic teaching, modeling, and role-playing to enhance positive social interactions, teach nonviolent methods for resolving conflict, and establish or strengthen nonviolent beliefs in young people.

4. *Mentoring Strategy*

Research has shown that the presence of a positive adult role model to supervise and guide a child's behavior is a key protective factor against violence. The absence of such a role model—whether a parent or other individual—has been linked to a child's risk for drug and alcohol use, sexual

promiscuity, aggressive or violent behavior, and inability to maintain stable employment later in life. Mentoring—the pairing of a young person with a volunteer who acts as a supportive, nonjudgmental role model—has been touted by many as an excellent means of providing a child or adolescent with a positive adult influence when such an influence does not otherwise exist. Evidence has shown that mentoring can significantly improve school attendance and performance, reduce violent behavior, decrease the likelihood of drug use, and improve relationships with friends and parents. And the Council on Crime in America identified mentoring as one of three interlocking crime-prevention strategies (the other two—monitoring and ministering—also provide adult contact).

CRIME PREVENTION

Although not specific to homicide, the National Institute of Justice's document *Preventing Crime: What Works, What Doesn't, What's Promising*, identifies a number of areas in which successful intervention have been proven to be successful.²⁹

Communities and Crime Prevention

What's Promising?

1. *Gang violence prevention* focused on reducing gang cohesion, but not increasing it (some anti-gang programs may actually increase group cohesion).
2. *Volunteer mentoring* of 10 to 14 year-olds by Big Brothers/Big Sisters is promising for the reduction of substance abuse, but not delinquency.

What's Doesn't Work?

1. *Community mobilization* against crime in high-crime inner-city poverty areas.
2. *Gun buyback* programs operated without geographic limitations on gun sources.

Family-Based Crime PreventionWhat Works?

1. Long-term frequent home visitation combined with preschool prevents later delinquency.
2. Infant weekly home visitation reduces child abuse and injuries.
3. Family therapy by clinical staff for delinquent and pre-delinquent youth.

What Doesn't Work?

1. Home visits by police after domestic violence incidents fails to reduce repeat violence.

What's Promising?

1. Battered women's shelters for women who take other steps to change their lives.
2. Orders of Protection for battered women.

School-Based Crime PreventionWhat Works?

1. Programs aimed at building school capacity to initiate and sustain innovation.
2. Programs aimed at clarifying and communicating norms about behaviors by establishing school rules, improving the consistency of their enforcement (particularly when they emphasize positive reinforcement of appropriate behavior), or communicating norms through school-wide campaigns (e.g., anti-bullying campaigns) or ceremonies.
3. Comprehensive instructional programs that focus on a range of social competency skills (e.g, developing self-control, stress-management, responsible decision-making, social problem-solving, and communication skills) and that are delivered over a long period of time to continually reinforce skills.

Substance use:

1. Programs aimed at clarifying and communicating norms about behaviors.
2. Comprehensive instructional programs that focus on a range of social competency skills (e.g, developing self-control, stress-management, responsible decision-making, social problem-solving, and communication skills) and that are delivered over a long period of time to continually reinforce skills.
3. Behavior modification programs and programs that teach "thinking skills" to high-risk youth.

What Does Not Work?

1. Counseling students, particularly in a peer-group context, does not reduce delinquency or substance use.
2. Offering youths alternative activities such as recreation and community service activities in the absence of more potent prevention programming does not reduce substance use. This conclusion is based on reviews of broadly-defined alternative activities in school- and community settings. Effects of these programs on other forms of delinquency are not known.
3. Instructional programs focusing on information dissemination, fear arousal, moral appeal, and affective education are ineffective for reducing substance use.

*What is Promising?**Crime and delinquency:*

1. Programs that group youth into smaller "schools-within-schools" to create smaller units, more supportive interactions, or greater flexibility in instruction.
2. Behavior modification programs and programs that teach "thinking skills" to high-risk youth.

Substance use:

1. Programs aimed at building school capacity to initiate and sustain innovation.
2. Programs that group youths into smaller "schools-within-schools" to create smaller units, more supportive interactions, or greater flexibility in instruction.

3. Programs that improve classroom management and that use effective instructional techniques.

Labor Markets and Crime Risk Factors

What Works?

1. Short-term vocational training programs for older male ex-offenders no longer involved in the criminal justice system.

What Does Not Work?

1. Summer job or subsidized work programs for at-risk youth.
2. Short-term, non-residential training programs for at-risk youth.
3. Pre-trial diversions for adult offenders that make employment training a condition of case dismissal.

What is Promising?

1. Intensive, residential training programs for at-risk youth (Job Corps).
2. Prison-based vocational education programs for adults.
3. Housing dispersion programs.
4. Enterprise Zones.

What Do We Not Know Enough About?

1. Community Justice System-based programs for juvenile offenders.
2. Post-release transitional assistance for offenders.
3. Reverse commuting.
4. Wage subsidies.
5. Bonding programs.
6. Community development as done through the Community Development Block Grant Program.
7. School-to-Work programs funded by the School-to-Work Opportunities Act.

Policing for Crime Prevention

What Works?

1. Increased directed patrols in street-corner hot spots of crime.
2. Proactive arrests of serious repeat offenders.
3. Proactive drunk driving arrests.
4. Arrests of employed suspects for domestic assault.

What Doesn't Work?

1. Neighborhood block watch.
2. Arrests of some juveniles for minor offenses.
3. Arrests of unemployed suspects for domestic assault.
4. Drug market arrests.
5. Community policing with no clear crime-risk factor focus.

What's Promising?

1. Police traffic enforcement patrols against illegally carried handguns.
2. Community policing with community participation in priority setting.
3. Community policing focused on improving police legitimacy.
4. Zero tolerance of disorder, if legitimacy issues can be addressed.
5. Problem-oriented policing generally.
6. Adding extra police to cities, regardless of assignments.
7. Warrants for arrest of suspect absent when police respond to domestic violence.

ENVIRONMENTAL QUALITY

Objective 8-1: Reduce the proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health-based standards for ozone.

Objective 8-2: Reduce the proportion of non-smokers exposed to environmental tobacco smoke.

Objective 8-3: Eliminate elevated blood lead levels in children.

Objective 8-4: Increase the proportion of persons served by community water systems who receive a supply of drinking water that meets the regulations of the Safe Drinking Water Act.

Objective 8-5: Increase the proportion of persons who live in homes tested for Radon concentrations.

Objective 8-6: Reduce infections caused by key foodborne pathogens.

SUMMARY

Recommended interventions to meet the Environmental Quality objectives focus on six distinct areas: Ozone levels in outdoor air, reductions in lead exposure, decreased exposure to environmental tobacco smoke (also discussed in LHI 3), providing safe drinking water, encouraging radon testing, and reducing foodborne diseases.

Strategies to improve **air quality** include 1) Source reduction; 2) Cleaner electric generation at utilities and other sources; 3) Increased energy efficiency; 4) Reduced emissions; and 5) Public education to help people reduce their exposure to dangerous ozone levels in outdoor air. Strategies to address the issue of **lead exposure** focus on two key areas: 1) Improved screening and follow up by health care providers and health insurance systems, and 2) Governmental efforts to use code enforcement and other legal avenues to require abatement of lead in housing units.

Safe drinking water interventions involve state development of a Source Water Assessment Program, described by the 1996 amendments to the federal Safe Drinking Water Act. The EPA's suggested **radon strategy** includes adoption of a "risk trading" method that encourages states to develop a Multimedia Mitigation (MMM) program. The MMM approach focuses on "trading" higher allowable concentrations of radon in public drinking water systems for more

intensive efforts in statewide radon testing and mitigation of existing buildings and encouragement of radon-resistant construction techniques.

Interventions to reduce the incidence of **foodborne diseases** include improving regulatory program effectiveness, coordinating food safety with federal, state, and public health entities, and improving public education efforts.

SPECIFIC INTERVENTIONS

Air Quality Standards: Ozone

While the EPA has set air quality standards related to ozone, it has not developed a generic evidence-based strategy guide or best practices guide for communities to follow. Instead, it requires each state to develop a detailed plan to address its own air quality issues (Rhode Island's plan is available at www.state.ri.us/dem/programs/benviron/air/pdf/o3attain.pdf). In looking at the issue generally, there are two primary approaches: reducing sources of emissions and educating the public about ways to reduce their exposure.

1. *Source Reduction*

In 1999, the State and Territorial Air Pollution Program Administrators (STAPPA) Association of Local Air Pollution Control Officials (ALAPCO) suggested a “harmonized” approach to source reductions that include interventions that could “simultaneously reduce emissions of both GHGs (green house gases) and criteria pollutants, such as ozone” to achieve better results than addressing compartmentalized approaches to individual pollutants.³⁰ The suggested interventions included:

2. *Cleaner Electric Generation at Utilities*

- A. *Gas-Fired Capacity Converted to (or Displaced by) Gas Combined-Cycle:* This strategy assumes that a percentage of the electric generating capacity fueled by natural gas in the area is converted to combined-cycle generation to increase efficiency, or is displaced by newly constructed gas combined-cycle capacity. Output-based emission rates decrease as a result of increased plant efficiency, yielding lower emissions for the same output.
- B. *Fuel Switch to Natural Gas:* This strategy is a simple fuel switch of oil or coal-fired capacity to natural gas, which generally allows for summer

combustion of natural gas and winter combustion of fuel oil and coal. This is consistent with ozone control strategies where sources may choose to switch to natural gas during the summer season to comply with more stringent emission rates. Retaining dual-fuel capability is also a strategy for obtaining more favorable gas prices during the summer months when gas supply is plentiful and demand is low.

- C. *Coal Displaced by Natural Gas Combined-Cycle*: This strategy assumes that new natural gas combined-cycle plant construction will displace existing conventional coal generation in the restructured electricity markets. Small combined cycle and combined-cycle cogeneration facilities are assumed to penetrate the market.

3. Cleaner Electric Generation Sources

- A. *Renewables*: A combination of biomass, solar, hydro and wind power generation is assumed to displace a percentage of the power generation.
- B. *Fuel Cells*: Fuel cell power generation is assumed to penetrate niche markets where it is economical. In addition to commercial-sized fuel cells, residential-sized fuel cells are also anticipated to enter the market within the next three to five years. Existing generation will be displaced.

4. Increased Energy Efficiency

- A. *Reduced Residential Energy Demand*: A reduction of residential energy demand is assumed for each area. These reductions are primarily achieved as a result of improved water heater designs and reduced hot water consumption (e.g., low volume shower heads, more efficient home heating systems and better insulated homes and windows).
- B. *Reduced Commercial and Residential Electricity Demand*: Implementation of improved lighting, electric motor efficiency, variable frequency drives and building efficiency strategies are assumed to reduce residential and commercial electricity demand by a given amount for each area.

5. Transportation

- A. *Light-Duty Gasoline Vehicle Reduction Strategies Other Than Efficiency Emission*: Emission reductions are applied to the entire light-duty gasoline vehicle inventory for each area. Light-duty gasoline vehicle use is assumed to decrease by a given amount through increases in a combination of strategies, such as mass transit use, carpools,

telecommuting, the use of alternative lower carbon fuel and advanced technology vehicles and urban sprawl initiatives.

- B. *Improved Light-Duty Vehicle Fuel Economy*: Improved average annual light-duty vehicle fuel economy is modeled to reflect assumptions for the area. This per-year improvement is based on either incremental increases in vehicle fuel economy as a result of Corporate Average Fuel Economy (CAFE) requirements, or moderate penetration of high efficiency automobiles from the Partnership for a New Generation of Vehicles (PNGV) which would raise the annual average fuel economy by the percentage predicted. It should be noted that this would occur notwithstanding the growing popularity of sport utility vehicles, which is steadily decreasing the average fuel economy of the urban fleets.

6. Industrial

- A. *Reduced Industrial Process Emissions*: For each area, industrial process emissions are assumed to be reduced by a given percent. These reductions could be achieved via a combination of fuel switching, updating of process methods and revised product compositions (e.g., blended cement) that would, in combination, reduce the overall process emissions.
- B. *Increased Industrial Cogeneration*: For the industrial sector, a given level of heating is predicted to be displaced by electric generating station cogeneration of power and heat. Potential cogeneration energy available was determined based on the current electric generation in the region. Cogeneration was assumed to achieve a specified level of availability.

7. Public Education

The EPA's Office of Air Quality Planning and Standards' web site (www.epa.gov/air/oaqps/publicat.html) contains a number of public information brochures, including:

- Air Quality Guide for Ozone – 1999
- Air Quality Index - A Guide to Air Quality and Your Health – 2000
- Air Pollution Operating Permit Update, Key Features and Benefits - 1998
- Evaluating Exposures to Toxic Air Pollutants: A Citizen's Guide – 1991
- Haze - How Air Pollution Affects the View – 1999
- Ozone - Good Up High Bad Nearby - 1997
- Ozone and Your Health – 1999
- The Plain English Guide to the Clean Air Act – 1993

- Regional Approaches to Improving Air Quality - 1997
- Regional Haze and Visibility Protection: Clearing the Air and Improving the View – 1999
- Regulating Smog and Particle Air Pollution: An Integrated Approach – 1997
- Risk Assessment for Toxic Air Pollutants: A Citizen's Guide – 1991
- Smog - Who Does it Hurt? – 1999
- Taking Toxics Out of the Air -- Progress in Setting "Maximum Achievable Control Technology" Standards Under the Clean Air Act - 2000

The American Lung Association web site (www.lungusa.com) also contains a searchable database by zip code of the quality of air in a specific part of the country, rating the area's ozone grade, weighted average, and Orange, Red and Purple Ozone days per year.

Lead Exposure

The American Academy of Pediatrics recommends the following strategies to pediatricians and government to reduce lead exposure in children.³¹

Pediatricians

Pediatricians should provide anticipatory guidance to parents of all infants and toddlers. This includes information on potential risk factors for lead exposure and specific prevention strategies that should be tailored for the family and for the community in which care is provided. Pediatricians, in conjunction with local health agencies, should help develop risk assessment questionnaires that supplement the standard questions recommended by the CDC.

Pediatricians should screen children at risk. To prevent lead poisoning, lead screening should begin at 9 to 12 months of age and be considered again at ~24 months of age when BLLs peak. The CDC developed explicit guidance to state health departments for developing community screening policies. In communities where universal screening is recommended, pediatricians should follow this recommendation. In communities where targeted screening is recommended, pediatricians should determine whether each young patient is at risk and screen when necessary. Managed health care organizations and third-party payors should cover fully the costs of screening and follow-up. A history of possible lead exposure should be assessed periodically between 6 months and 6 years of age, using community-specific risk-assessment

questions. Blood lead testing also should be considered in abused or neglected children and in children who have conditions associated with increased lead exposure.

Pediatricians individually and through AAP chapters should be actively involved and provide input in state and local community recommendation development.

Government

1. Testing and treating children for lead exposure must be coupled with public health programs to ensure environmental investigation, transitional lead-safe housing assistance, and follow-up for individual cases. Lead screening programs in high-risk areas should be integrated with other housing and public health activities.
2. The AAP supports efforts of environmental and housing agencies to eliminate lead hazards from housing and other areas where children may be exposed. These include financial incentives that can be used to promote environmental abatement. Training and certification of abatement workers are needed to avoid additional lead exposure during deleading activities. Local health authorities should provide oversight of abatement activities to ensure that additional environmental contamination does not occur. Also, less expensive, safe technologies for abatement are needed to make primary prevention efforts more cost-effective.
3. The AAP supports legislation to reduce the entry of lead into the environment and into consumer products with which children may come in contact.
4. Government, like the medical community, should focus its efforts on the children who are most at risk. To do this, more data about the prevalence of elevated BLLs in specific communities are needed. A better understanding of the distribution of lead in the environment would allow more efficient screening efforts.
5. Research is needed to determine the effectiveness of various strategies to prevent and treat lead poisoning, to compare methods for abating lead in households, and to determine the effectiveness of chelating agents with long-term follow-up through controlled trials. Studies to determine the effectiveness and cost of educational interventions also are needed.
6. The CDC should review studies of the efficacy of lead screening and monitor the scientific literature to ensure that screening is being performed in the most public health-protective, least intrusive, and most cost-effective manner possible. In particular, the risk-assessment questions, follow-up

recommendations, and models of case management need periodic reevaluation.

7. Federal and state government agencies and legislative bodies should require coverage of lead testing for at-risk children by all third-party payors, by statute or by regulation.

Alliance to End Lead Poisoning

The Alliance for Healthy Homes (previously the Alliance to End Lead Poisoning) has identified best practices towards reducing exposure through code enforcement and housing programs. In *Ten Effective Strategies for Preventing Childhood Lead Poisoning Through Code Enforcement*, the Alliance recommends the following interventions:³²

1. Require owners to secure a license for rental property.
2. Conduct routine, periodic inspections.
3. Enforce chipping and peeling paint violations.
4. Include lead-based paint and dust hazards as prosecutable offenses in housing codes.
5. Train and require code enforcers to conduct visual inspections for potential lead hazards in all pre-1978 housing and, where appropriate, sample household dust.
6. Ban unsafe work practices, and require property owners to conduct repair work in a lead-safe manner and to undergo post-work clearance testing to ensure the absence of hazards.
7. Develop self-sustaining, effective enforcement programs.
8. Target intensive enforcement efforts to high-risk units and neighborhoods and to recalcitrant landlords.
9. Use lead hazard data gathered by code enforcers to prevent lead poisoning and neighborhood decay.
10. Collaborate with agencies working on environmental health and housing issues.

The Alliance has also identified 18 *Innovative Strategies for Addressing Lead Hazards in Distressed and Marginal Housing*, which include:³³

1. *Integrating Lead-Safety into Rental Property Maintenance*

Vermont Essential Maintenance Practices: Vermont law requires owners of rental property and child care facilities built before 1978 to alert

tenants/occupants of potential lead hazards and reduce lead hazards through building maintenance. Owners must: provide written material on preventing lead poisoning to tenants; perform a set of Essential Maintenance Practices (EMPs) designed to reduce a child's exposure to lead paint and dust hazards; ensure that any individual undertaking EMPs attend a three-hour training class or be supervised by a trained individual; and file an affidavit of performance with the state Health Department and their insurance carrier.

2. Prohibiting Unsafe Work Practices

New Orleans' Lead Paint Poisoning Prevention and Control Act: Recently passed legislation in New Orleans is helping to prevent exposure to lead hazards by prohibiting unsafe practices during work on metal structures and buildings constructed prior to 1978. The law contains notification requirements which have served not only to inform tenants, neighbors, workers and governmental agencies that work on leaded surfaces will take place, but also have increased citizen awareness of the problem of childhood lead poisoning. In addition, the law prohibits landlords from retaliating against tenants who complain about violations.

3. Low Cost Hazard Control

The St. Paul, Minnesota Weatherization Program: The St. Paul Health Department supplements weatherization activities in pre-1978 housing with a child under age six to include targeted lead hazard control activities. Window wells are capped and a thorough cleaning of window sills and floors is completed using a wet wash and HEPA vacuum. Pre- and post-intervention dust samples are collected to document the decline in lead-contaminated dust and to verify that the unit meets dust clearance standards.

4. Building Broad-Based Coalitions

Campaign to Enact Milwaukee's Lead Poisoning Prevention Ordinance: Wisconsin Citizen Action (WCA) led a 20-month campaign which mobilized parents of lead-poisoned children and a broad range of community organizations to build public and political support for a new lead poisoning prevention ordinance. The campaign succeeded in getting a law passed establishing a three-year pilot project that requires all pre-1950 rental units in two high-risk neighborhoods to meet mandatory lead safety standards.

5. Targeting High-Risk Neighborhoods

The Milwaukee, Wisconsin Pilot Project for Lead-Based Paint Hazard Control in Residential Rental Properties: The City of Milwaukee has enacted an ordinance establishing a three-year, proactive pilot project to prevent childhood lead poisoning and maintain the stock of affordable housing. The project targets approximately 800 units in two areas of the city found to pose the greatest threat of lead-based paint hazards with multiple strategies: landlord outreach and education; code enforcement; subsidies for lead hazard control; and a community registry for lead-safe housing.

6. Low-Cost Window Abatements

The Milwaukee, WI Window Specification: Following a multi-year evaluation of various techniques for treating windows painted with lead-based paint, the Milwaukee Health Department (MHD) developed an efficient and effective specification for abating windows. The specification is mandatory in areas of the City subject to a recently enacted lead poisoning prevention pilot project (See Best Practice #5) and in residences housing children with elevated blood lead levels.

7. Leveraging Lead Poisoning Prevention Resources

Local Agencies, Community-Based Organizations and the Private Sector Collaborate in San Francisco: San Francisco law provides for numerous governmental agencies, community-based organizations, and the private sector to play a role in the fight against childhood lead poisoning. As a result, the city has greatly expanded its ability to inform homeowners, landlords, tenants, parents of young children, painters and construction contractors about the disease and how to avoid it.

8. Early Warning Systems for Deteriorating Properties

Neighborhood Knowledge Los Angeles Neighborhood Knowledge: Los Angeles (NKLA) (www.nkla.ucla.edu/) is a web site dedicated to preventing housing and neighborhood deterioration by tracking multiple data points for properties throughout the city and making the information publicly available. The web site concentrates on the types of information that indicate properties in danger of decline, such as code complaints, contract nuisance abatements (city sponsored repairs to address public safety hazards), tax delinquencies, and utility liens.

9. Enforcing Housing Standards

The Los Angeles County Systematic Code Enforcement Program: This program is designed to ensure that tenants have a safe and habitable place to live by improving the condition of distressed housing and preventing marginal housing from becoming distressed. Under this program, all rental housing containing two or more units in the City of Los Angeles is routinely inspected.

10. A New Code for Old Building

New Jersey's Rehabilitation Subcode: New Jersey's Rehabilitation Subcode provides predictable standards governing rehabilitation work in existing structures. The Subcode has eliminated the uncertainty and high costs brought about when code standards for new construction are applied to rehabilitation projects, and has increased significantly rehabilitation work in the state's urban areas. The Subcode helps to reduce lead hazards in two ways: first, by encouraging renovation of existing structures; and second, by prohibiting unsafe work practices during work performed under the code.

11. A Community-Based Initiative to Address Environmental

Health Problems in Housing: The Los Angeles Healthy Homes Pilot Project Collaboration. The LA Healthy Homes Pilot Project is a community-based, collaborative effort to identify and address housing conditions related to children's environmental health, including lead poisoning, asthma, allergies, and cockroach infestation, as well as the conditions of poverty that perpetuate these problematic conditions in the Maple-Adams and Hoover-Adams communities of LA. The project has six main components: 1) training and hiring low-income community residents; 2) conducting door-to-door health surveys, education, and visual inspections; 3) screening children for lead; 4) organizing tenants; 5) reducing environmental hazards in housing; and 6) organizing and advocacy to establish new city policies for prevention via housing code enforcement.

12. Holding Property Owners Accountable

New Jersey Multiple Dwelling Registration and Inspection Program: Identifying and locating owners of poorly maintained multi-family dwellings in some cases can prove difficult and burdensome for governmental authorities as well as tenants. New Jersey has sought to facilitate the identification of owners and

maintenance of its housing stock by requiring that multiple dwellings be registered and periodically inspected.

13. *Saving Properties from Deterioration and Condemnation*

Minnesota's Tenant Remedies Act: Minnesota's Tenant Remedies Act (TRA) enables tenants or community groups on their behalf to improve substandard housing conditions. Tenants or their advocates can request a building inspection and, if code violations are not corrected within the time allotted, seek relief in court. The TRA has been used by community groups to save hundreds of housing units from deterioration or condemnation.

14. *Leveraging Medicaid Resources for Prevention*

Rhode Island's Window Replacement Program The Rhode Island Window Replacement Program was designed to address the most common lead hazard – badly deteriorated old windows – in units repeatedly exposing children to dangerous levels of lead. Under this program, window replacement is a Medicaid-reimbursable service in units where poisoned children have been identified. The program not only protects already-poisoned children from further exposure, but prevents the poisoning of siblings and future occupants.

15. *Financial Incentives: Massachusetts Income Tax Credit*

Any Massachusetts resident who has an income tax liability and controls lead-based paint hazards in a housing unit can qualify for a credit toward the state's personal income tax which is equal to the amount spent, up to \$1500 for complete removal of paint or up to \$500 for controlling lead hazards.

16. *Purchase of Real Estate for Public Benefit*

Land Trust, New York City: The tax credit program provides a monetary incentive to control lead hazards. This project was undertaken in response to the recognized social value of community gardens in New York City. Users and supporters of the gardens mobilized to preserve them, and as a result individuals and private foundations donated \$4.2 million to the Trust for Public Land and the New York Restoration Project to purchase 114 lots for use in perpetuity as community gardens.

17. Unconventional Funding Sources

The Portland, Oregon Water Bureau Lead Hazard Reduction Program Lead levels in Portland's drinking water periodically exceeded EPA standards due to the relatively soft water causing corrosion in the lead solder in the water supply system. In recognition of the fact that lead-based paint hazards in low-income housing pose a far greater risk than lead in water, and in response to environmentalist's resistance to changing the drinking water's pH level, the Portland Water Authority responded by funding lead hazard control in housing units occupied by low-income families. Even though the water authority subsequently met drinking water standards, it continued to provide funds for lead hazard control in high-risk housing.

18. Training and Employing Low-Income Community Residents in Hazard Control

The Manchester, New Hampshire "Healthy Home Services" Healthy Home Services (HHS) is a program of The Way Home (TWH), a non-profit tenant rights and social services agency based in Manchester, NH. The program trains and employs low-income community residents, including some parents of lead-poisoned children and children at high risk, to provide environmental health services to their communities. These services primarily consist of: low-cost hazard control; cleaning; peer education; and the provision of products that reduce environmental health hazards. Some of these services are provided free-of-charge to tenants, while others are offered for a fee to rental property owners.

Rhode Island Lead Screening

The Assistant Secretary for Health of the U.S. Department of Health and Human Services' Best Practice Initiative identified Improved Childhood Blood Lead Screening in Rhode Island as a "Best Practice in Health," identifying the following "core components:"³⁴

1. On a quarterly basis, children enrolled in participating MCOs (managed care organizations) who are 24 to 26 months of age and have no claim records for a lead screening are identified.
2. The list of children without a screening claim is provided to the Department of Health and electronically matched against its lead poisoning surveillance database. A list of children who also have no screening record in the

surveillance database is returned to the MCO. The MCO then contacts each child's primary care provider and asks if the child has been screened, if the office will follow-up, or if additional interventions are needed.

3. When the children are 28 to 30 months of age, a final data comparison is made to identify all additional children that have been screened as a result of this intervention.

The Lead Program provides technical assistance in the form of project oversight, data management and analysis, and report generation. MCOs receive lists of unscreened children, perform a comparison against their records, forward the information to primary care providers for assessment and intervention, and report outcomes to the Lead Program.

Access to Clean Drinking Water

In *State Source Water Assessment and Protection Programs Guidance*, the EPA identified two overarching objectives for states in implementing the Amendments to the Clean Drinking Water Act:³⁵

1. A clear state lead, with flexibility and resources to achieve results. This is necessary because prevention is ultimately about land use and water quality management, which generally are exercised at the state and local levels.
2. A strong ethic of public information and involvement within the states' decision-making processes.

In order to help the states meet these objectives, EPA committed itself to take the following steps:

1. Ensure that each state sets aside and uses the amount of funding from the DWSRF necessary to do a solid job on the assessments.
2. Stretch the assessment dollars by working to get the strong involvement of all appropriate participants and contributors.
3. Encourage networks for exchange of information about models for assessments that have worked for states, communities, and water suppliers in other areas.
4. Identify and help use other applicable information that can contribute to or serve for the assessments, as the law provides.

The New England Interstate Water Pollution Control Commission (NEIWPCC) in its publication, *Source Protection: A National Guidance Manual for Surface Water Supplies*, notes that the 1996 Safe Drinking Water Act (SDWA) amendments require each state to develop a Source Water Assessment Program (SWAP), which:

1. Delineate protection areas for all public drinking water sources
2. Inventory existing and potential sources of contamination
3. Determine the susceptibility of each public water source to contamination from inventoried threats
4. Communicate results to the public.³⁶

In *Source Water Protection: Plain and Simple*, published by the International City/County Management Association (adapted from The National Center for Small Communities' publication *A Small Town Source Water Primer*), suggested two additional steps:³⁷

1. Implementing measures to manage the identified sources; and
2. Establishing a contingency plan for responding to contamination incidents and planning for the future.

The report also suggest steps that local governments can take to improve source water protection, including:

1. Zoning and other land use controls;
2. Point source pollution restrictions, requirements or controls for fixed sources, such as waste processing plants;
3. Health regulations (including sanitary setbacks for septic tanks or sewer lines from drinking water wells);
4. Land acquisition authority that provides protective zones around water sources;
5. Best management practices (ensuring that municipal operations, for example, do not impact drinking water supplies through such activities as pesticide application, dispensing fuel, etc.); and
6. Public education and outreach campaigns.

The NEIWPCC report suggests that communities can implement source protection plans by implementing the following five steps:

1. Organize a Community Planning Team
2. Delineate Your Watershed
3. Inventory and Prioritize Threats
4. Prepare Source Protection Plan

5. Implement the Plan and Educate

Radon

In its 1999 proposed “National Primary Drinking Water Regulations,” the EPA identified four “key priority areas for indoor radon.³⁷”

1. Targeting Efforts on the Greatest Risks First
2. Promote Radon-Resistant New Construction
3. Promote Testing and Mitigation During Real Estate Transactions
4. Promote Individual and Institutional Change through Public Information and Outreach Programs

The draft regulations (which have not yet been adopted) involve a “risk trading” strategy included in the 1996 amendments to the Safe Drinking Water Act. States that choose to adopt the Multimedia* Mitigation (MMM) approach, which the EPA sees as “the most cost-effective way to achieve the greatest radon risk reduction,” need to develop a comprehensive plan to address levels of radon in indoor air in their jurisdictions. In exchange, local water systems can focus their radon reduction efforts on meeting the lower standard of 4,000 pCi/L, rather than the higher requirement of 300 pCi/L (local water systems in states not using an MMM approach can also develop their own MMM plans to allow them to meet the lower, 4,000 pCi/L standard).

To be approved by EPA, MMM plans need to meet the following four criteria:

1. Public participation,
2. Setting quantitative goals,
3. Strategies for achieving goals, and
4. Plan to track and report results.

Rhode Island’s 2003-2004 State Indoor Radon Grant (SIRG) Work Plan submitted to the EPA includes the following goals:³⁸

1. Encouraging Radon Resistant Construction in new Homes.
2. Getting Quality Disclosure, Testing, and Mitigation in Conjunction with Transfers of Real Estate.
3. Building & Sustaining Coalitions of Local governments and Other Partners.
4. Setting Results Goals for Radon Testing, Mitigation and New Construction.

* Multimedia refers to looking at both air and water

5. Having Schools Tested and, Where Necessary, Mitigated for Radon.
6. Other Goals:
 - A. Maintenance of the state Radon databases for all reported Radon in air measurements, inclusive of residential and public & high priority buildings.
 - B. With the adoption of the CABO, Appendix F building codes, a mechanism, contingent on available funds, will need to be developed to provide an effective mechanism to track the number of Radon resistant homes constructed.*
 - C. Attendance at the New England Radon Committee Meetings, the EPA All States Conference, and other informative meetings.
 - D. Additional mechanisms to provide more visibility, and improving cooperation with other agencies is realized through an active involvement of members of the Radon Program on committees or working directly with other state agencies.
 - E. A member of the Radon staff is currently a member of HEALTH internal Minority Health Coordinating Committee. In addition, HEALTH will be working closely with the RI Department of Children, Youth & Families, to have Radon tests taken in home day cares that serve five or more children.
7. Multi-Media Mitigation Plans.
8. Quality Assurance Project Plan.

*Later, the document notes that “efforts to persuade the State Building Code Commission to adopt the Council of American Building Officials Appendix F,” have not yet been successful.

Food Safety

Because the risk of food contamination can occur at a number of different levels and because different types of foods require different protection measures, responsibility for preventing infections caused by foodborne pathogens spans a myriad of different federal, state, and local agencies. As a result, no single document or series of documents describes best practices for states to implement the Healthy People 2010 objectives, other than established regulations such as the FDA's Food Code or the USDA's HACCP (Hazard Analysis and Critical Control Points System).

In its recent publication, *Goals for Enhancing Public Health: Strategies for the Future 2003 FSIS Food Safety Vision*, the Food Safety and Inspection Service of the United States Department of Agriculture identified the following five key goals:³⁹

1. Improve the management and effectiveness of regulatory programs.
2. Ensure that policy decisions are based on science.
3. Improve coordination of food safety activities with other public health agencies.
4. Enhance public education efforts.
5. Protect meat, poultry, and egg products against intentional contamination.

IMMUNIZATION

Objective 9-1: Increase the proportion of young children who receive all vaccines that have been recommended for universal administration for at least 5 years.

Objective 9-2: Increase the proportion of adults aged 65 and older who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease.

SUMMARY

Recommended interventions to meet the Immunization objectives focus on three key areas: 1) Improve providers' and health care systems' ability to record, track, and promote appropriate vaccinations; 2) Educate the public about the importance of vaccinations; and 3) Improve access to vaccines for people at risk of not being immunized.

SPECIFIC INTERVENTIONS

The Community Guide reviewed the following interventions for "Increasing Community Demand for Vaccinations:"⁴⁰

Strongly Recommended Strategies

1. Client reminder/recall systems

Involves reminding members of a target population that vaccinations are due (reminders) or late (recall). Delivery techniques include telephone calls, letters, or postcards. Messages may be specific or general.

2. Multicomponent interventions + education

Target populations receive education about vaccinations through mailings, newspaper, media and other public sources. In some instances, vaccine providers also receive education. In addition to education, other intervention components include provider reminders, expanded hours or access, client

reminders, reduced out-of-pocket costs for clients, client-held vaccination records, WIC interventions, psychosocial assessments, nutrition services, or home visits. Multicomponent interventions that include education increase community awareness of the availability, usefulness, and relevance of vaccination services, as well as provide the information necessary to use these services.

3. Reducing out-of-pocket costs

Reducing out-of-pocket costs for vaccinations can be accomplished by providing free vaccinations, reducing administrative costs associated with vaccines, providing insurance coverage, or reducing co-payments for vaccinations at the point of service.

4. Multicomponent intervention to expand access

Expanded access makes medical or public health clinical settings in which vaccinations are offered more readily available to patients by decreasing the distance between the setting and the population, increasing the hours during which vaccination services are provided, delivering vaccinations where they were not previously provided (e.g., emergency departments, inpatient units, or sub-specialty clinics), or reducing administrative barriers to obtaining vaccination services within clinics (e.g., developing a “drop-in” clinic or an “express lane” vaccination service). Efforts found in multicomponent programs typically include reminding patients that it’s time to be vaccinated (“client reminder/recall”). They can also include provider education, clinic-based education, reducing costs, standing orders that allow healthcare professionals who are not doctors to deliver vaccinations without a doctor’s order, community-wide education, client incentives, WIC interventions, home visiting, and provider assessment and feedback.

5. Provider reminder/recall systems

Informs those who prescribe or administer vaccinations when individual clients are due (reminder) or overdue (recall) for specific vaccinations. Content and methods used to deliver the reminders vary. These can include client flagging charts and reminder by computer or by mail.

6. Assessment & feedback for providers

Involves retrospectively evaluating the performance of providers in delivering one or more vaccinations to a client population and giving this information to the providers. Can involve other activities, such as incentives or benchmarking.

7. Standing orders – adults

Standing orders involve programs in which non-physician medical personnel prescribe or deliver vaccinations to clients without direct physician involvement at the time of the visit. These programs are carried out in clinics, hospitals, and nursing homes.

Recommended Strategies (Sufficient Evidence)

1. Requirements for child care or school attendance

2. Programs in women, infants, & children (WIC) settings

Identifies at-risk, low-income children in non-medical settings. At a minimum, requires assessment of each child's immunization status and referral of under-immunized children to a health provider. Can also include education, provision of vaccinations, and incentives to receive vaccinations.

3. Home visits

Provide face-to-face services to clients in their homes. Services can include education, assessment of need for vaccinations, referral for vaccinations, or giving vaccinations. Clients often receive telephone or mail reminders with specific or general messages.

Strategies with Insufficient Evidence to Determine Effectiveness

1. Community-wide education only
2. Clinic-based education only
3. Client or family incentives
4. Client-held medical records
5. Expanding access only

6. Program in schools
7. Programs in child care centers
8. Standing orders – children
9. Provider education only

Rhode Island is currently using two other best practices in the area of immunization:

1. *The AFFIX approach*: Assessment of the immunization coverage of public and private providers; Feedback of diagnostic information to improve service delivery; Incentives (or recognition) for improved performance; and exchange of information among providers (see www.cdc.gov/nip/publications/pink/default.htm).
2. *Immunization Registries* (see www.cdc.gov/mmwr/preview/mmwrhtml/rr5017a1.htm)

ACCESS TO HEALTH CARE

Objective 10-1: Increase the proportion of persons with health insurance.

Objective 10-2: Increase the proportion of persons who have a specific source of ongoing care.

Objective 10-3: Increase the proportion of pregnant women who receive early and adequate prenatal care.

SUMMARY

Recommended interventions to meet the Access to Health Care objectives focus on four key areas: 1) Improve coverage of the uninsured by expanding public programs; 2) Develop policies to encourage more people to use employer-based insurance; 3) Improve access to care by increasing the number of providers available in underserved areas, and 4) Loosen income and other eligibility requirements that limit access to prenatal care.

SPECIFIC INTERVENTIONS

Because the issue of Access to Health Care spans a number of different areas, there is no one document that identifies evidence-based strategies or best practices. Additionally, since many states are struggling to maintain existing coverage given current economic conditions, many recent publications focus more on ways to prevent rollback of existing benefits rather than looking at a comprehensive plan to improve access to health care.

HEALTH INSURANCE

In its January 2003 report, “Small But Significant Steps to Help the Uninsured,” the Commonwealth Fund recommended the following steps for specific populations:⁴¹

1. Workers Changing Jobs

- A. Extending COBRA continuation coverage to all workers who need it.
- B. Adding health insurance assistance to unemployment insurance.

2. Workers in small businesses

- A. Testing a Federal Employees Health Benefits Program buy-in through a demonstration.
- B. Testing an individual insurance tax credit through a demonstration.

3. Low-Income People

- A. Gradually phasing in public coverage of poor adults.

4. Young adults aging out of Children's Health Coverage

- A. Extending private plans' dependent coverage up to age 21.
- B. Extending Medicaid/CHIP options up to age 21.

5. Older Adults Losing Access to Job-Based Coverage

- A. Extending COBRA continuation coverage for early retirees.
- B. Creating a Medicare buy-in for younger spouses of Medicare beneficiaries.

6. People with Health Problems Facing Limited Access to Private Coverage

- A. Allowing Medicaid to act as a high-risk pool.
- B. Gradually phasing out Medicare's 24-month waiting period.

7. Insured People at Risk of Becoming Underinsured

- A. Creating a national health coverage advisory commission.

Employer-Based Coverage

In *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs*, an Economic and Social Research Institute report made the following recommendations⁴²:

- 1. Policymakers must reduce access barriers facing both employers and employees for maximum effect.

2. Planners must define the target population, design the program to fit its specific needs and characteristics, and learn how to direct outreach and marketing to best reach it.
3. Spreading risk and addressing adverse selection are critical to prevent the programs from spiraling into a high-risk pool and to retain private health plan participation.
4. There is a need for a stable and sufficient funding source.
5. Program designers must weigh the pros and cons of crowd-out in determining whether to include a look-back period in their eligibility criteria.
6. Community-based public-private partnerships or private initiatives, state-only, and state-federal approaches all present tradeoffs that involve financial resources, independence, and flexibility.
7. Initial and continuing community involvement is critical for local programs.
8. Policymakers should acknowledge that a voluntary program that targets a portion of the working uninsured must be part of a broader, comprehensive approach to expand access.

In *Expanding Health Insurance Coverage: Creative State Solutions for Challenging Times*, The Commonwealth Fund detailed lessons learned from expansion of coverage in states receiving State Planning Grants from the Health Resources Services Administration (HRSA).⁴³ According to the report:

1. State-specific data are essential for identifying gaps in coverage and access, understanding the factors behind those gaps, developing strategies, and securing support for reform.
2. There are opportunities to obtain external funding from public and private sources to support research and policy development.
3. Designing a program for expansion (e.g., building on existing programs versus starting new programs) involves trade-offs concerning fragmentation, administrative complexity, financial stability, and state autonomy. The right balance for each state depends on ideological, historical, financial, and political factors.
4. A common enrollment process and communication among various coverage programs eases transitions and minimizes having people “fall through the cracks.”
5. Successful coverage reform requires political leadership and a clearly defined mission.
6. Partnering with employers to boost coverage is slow and fraught with difficulties, but new models are emerging.

7. Essential ingredients for success are fostering dialogue among stakeholders, obtaining public input, and building broad-based coalitions to work actively for reform.
8. Maintaining or expanding managed care capacity is an ongoing challenge; states may consider supporting a “backup” in the form of a Community Health Center–based safety net health plan.
9. Challenges are involved in minimizing the substitution of private coverage for public coverage. Anti-crowd-out mechanisms such as look-back periods and minimum employer contributions may result in inequities and low participation.
10. There is a need for creative approaches to economic realities, including stretching existing dollars to provide some coverage to the uninsured. Close monitoring and evaluation of these experiments, with a focus on the impact on access to care, is vital.

Given the current difficult economic situation, states are considering policies in the following two areas to address the problem of access to health insurance:

1. Experimenting with public coverage expansions, such as modifying benefit packages and/or increasing cost-sharing for certain populations to allow for coverage of new populations.
2. Expanding coverage through public–private linkages, such as subsidizing employer-sponsored insurance premiums through Medicaid or CHIP to tap federal matching funds and retain employer/employee contributions; using public funds to reinsure private health plans, thereby promoting lower-cost options for businesses and individuals; and allowing employers and workers to buy in to public coverage (potentially under the Health Insurance Flexibility and Accountability initiative).

The report notes critics of the HIFA (Health Insurance Flexibility and Accountability) approach are concerned that:

1. Existing enrollees may lose access to important services if benefits are cut or cost sharing discourages the use of services and reduces take-up rates.
2. HIFA sets a dangerous precedent of allowing states to modify federally mandated benefits.
3. If some people previously enrolled in Medicaid are shifted into private insurance (through HIFA premium assistance programs), they may not only lose certain Medicaid benefits, but they may also lose protections provided by being part of the public system (e.g., appeals procedures).

4. Some cost-sharing measures may result in indirect cost-shifts to certain providers when patients cannot make their co-payments or are not covered for certain necessary services, or when disproportionate share hospital funds are diverted to new coverage.

Published in December 2001, as states' fiscal crises were becoming an issue, but before the extent of the problem was known, *State Planning Grants Program: Synthesis of State Experiences*, written by the Academy of Health Services, looked primarily at the experiences of the 11 initial states that had received funding from HRSA's State Planning Grants (SPG) Program to address the issue of people who were uninsured.⁴⁴ The report identified the following "guiding principles" that a number of states had adopted in their approach to dealing with the problem.

State Capacity

1. Reflect that state governments cannot fully solve the problem of the uninsured; states will require increased federal funding and flexibility to address the uninsured more comprehensively.
2. Be politically acceptable and serve the needs of all citizens, whether currently insured or not.
3. Reflect that even under optimal circumstances, reaching 100 percent coverage in the current system is difficult, if not impossible (some states examined health care systems outside the U. S. to better understand the meaning of 'universal'.)
4. Reflect the economic changes that have occurred during the course of the grant.
5. Reflect that health care should be accessible, affordable, and provided for seamlessly and in cooperation with all stakeholders involved (e.g., providers, employers, public sector, etc.)

Program Features

1. Promote individual responsibility and self-reliance and include prevention and wellness to avert avoidable costs.
2. Be incremental and maintain gains of the past: Build on existing public and private structures but allow for changing existing programs if necessary or appropriate.
3. Be implemented within a short timeline of one to three years.
4. Reduce existing system complexities and encourage cost and quality consciousness.

Building on Private Coverage

1. Maintain employer-based system as the foundation upon which the system is built and build on public-private partnerships where applicable.
2. Target the working uninsured and small employers, where the majority of uninsured are employed.
3. Avoid replacing private coverage with public coverage.

Financing

1. Maximize available state and federal dollars.
2. Produce the highest ratio of people covered per state dollar spent.
3. Be properly financed, including clearly identifying the costs and ensuring long-term solvency.

Target Groups

1. Reflect the needs and characteristics of the different subgroups of uninsured (e.g., Hispanic, black, rural).
2. Address those affected by state policies such as state contracted workers and those who are employed by organizations that are primarily dependent on state funding (e.g., nursing facility employees).
3. Educate consumers, employers and other stakeholders of the health care system and their options within it.
4. Target the most financially needy, particularly those below 200 percent FPL (some states stipulated that many of these individuals would need to be publicly subsidized through existing or new programs).
5. Target the uninsured first and those at risk of becoming uninsured or who are underinsured.
6. Reflect that it is better to cover more people with a scaled-back benefits package than to cover fewer people with a more comprehensive package.

In expanding coverage, the report identified the following possible options that SPG states had taken or were considering:

1. *Improvements in Program Administration and Outreach*

Several states have proposed simplification and improved outreach for existing public programs. Quantitative analysis has been effective in identifying

subpopulations eligible but not enrolled in public programs. States are particularly interested in maximizing federal matching funds.

2. Public Program Eligibility Expansions

Like simplification, expanding eligibility in public programs allows states to build on existing structures and maximize state and federal funding. Several states have proposed expanding eligibility to parents of Medicaid-eligible children through Section 1931. A few states have proposed expanding eligibility in public programs to individuals with higher incomes, although these might be less feasible given current economic circumstances.

3. Supporting Employer-Based Coverage

A number of states are looking at how they can support low-income individuals who have access to employer-based coverage. Data from many states show that subsidizing private coverage has the potential to reach a large number of working uninsured. States primarily are doing so through the Medicaid Health Insurance Premium Payment (HIPP) and SCHIP programs. States also hope to couple these expansions with HIFA flexibility to decrease the cost of providing generous Medicaid and SCHIP benefit packages and being confined by strict cost-sharing rules.

4. Consumer and Employer Education

Several states are pursuing options that improve communication and education about existing options within the private insurance market. States hope to improve knowledge and use of tax credit programs, purchasing pools, and recent regulatory reforms or publish and disseminate information on available carriers and plan rates. Whether educating small employers of their options or individuals of eligibility criteria, states are identifying this as an ongoing need.

5. Pooling/Purchasing Strategies

By aggregating purchasing power to negotiate lower prices with providers and reducing administrative costs through common administrative mechanisms, states hope to increase small group coverage by reducing premiums and/or increasing choice of alternative plans for small groups. States are exploring establishing or enhancing existing purchasing pools or allowing small

businesses and individuals to purchase coverage through state employees' purchasing pools.

6. State Tax Credits

States are exploring the use of tax credits to incentivize the offering or take-up of health insurance. A credit would defray the cost or portion of the cost of premiums paid for individual or group coverage. Combining federal and state tax incentives would make options more affordable.

7. Options that would require reform at the federal level

Massachusetts is exploring complementary tax credits should the federal government implement refundable tax credits for the uninsured. The state is also calling on the federal government to allow deduction of the full cost of health insurance for the self-employed and all individuals and families that lack access to employer-sponsored coverage. Iowa is researching the impact that a federal tax credit would have on uninsured families and on employers not offering coverage. States are also modeling a combined federal credit and Medicaid/SCHIP expansion. New Hampshire and Texas hope to build expansions based on federal tax credits.

8. States are exploring a number of ideas that combine strategies previously tried or establish new approaches to the problem of the uninsured in their state (including giving preference to state contractors to organizations that pay 50 percent of health insurance premium, single payer systems, and a combination of different proposals).

The **Commonwealth Fund** identified Rhode Island as one of a few states focusing on improving the quality of care for people participating in public health insurance programs as a "promising strategy" in dealing with the current budgetary problems.⁴⁵ Its report, *Building Quality into RITE CARE: How Rhode Island is Improving Health Care for its Low-Income Populations*, identified "lessons" in the following categories:"

1. Early interventions and expansion of the medical model

- A. Improving access to essential primary and preventive care services is likely to improve health outcomes, and in some cases, will lead to subsequent savings as babies are born healthier, chronic health

conditions are brought under control, and emergency room visit rates and length of hospital stays are reduced.

- B. An important part of enhancing access involves increasing the pool of service providers, thereby easing the burden on community health centers and hospital clinics.
- C. The traditional medical model could be extended to include services that address social determinants of health, such as hazardous exposure to lead in the home, transportation and language barriers, and tobacco use.

2. Performance Goal Program

- A. Collaboration with health plans in developing and modifying an incentives program is critical for enhancing health plan “buy in” and cooperation. Flexibility is equally important.
- B. An incentives program requires solid administrative support, including qualified staff to monitor and analyze the results and to spend sufficient time working with the health plans on system improvements, particularly in the clinical areas.
- C. Incentives should be structured to reward improvement as well as realization of goals; health plans should know that some goals are attainable in the relatively short term.
- D. The program should not impose excessive burden on health plans and providers: e.g., the number of goals and the work involved in collecting necessary data should be minimized.

3. Research and evaluation (R&E)

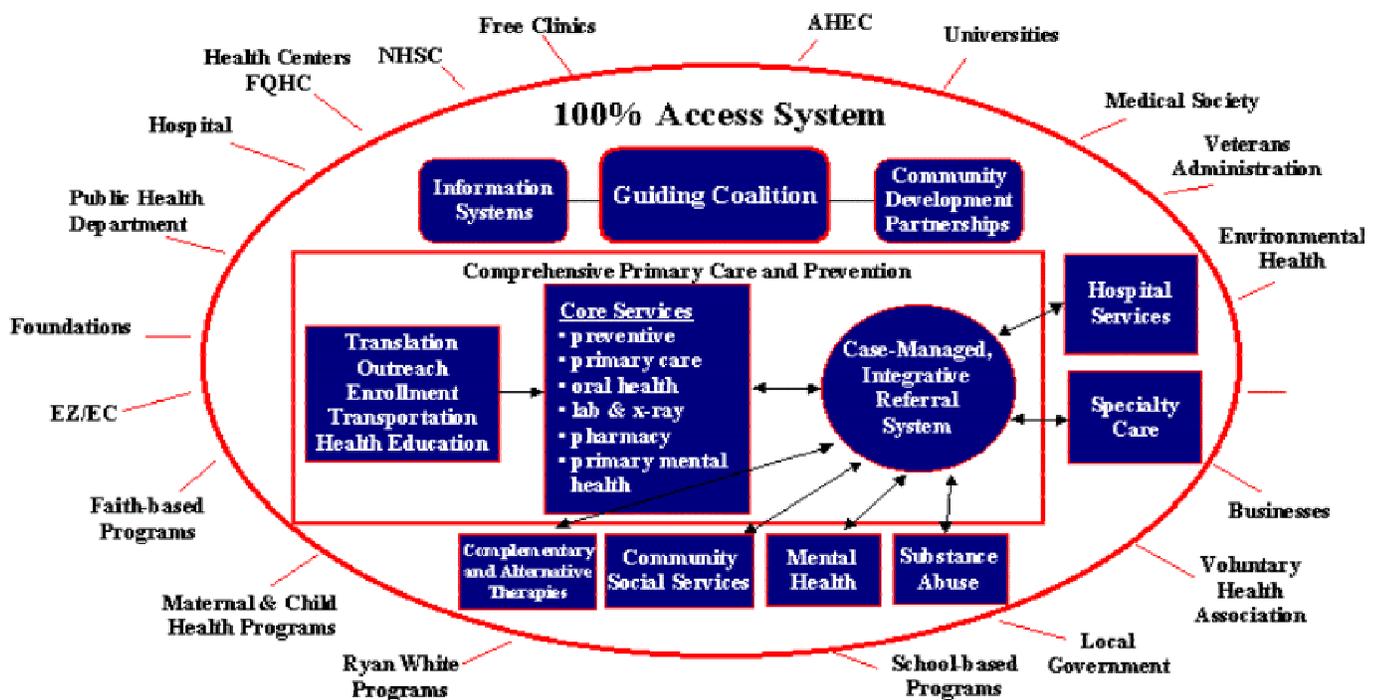
- A. Data can be used in a variety of ways: identifying service gaps that can be filled; revealing patterns of over-utilization of high-cost services; highlighting interventions that improve outcomes and should be expanded; and demonstrating success that can build support for the program among legislators and advocates.
- B. R&E should be integrated into the coverage program, for example, through an “onsite” presence that improves access to information and encourages greater interactions among state program staff and researchers.
- C. The research and evaluation team should be interdisciplinary, with individuals selected for their interpersonal skills as well as their knowledge and expertise.
- D. Particularly in times of Medicaid budget constraints, it is helpful to supplement R&E funding with private grants.

- E. Priority should be given to obtaining and organizing data sets and records.

ACCESS TO CARE

In order to meet a goal of “100 percent access and 0 health disparities,” HRSA’s Bureau of Primary Health Care envisions the following “The Integrated Primary Care Community-Based Health System.”⁴⁶ The system requires:

1. Strengthening the safety net, expanding and integrating dental and mental health services into primary care, and expanding the National Health Service Corps’ interdisciplinary approach to care.
2. Expanding the systems of care to additional needy areas.
3. Improving and expanding the work force and its diversity.
4. Increasing excellence in medical practice by using outcomes to measure performance, affirming our commitment to continuous quality improvement, eliminating health disparities among ethnic and racial minorities, and seeking outside validation, such as accreditation from the Joint Commission on Accreditation of Healthcare Organizations for 90 percent of our Health Centers.



PRENATAL CARE

As noted previously, The Commonwealth Fund identified Rhode Island's success in improving prenatal care as a "promising strategy."⁴⁷ Its report focused on the following key innovations that address barriers to care among women receiving Medicaid:

1. Streamlined application process
2. Reimbursement policies
3. Toll free hotlines
4. Outreach campaigns
5. Free pregnancy testing

In evaluating California's experience with improving access to prenatal care, The Kaiser Family Foundation identified the following "eligibility expansions and system reforms" that have contributed to recent improvements:⁴⁸

1. Coverage extended to undocumented foreign-born women
2. Income eligibility raised from 110% to 185% of poverty
3. Eligibility workers 'outstationed' at prenatal clinics
4. Reimbursement to providers increased
5. Income eligibility increased to 200% of poverty
6. Assets test eliminated for women with incomes 185-200% of poverty
7. Presumptive eligibility implemented
8. Shortened application form
9. Assets test eliminated for women under 200% of poverty

The report suggested that future improvements could be made by focusing on:

1. Access to early insurance coverage
2. Family planning and other "non-insurance factors"

Worksite Recommendations

In *HEALTHY WORKFORCE 2010, An Essential Health Promotion, Sourcebook for Employers, Large and Small*, the Partnership for Prevention recommends the following interventions related to access to health care for employers⁴⁹:

1. Form or participate in purchasing cooperatives to bargain for affordable health insurance premiums and health plans that cover appropriate clinical preventive services.
2. Fully administer COBRA provisions for those affected by a qualifying event.
3. Offer group health plan coverage or a medical savings account (MSA) option that is fully employee paid (only as an alternative for small employers who cannot otherwise offer employees health benefits).

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