2011

Community Preventive Services Task Force

FIRST ANNUAL REPORT TO CONGRESS

AND TO AGENCIES RELATED TO THE WORK OF THE TASK FORCE

Community Preventive Services Task Force

The Guide to Community Preventive Services
THE COMMUNITY GUIDE
What Works to Promote Health

The Patient Protection and Affordable Care Act (ACA), *§ 4003(b)(1)* amends the Public Health Service (PHS) Act to add *Section 399U Community Preventive Services Task Force*, which authorizes the provision of an independent Community Preventive Services Task Force convened by the Director of the Centers for Disease Control and Prevention. It also describes duties of the Community Preventive Services Task Force (heretofore known as the Task Force on Community Preventive Services, and referred to hereafter as the Community Preventive Services Task Force or "Task Force"), which include:

"…*providing yearly reports to Congress and related agencies identifying gaps in research and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations."* (ACA, § *4003(b)(1)*; PHS Act § *399U(b)(6)*) (ACA pages *425-426*)

The 2011 annual report was prepared by the Task Force in response to this legislation.

The Centers for Disease Control and Prevention provides *"ongoing administrative, research, and technical support for the operations of the Task Force*." (ACA, § *4003(b)(1)*; PHS Act § *399U(c)*) (ACA page 426)

Executive Summary

INTRODUCTION

Decision makers in communities, companies, health departments, health plans and healthcare systems, non-governmental organizations, and at all levels of government can better protect and improve the public's health by knowing what works. For this, they can rely on recommendations by the Community Preventive Services Task Force (Task Force), compiled in *The Guide to Community Preventive Services* (*Community Guide*; www.thecommunityguide.org). These recommendations identify programs, services, and policies proven effective in a variety of real-world settings—such as communities, worksites, schools, and health plans. Task Force recommendations empower community, local, state, federal, tribal, territorial, corporate, public health, and healthcare decision makers to optimize resources to:

- Protect and improve health;
- Reduce demand for future healthcare spending that is driven by preventable disease and disability; and
- Increase productivity and competitiveness of the U.S. workforce.

This report—the Task Force's first Annual Report to Congress—provides background on the Task Force, its methods, findings, and recommendations, and describes both gaps in existing research on community preventive services and priorities for future Task Force efforts.

BACKGROUND

The Task Force is an independent, nonfederal, volunteer body, appointed by the Director of the Centers for Disease Control and Prevention (CDC), whose members represent a broad range of research, practice, and policy expertise in community preventive services, public health, health promotion, and disease prevention. The Task Force was established in 1996 by the U.S. Department of Health and Human Services to provide evidence-based recommendations about *community preventive services, programs, and policies* that are effective in saving lives, increasing longevity, and improving Americans' quality of life.

> *"The Community Guide is a foundational resource for our health strategy at Dow. It is a critical, valuable, go-to source for evidence-based strategies, policies and programs for population health."*
>
> Catherine M. Baase, MD
> Chief Health Officer,
> The Dow Chemical Company

Policy makers, practitioners, and other decision makers use Task Force findings and recommendations to help them make informed decisions about allocating scarce resources to effective programs, services, and policies across a broad range of health priority areas. CDC is mandated to provide the Task Force with ongoing administrative, research, and technical support for all of its operations.

The Task Force bases its recommendations on a rigorous, replicable "systematic review" process that:

- Evaluates the strength and limitations of existing research evidence for community-based health promotion and disease prevention programs, services, and policies in high-priority topic areas;
- Assesses whether the programs, services, and policies are effective in promoting health and preventing disease, injury, and disability;
- Examines the applicability of these programs, services, and policies to varied populations and settings; and
- Conducts appropriate economic and financial analyses of cost and return on investment, to provide a full complement of information to inform decision-making.

These systematic reviews are conducted, with oversight from the Task Force, by scientists and other subject matter experts from CDC in collaboration with a wide range of government (federal, state, and local), academic, policy, and practice-based partners and stakeholders. The Task Force examines the evidence, produces findings and recommendations about effective and ineffective programs, services, and policies, and identifies research gaps that need to be filled.

In all aspects of its work, the Task Force obtains input from partner organizations and agencies, and from individual policy makers, practitioners, and researchers. Many of the nation's leading health practice and research agencies and organizations hold official Liaison status with the Task Force. They participate in meetings of the Task Force; serve on systematic review teams; represent the views, concerns, and needs of their organizations and constituents; and disseminate findings to their members and constituents.

Task Force reviews, findings, and recommendations are compiled in the *Guide to Community Preventive Services* (*Community Guide*). The *Community Guide* (www.thecommunityguide.org) provides a range of information that can inform multiple decision makers and stakeholders about effective allocation of scarce resources to proven programs, services, and policies.

The Task Force's evidence-based findings and recommendations (218 to date) address high-priority topics including those related to the nation's leading causes of preventable morbidity and mortality, which affect Americans of all ages and all population subgroups. Topics of Task Force reviews and recommendations include: chronic diseases, such asthma, cancer, depression, diabetes, and heart disease; infectious diseases; behavioral health risks related to diet, physical activity, and alcohol and

> *"Before we had the Community Guide recommendations, we lacked scientifically based guidance for developing sound and effective policies and interventions for the problems we collectively face (as state public health officers). This lack of evidence made our jobs that much more difficult, especially since elected public officials have increasingly asked us to do more with fewer resources, and hold us accountable for cost-effective results. This is where the Community Preventive Services Task Force plays such a vital role."*
>
> Martin P. Wasserman, MD, JD
> Former Secretary of the Maryland Department of Health & Mental Hygiene, and Former State Health Officer and Administrator, Oregon Health Division, Department of Human Services

tobacco use; workplace health promotion; and public health and healthcare systems and supports required to deliver evidence-based preventive services.

CURRENT RESEARCH GAPS

The Task Force has identified, and discusses in detail in the full report, three types of research gaps. These gaps limit the Task Force's ability to provide decision makers with the full complement of information they need to combat their most pressing public health concerns.

1. Research gaps where there is insufficient evidence to determine whether or not programs, services, and policies are effective in *any* populations, settings, and circumstances.

2. Research gaps where there is insufficient evidence to know whether programs, services, and policies found to be effective in *some* populations, settings, and contexts would be effective in *others*.

3. Research gaps related to information that is needed to adequately support practitioners, policy makers, and other decision makers in selecting and implementing effective community-based programs, services, and policies that meet their needs, preferences, constraints, and available resources.

PRIORITIES FOR FUTURE TASK FORCE REVIEW TOPICS

Future Task Force review topics are identified and prioritized through a multi-stage process that includes extensive input from partners, stakeholders, and the general public. Currently, the highest-priority topics for future Task Force reviews include:

- Cardiovascular disease prevention and control (new reviews);
- Childhood and adult obesity prevention and control (new reviews);
- Promoting good nutrition (new reviews);
- Promoting physical activity (updates and new reviews);
- Emergency preparedness and response (new reviews);
- Tobacco use prevention and cessation (updates and new reviews); and
- Worksite health promotion (new reviews).

Within each of these topics, the Task Force will assess the overall effectiveness of as many as 15 specific community-based programs, services, and policies. These reviews will also help clarify the applicability of these programs, services, and policies to specific sub-populations and age groups not adequately addressed by current recommendations. Additionally, as the Task Force updates its existing findings and recommendations at regular intervals to ensure they are based on the most current evidence, it has the opportunity to assess whether researchers and research funders are adequately addressing recognized research gaps.

THE *COMMUNITY GUIDE* IN ACTION: HOW COMMUNITIES USE TASK FORCE RECOMMENDATIONS

- Arizona's San Carlos Apache Tribal Police Department implemented Task Force-recommended interventions aimed at reducing alcohol-impaired driving. Motor vehicle crashes decreased 29% from 2004 to 2009.
- The city of Mount Prospect, Illinois, implemented Task Force-recommended "street-scale infrastructure improvements" (e.g., sidewalks, marked crossings) to increase student activity levels. The number of students walking to school doubled, saving the school system $66,657 yearly on busing.
- Implementing the Task Force recommendation to combine (1) employee assessment of health risk with (2) feedback to employees and (3) follow-up health improvement programming—as was done by Johnson & Johnson and BAE Systems' worksite wellness programs—returned to these employers approximately $3.00 for every $1.00 invested within a 3-year period.

More detailed examples of the impact of Task Force findings and recommendations are provided on pages 10-14 of the full report, and available at www.thecommunityguide.org.

LOOKING AHEAD TO 2012

Demand for Task Force recommendations is stronger now than ever before. Policy makers, healthcare and public health sectors, employers, and the public recognize the imperative to keep people healthy, productive, and independent, and reduce the drag of healthcare costs on U.S. economic competitiveness. It has become clear that critical population health improvements depend not just on quality medical care but on effective community preventive services reaching Americans where they live, learn, work, worship, and play.

"The Community Guide is the most respected, most trusted reference on the effectiveness, efficiency, and feasibility of interventions for health promotion and disease prevention…I oversee the planning and execution of Blue Cross and Blue Shield of Minnesota's $241 million, long-term progress aimed at reducing tobacco use, increasing physical activity and increasing healthy eating across Minnesota. The Community Guide has been an invaluable resource to help guide our planning and to ensure that our strategies are science based. Referencing the Guide added credibility to all our efforts and helped us defend and explain our priorities."

Marc W. Manley, MD, MPH
Vice President and Medical Director,
Population Health,
Blue Cross Blue Shield of Minnesota

To meet the demand, the Task Force is:

- **Accelerating the completion of high-priority reviews**—both new reviews and updates to existing reviews so Task Force recommendations remain current.
- **Enhancing dissemination efforts to better meet the needs of a wide range of users**—including updating the *Community Guide* website (www.thecommunityguide.org) to streamline information access, and using a wider range of formats and channels to provide partners with timely information so they, in turn, can inform their members, constituents, and the public about effective community preventive services.

- **Increasing and refining technical assistance to decision makers and implementers who want help in selecting and implementing Task Force recommendations**—including helping Task Force Liaisons and partners to provide hands-on technical assistance to their members and constituents.
- **Continuing to identify and communicate important research gaps to help policy makers, funders, and scientists optimize resources for research and for evaluation of existing programs, services, and policies**—including providing technical assistance to funders as they develop funding opportunities to address these research gaps.
- **Working closely with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices**—to complement their recommendations on effective clinical preventive services and immunization practices.
- **Preparing a second Annual Report to Congress for release in the fall of 2012.**

Community Preventive Services Task Force First Annual Report to Congress

and to Agencies Related to the Work of the Task Force 2011

OVERVIEW

When decision makers—in communities, companies, public health agencies, and healthcare institutions and at the local, state, and federal level—need to know what works to improve and protect health, they can rely on recommendations from the Community Preventive Services Task Force (Task Force). The Task Force recommendations, which are compiled in *The Guide to Community Preventive Services* (*Community Guide*; see www.thecommunityguide.org), include programs, services, and policies proven effective in a variety of real-world settings—from communities and counties to worksites, schools, and health plans—so that scarce resources can be optimized to:

- Protect and improve population health;
- Reduce future demand for healthcare spending that is driven by preventable disease and disability; and
- Increase the productivity and competitiveness of the U.S. workforce.

Programs, services, and strategies recommended by the Task Force are recognized and applied as essential building blocks to improve Americans' health and quality of life where they live, learn, work, worship, and play. Methods, findings, products, and impact of the Task Force are briefly outlined in this report, with particular attention to important current research gaps and to priorities for future Task Force reviews and recommendations.

BACKGROUND

The U.S. spends a higher portion of its gross domestic product on health than any other country, but our overall health system performance ranks 37th, well below many countries that spend less.[1] Preventing disease and injury is the most effective, common-sense way to improve and protect health. Although approximately 91% of U.S. health spending goes to healthcare services, administration, and health insurance,[2] an estimated 60% of the U.S. population's health is the result of individuals' behaviors and what happens in the community, not inside clinics.[3] Community preventive efforts can:

- ***Increase longevity***—Today's youth could be the first generation to live shorter and less healthy lives than their parents.[4]
- ***Reduce illness burden***—Many Americans suffer from preventable, costly chronic conditions, such as diabetes, for a long period prior to death.[5]

- ***Reduce the likelihood of becoming ill***—Protecting Americans' health by preventing diseases makes sense and can save money.[6]
- ***Reduce healthcare spending***—Community-based disease prevention efforts can help restrain the growth in healthcare spending by reducing both the need and demand for clinical services.[7]
- ***Make healthy choices easy choices***—Making healthy choices is easier with access to options such as healthy food, safe physical activity and recreation, and smoke-free environments.[8]
- ***Maintain or improve economic vitality***—A healthy, vibrant community is a productive community with a resilient workforce and economic vitality. Healthy, safe communities may help attract new employers and industries, create jobs, increase housing values, enhance community prosperity, and support global competitiveness.[9]
- ***Reduce waste***—Implementing Task Force-recommended programs and services can increase delivery of recommended clinical preventive services in multiple settings (e.g., clinics, worksites, schools), reducing the healthcare services otherwise needed for preventable conditions and related productivity losses.[10]
- ***Enhance national security***—According to the 2010 Mission: Readiness report, "*Too Fat to Fight*," obesity is the leading medical reason why unprecedented numbers of young men and women fail to qualify for military service.[11]
- ***Prepare communities for emergencies***—First responders and public health workers are fortified with evidence-based guidelines for responding to tornadoes, hurricanes, floods, other natural disasters, infectious disease outbreaks, and other threats.[12]
- ***Empower individuals, families, employers, schools, and communities***—Putting Task Force-recommended community preventive services into practice provides information, resources, skills, and environments in which people, communities, and organizations can thrive.[13]

Task Force Helps Navy-Marine Corps Meet Health Mission

In their mission to help ensure workforce readiness in support of the National Military Strategy, the Navy and Marine Corps Public Health Center (NMCPHC) has applied Task Force recommendations, which are compiled in the *Community Guide*, to tobacco policy and staff health promotion programs. According to William Calvert, Deputy Director for Public Health at NMCPHC, "The *Community Guide* helps us meet our mission. With limited prevention resources, it's important to the Navy to incorporate interventions proven to work. Our goal is to increase the quality and years of healthy life for our active duty, beneficiary, and civilian workforce. The *Community Guide* helps us do that."

The Task Force is an independent, nonfederal, volunteer body, appointed by the Director of the Centers for Disease Control and Prevention (CDC), whose members represent a broad range of research, practice, and policy expertise in community preventive services, public health, health promotion, and disease prevention (see Appendix A). The Task Force was established in 1996 by the U.S. Department of Health and Human Services to provide evidence-based recommendations about *community preventive services, programs, and policies* that are effective in saving lives, increasing longevity, and improving Americans' quality of life.

Policy makers, practitioners, and other decision makers use the Task Force findings and recommendations to help them make informed decisions about allocating scarce resources to effective programs, services, and policies across a broad range of public health priority areas. CDC is mandated to provide ongoing administrative, research, and technical support for all Task Force operations.

The Task Force was created as a complement to the U.S. Preventive Services Task Force (USPSTF), which was established in 1984 to provide evidence-based recommendations for clinicians, other healthcare professionals, and decision makers on effective *clinical preventive services*—such as screening, counseling, and preventive medications. The Agency for Healthcare Research and Quality (AHRQ) is mandated to provide ongoing administrative, research, and technical support to the USPSTF to support its operations. A diagram outlining the domains of the Task Force and USPSTF is shown in Figure 1. The Task Force also complements the work of the Advisory Committee on Immunization Practices (ACIP), which develops recommendations for the routine administration of vaccines to children and adults.

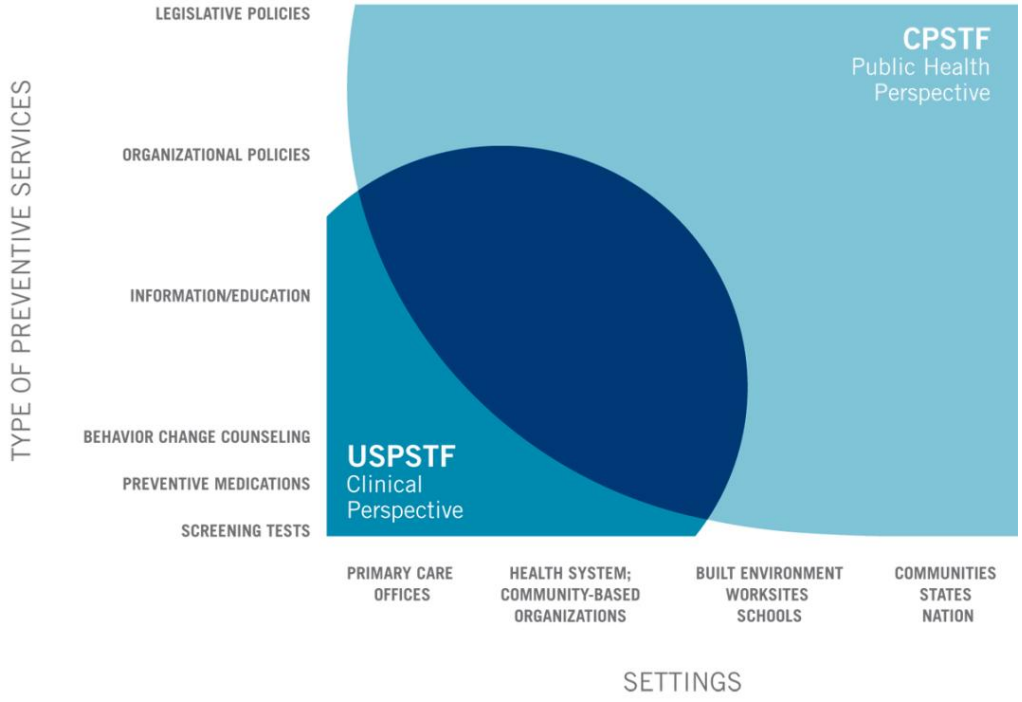


Figure 1. Complementary Work of the Community Preventive Services Task Force (CPSTF) and the U.S. Preventive Services Task Force (USPSTF)

The Task Force bases its recommendations on a rigorous, replicable "systematic review" process that:

- Evaluates the strength and limitations of existing research evidence on community-based health promotion and disease prevention programs, services, and policies in high-priority topic areas;
- Assesses whether the programs, services, and policies are effective in promoting health and preventing disease, injury, and disability;

- Examines the applicability of these programs, services, and policies to varied populations and settings (e.g., based on age, gender, race/ethnicity, income, inner city/suburban/rural location); and
- Conducts appropriate economic and financial analyses of cost and return on investment, to provide a full complement of information to inform decision-making.

These systematic reviews are conducted, with oversight from the Task Force, by scientists and other subject matter experts from CDC in collaboration with a wide range of government (federal, state, and local), academic, policy, and practice-based partners and stakeholders. The Task Force examines the evidence, produces findings and recommendations about effective and ineffective programs, services, and policies, and identifies research gaps that need to be filled.

The compilation of all Task Force reviews, findings, and recommendations is known as the *Guide to Community Preventive Services* (*Community Guide*). The *Community Guide* helps decision makers, practitioners, and researchers select the prevention strategies best suited to their settings and populations—based on the strength of evidence for or against the effectiveness of specific policies, programs, and services, and their applicability to varied populations and circumstances. The research gaps that are identified help researchers and research funders focus their future efforts.

> *"To develop the Chicago Public Health Agenda, we drew from The Community Guide, as an authoritative source of evidence-based strategies. Informing our efforts with interventions, policies and practices from The Community Guide enabled us to leverage and maximize our resources and focus on public health issues and actions with measurable outcomes."*
>
> Bechara Choucair, MD
> Chicago Department of Public Health

The Task Force:

- Sets priorities for selecting topics for systematic review;
- Participates in developing and refining systematic review methods;
- Assigns members to serve on each systematic review team;
- Assesses the findings of each review and makes recommendations for policy, practice, and research;
- Identifies key research and evidence gaps and recommends new research to be conducted in critical areas; and
- Helps to disseminate findings and recommendations to public health and healthcare practitioners and policy makers, and provide tools and technical assistance to help implement those findings and recommendations.

In all aspects of its work, the Task Force obtains input from partner organizations and agencies, and from individual policy makers, practitioners, and researchers. Many of the nation's leading public health practice and research agencies and organizations hold official Liaison status with the Task Force (see Appendix B). They participate in meetings of the Task Force and represent the views, concerns, and needs of their organizations and constituents as they:

- Help the Task Force identify the most pressing current public health priorities;
- Serve on and recommend other participants for systematic review teams;

- Provide input while the Task Force examines the systematic review findings to reach its recommendations;
- Disseminate the Task Force recommendations and implementation guidance, and help their members and constituents translate evidence-based recommendations into action; and
- Convey the critical research (evidence) gaps and needs identified by Task Force review teams to the nation's leading public and private research funders, researchers, evaluators, and other stakeholders.

The relationships among the Task Force, CDC, Liaisons, partners, and the *Community Guide* are illustrated in Appendix C.

CURRENT TASK FORCE REVIEWS AND RECOMMENDATIONS

The Task Force uses a rigorous, replicable, systematic review process to develop evidence-based recommendations for prevention services, policies, and programs. The recommendations can be used population-wide or in selected community settings, such as schools, worksites, community centers, faith-based organizations, health plans, public health clinics and departments, and large, integrated healthcare systems. Each systematic review encompasses an exhaustive search for, and rigorous appraisal of, relevant research and evaluation studies. Reviews and recommendations grade the quality of the available evidence and judge its applicability to the general population and to specific subgroups, based on age, gender, race/ethnicity, income, setting, and context (with context including such things as the physical, psychosocial, and economic environments, and access to needed resources and infrastructure).

Evidence-based recommendations seek both to reduce health and economic burdens from "missed" public health opportunities and to prevent wasteful use of resources on programs and strategies lacking demonstrated benefit. The Task Force has published a total of 218 evidence-based findings and recommendations. Table 1 lists broad topic areas addressed to date by Task Force reviews.

> *"If all states required evidence-based practices like Florida did with their tobacco dollars, the result would be a more effective use of the tax dollars that are available."*
>
> Kim Barnhill, MS, MPH
> Administrator, Jefferson & Madison County Health Departments, Florida

Table 1. Topic Areas Addressed to Date by Task Force Reviews

- Adolescent Health
- Preventing Excessive Alcohol Consumption
- Asthma Control
- Prevention of Birth Defects
- Cancer Prevention & Control
- Diabetes Prevention & Control
- Prevention of HIV/AIDS, Other STIs & Pregnancy
- Health Communication & Social Marketing
- Mental Health & Mental Illness
- Motor Vehicle-Related Injury Prevention
- Promoting Good Nutrition
- Obesity Prevention & Control
- Oral Health
- Promoting Physical Activity
- Tobacco Use
- Vaccinations to Prevent Diseases
- Violence Prevention Focused on Children & Youth
- Worksite Health Promotion
- Promoting Health Through the Social Environment

Appendix D identifies all current Task Force findings and recommendations, including (a) programs, services, and policies for which there is strong (72) or sufficient (37) evidence of effectiveness; (b) those for which there is strong (2) or sufficient (0) evidence of harm or lack of effectiveness; and (c) those for which there is insufficient evidence to determine effectiveness or ineffectiveness (107). The recommendations address disease, disability, and injury prevention and health promotion programs, services, and policies affecting Americans across the life span. Community preventive services in each category are reviewed for the applicability of available evidence to the general population and to specific relevant settings and sub-populations, including those in lower income and racial/ethnic minority populations, and communities at greatest risk for preventable disease, disability, and injury.

MAJOR RESEARCH GAPS IDENTIFIED

The Task Force has identified three types of research gaps. These gaps limit the Task Force's ability to provide decision makers with the full complement of information they need to combat their most pressing public health concerns. The research gaps effectively equate to evidence gaps, and they can be filled by a combination of research studies and evaluations of real world programs, services, and policies.

1. Research gaps where there is insufficient evidence to determine whether or not specific programs, services, and policies are effective.

As shown in Appendix D, when 107 of the community-based programs, services, and policies that the Task Force has evaluated to date were reviewed, there was insufficient evidence to determine whether or not they were effective. (More information about "insufficient evidence" is available in Appendix D and at www.thecommunityguide.org.) These 107 insufficient evidence findings stretch across the full range of high-priority topics that the Task Force has addressed to date. Research is still needed, therefore, to determine if these programs, policies, and services are effective or not.

Task Force recommendations are made for very diverse user audiences—including decision makers at federal, state, local, and organizational levels, each of whom has to address the health issues of greatest concern for their own populations, settings, and contexts. Additionally, all *Community Guide* reviews conducted to date have been in high-priority areas. The Task Force therefore recommends that research be supported across the range of programs, services, and policies for which evidence was insufficient. Summaries of the research gaps identified through the systematic review process for each of these programs, services, and policies are available at www.thecommunityguide.org.

One type of research gap routinely seen across a wide range of topics deserves special mention: research related to new or emerging delivery systems and technologies. Internet-based health behavior change programs hold the potential for greater reach at lower cost than face-to-face community and organizational programs. Electronic medical records hold unparalleled potential to target medically and socio-demographically high-risk populations, and to assist people living in hard-to-reach inner-city and rural settings. Likewise, emerging social media technologies (e.g., Internet, mobile devices, Facebook©, Twitter©) hold great potential to strengthen the effectiveness

of mass media community campaigns. However, for most topics the Task Force has addressed to date, there has been insufficient research to determine the effectiveness of these relatively new delivery systems and technologies in bringing people to the point of care; decreasing death, disability, and injury; or increasing health-related quality of life.

2. Research gaps where there is insufficient evidence to know whether programs, services, and policies found to be effective in some populations, settings, and contexts would be effective in others.

To date, the Task Force has recommended 109 programs, services, and policies on the basis of strong or sufficient evidence of their effectiveness. For some of these programs, services, and policies, there is a substantial body of research that shows them to be effective across a wide range of different population groups, settings, and contexts. But for others, available studies have only considered the population at large or have only considered a limited range of populations, settings, and contexts. This has left the Task Force with questions about effectiveness in underserved populations, or populations at particularly high risk of disease, disability, or injury.

The Task Force has often found a lack of research about effectiveness of community preventive programs, services, and policies for lower-income and racial/ethnic minority populations and communities, as well as for people living in inner-city and rural areas. The Task Force has also regularly found less evidence on effectiveness of community preventive services for children, adolescents, and older adults than for adults through middle age. Determining whether programs, services, and policies are effective for these populations and settings, and studying how those that are less effective might be modified to make them more effective for these populations and settings is critical for addressing current disparities in community environments, services, and health outcomes. Information on research gaps related to the effectiveness of programs, services, and policies for at-risk or underserved populations, settings, and contexts can be found at www.thecommunityguide.org.

> *"The biggest outcome of using the Community Guide is that our staff doesn't spend a lot of time and resources on programs that traditionally have not worked."*
>
> Rita Miracle, Knox County Health Department, Kentucky

3. Research gaps related to information that is needed to adequately support practitioners, policy makers, and other decision makers in selecting and implementing effective community-based programs, services, and policies that meet their needs, preferences, constraints, and available resources.

Task Force findings and recommendations will be of limited usefulness if intended user audiences are not able to identify which evidence-based programs, services, and policies will meet their needs, preferences, available resources, and constraints; or determine how to successfully implement selected evidence-based programs, services, and policies in their specific setting. At the present time, considerable research gaps exist in both of these areas, related to the following needs for information:

- *Information on the most critical elements of effective community preventive programs, services, and policies*—To plan as efficiently as possible for staffing and resource implications, decision makers and implementers want to know whether the impact of community preventive

services would be increased or diminished if they are delivered by different types of providers, or if a particular intensity, duration, or component of a service is critical to its success. Unfortunately, many studies lack this information, leaving the Task Force to recommend more research to provide greater clarity.

- *Cost and economic outcomes*—Policy makers, practitioners, and other users of the *Community Guide* regularly ask for information about the cost and economic value of Task Force-recommended programs, services, and policies. Many indicate that this is critical information for decision-making, especially during fiscally tight times. The Task Force systematically searches for all available published cost data, and undertakes the most appropriate economic and financial analyses of cost and return on investment for all programs, services, and policies it recommends as effective. Economic findings are provided alongside Task Force findings on effectiveness, to help inform decision-making. Unfortunately, data on cost and economic value are frequently limited or absent altogether. Many *Community Guide* reviews thus recommend further economic and financial analyses.
- *Interaction of multiple policies, services, and programs*—Many community preventive strategies work best in combination. Examples include community- and organization-based health education and behavior change programs, and disease management programs where patient-, provider- and healthcare system-focused strategies produce significantly greater health benefits when combined and integrated. More studies that examine the incremental benefits of effective multi-part interventions are needed to strengthen Task Force reviews and recommendations for complex public health issues.
- *"How to" methods for selecting and implementing Task Force-recommended community preventive services for specific populations, settings, and contexts*— Selecting and implementing evidence-based recommendations involves a mix of science, experience, and creativity on the part of decision makers. And different decision makers want different amounts of assistance with these processes. Some want suggestions of general strategies while others seek detailed, hands-on assistance. Task Force recommendations are most useful when paired with this kind of practical guidance. More research is therefore needed to help *Community Guide* users select and apply Task Force recommendations in a variety of real-world settings, as well as to evaluate the usefulness of varied forms of technical assistance.

> *"What we're seeing is that when boards of health and other decision makers understand the many uses of the Community Guide, public health infrastructure is strengthened by linking public health leadership and decision makers to evidence-based approaches to solve complex public health issues."*
>
> Jim Butler, Consultant from the National Association of Local Boards of Health to local boards of health in Michigan

SETTING PRIORITIES FOR FUTURE TASK FORCE REVIEWS

Hundreds of prevention programs, services, and policies hold potential to improve the health of the nation as a whole as well as of communities and organizations. Choices range from public and corporate policies, population-wide health communication campaigns, and preparedness strategies, to prevention initiatives for school, worksite, and health plan settings. Accordingly, topics selected for Task Force reviews must be carefully prioritized.

Future review topics are identified and prioritized through a multi-stage process that involves formally soliciting suggestions for high-priority topics from a wide range of stakeholders, including Task Force Liaison agencies and organizations (see Appendix B) and the public. The Task Force Prioritization Committee, made up of Task Force members, oversees the process of compiling extensive background information on all proposed topics; systemically evaluating this information to rank proposed topics using the prioritization criteria outlined below; and using multiple rounds of review by the entire Task Force to identify topics of "highest," "high," "medium," and "lower" priority.

The following criteria are used to define priority areas for future Task Force reviews:

- Potential magnitude of preventable morbidity, mortality, and healthcare burden for the U.S. population as a whole based on estimated reach, impact, and feasibility;
- Potential to reduce health disparities across varied populations based on age, gender, race/ethnicity, income, disability, setting, context, and other factors;
- Degree and immediacy of interest expressed by major *Community Guide* audiences and constituencies, including public health and healthcare practitioners, community decision makers, the public, and policy makers;
- Alignment with other strategic community prevention initiatives, including, but not limited to, *Healthy People 2020, The National Prevention Strategy*; the *County Health Rankings,* and *America's Health Rankings;*
- Synergies with topically related recommendations from the U.S. Preventive Services Task Force and Advisory Committee on Immunization Practices;
- Availability of sufficient research to support informative systematic evidence reviews; and
- The need to balance reviews and recommendations across health topics, risk factors, and types of services, settings, and populations.

The Task Force initially organizes and prioritizes reviews by topic rather than by individual programs, services, and policies. Selecting a priority topic and then sequentially or concurrently reviewing multiple services within that specific topic allows the Task Force to achieve significant economies of scale through: developing extensive expertise, partnerships, and support, which lead to greater efficiency; enabling analyses of the comparative reach and effectiveness of different programs, services, and policies within a topic; and enabling assessment of the critical intervention elements or combination of elements needed for change. Additionally, this provides decision makers with a menu of effective programs, services, and policies from which they can select those that best meet their population, setting, and context.

Through the topic prioritization process, with ongoing oversight by the Task Force Prioritization Committee, the Task Force has identified the following "highest" priority topics for new reviews in 2011-2012:

- Cardiovascular disease prevention and control (new reviews);
- Childhood and adult obesity prevention and control (new reviews);
- Promoting good nutrition (new reviews);

- Promoting physical activity (updates and new reviews);
- Emergency preparedness and response (new reviews);
- Tobacco use prevention and cessation (updates and new reviews); and
- Worksite health promotion (new reviews).

The list reflects the need to balance the production of new reviews with the requirement to update existing reviews, so that all Task Force recommendations remain current. As many as 15 separate programs, services, and policies will be reviewed under each topic, and will also be prioritized according to the criteria outlined above.

As with all Task Force reviews, these prioritized reviews will evaluate not only the overall effectiveness of existing programs, services, and policies, but also their applicability to different populations, settings, and contexts, and costs and return on investment—to help *Community Guide* users select community prevention strategies that meet their needs and constraints. Additionally, as the Task Force updates all existing findings and recommendations at regular intervals to ensure they are based on the most current evidence, it has the opportunity to assess whether researchers and research funders are adequately addressing recognized research gaps.

THE *COMMUNITY GUIDE* IN ACTION: HOW COMMUNITIES USE TASK FORCE RECOMMENDATIONS

Task Force reviews and resulting *Community Guide* recommendations are increasingly relied upon by decision makers in communities, workplaces, schools, public health departments and agencies, healthcare systems, non-governmental organizations, and at all levels of government. With 218 recommendations already available, and new ones added regularly, the Task Force gives decision makers a wide range of options for what to do and how to do it. Specific examples follow, illustrating the role of Task Force recommendations in the many factors that bring about successful and healthful changes.

INCREASING EVERYDAY PHYSICAL ACTIVITY

The problem: According to the CDC State Indicator Report on Physical Activity: 2010 Behavioral Indicators, only 64.5% of adults and 17.1% of children in grades 9 through 12 are physically active.[14] The nation's health can be greatly improved by increasing these percentages, given the proven and substantial health benefits of regular physical activity, including lower risk of early death, heart disease, stroke, type 2 diabetes, high blood pressure, abnormal blood lipids, some cancers, obesity, and depression symptoms. [15]

Task Force reviews have identified eight effective strategies for increasing levels of physical activity, including behavioral and social approaches for schools and communities, community-wide campaigns, and various community-level environmental and policy approaches (see Appendix D). These strategies have been widely endorsed and adopted by prevention leaders across the country to reach adults and children in a wide variety of communities. The *County Health Rankings* program now ranks every county in each state based on residents' physical activity levels, providing additional impetus for adopting Task Force recommendations.

***Community Guide* in Action:** For generations, children who lived near their schools could walk to school. Beginning in the mid-1970s, children in Mt. Prospect, Illinois, had to ride the bus for the short 1/3 mile trip to Frost Elementary School because local streets had become so busy with traffic, had no sidewalks, no stop signs, and no safe crossing locations. That changed in 2007 when Mount Prospect used a $76,000 federal *Safe Routes to School* grant to implement Task Force-recommended street-scale infrastructure improvements to promote physical activity. The project was so successful that the bus route was no longer needed. The school system saved $66,657 a year, and children became more active by walking to and from school.

> *"Implementing Community Guide-recommended street-scale improvement projects like this one at Frost Elementary School are benefiting children attending thousands of schools in geographically, economically and ethnically diverse communities across the nation—making it easier for them to walk or bicycle, and helping in the fight against childhood inactivity and obesity."*
>
> Deb Hubsmith, Director of Safe Routes to School National Partnership

IMPROVING WORKERS' HEALTH AND PRODUCTIVITY AND EMPLOYERS' BOTTOM LINES

The problem: More than 157 million Americans spend many of their waking hours at work. Poor health can reduce their effectiveness on the job. A healthy workforce is more productive, uses fewer healthcare resources, is absent less often, and thereby reduces organizational costs.[16] Many employers now recognize the potential benefit of employee health promotion and disease prevention programs and are seeking advice on best and promising practices.

"Lean*Works*" Includes Task Force Recommendations

CDC created a website, called "Lean*Works*!" (www.cdc.gov/leanworks/) to provide employers with interactive tools and evidence-based resources to design worksite obesity prevention and control programs. The tools include a free obesity cost calculator to estimate how much obesity is costing an employer and potential savings from different actions to address the issue. Lean*Works* refers extensively to Task Force recommendations related to policies, programs, and tools aimed at reducing obesity rates at the worksite.

The Task Force provides recommendations for worksite/employee wellness programs, including a recommendation to combine assessment of employees' health risk with feedback to employees, and follow-up health improvement programming. These recommendations, along with other applicable Task Force findings and recommendations—such as those for tobacco cessation, weight management, and onsite influenza vaccination programs—support health improvement efforts at the worksite (see Appendix D). The inclusion of Task Force recommendations in the design, implementation, and evaluation of employer-sponsored health promotion and disease prevention programs has been shown to generate health improvement and cost savings for many businesses.

***Community Guide* in Action:**

- *Johnson & Johnson: Health and Wellness.* A recent evaluation shows that Johnson & Johnson's comprehensive wellness program, which includes several Task Force recommendations, continues to improve employee health and save the company significant dollars on medical costs. From 2002-2008, the company had annual savings of $565 per employee (in 2009

dollars) and a return on investment of $1.88 to $3.92 for every $1.00 spent on the wellness program.[17]

- *BAE Systems: Setting Our Sights on Fitness*. BAE Systems' worksite wellness program—which incorporates a number of Task Force recommendations and is implemented through an employer–health plan partnership—documented health improvements and experienced a 3:1 return on investment within the first three years. Employee lifestyles showed substantial and sustained improvements and there was a 3.3% per year reduction in average medical claims.[18]

REDUCING ALCOHOL-IMPAIRED DRIVING AND MOTOR VEHICLE INJURIES AND DEATHS

The problem: In the U.S., someone dies every 48 minutes in a motor vehicle crash involving an alcohol-impaired driver (one in three of all traffic-related deaths).[19] More than one in ten children under the age of 14 who die in motor vehicle crashes are killed in alcohol-impaired driving crashes.[20] These crashes carry a large monetary cost as well: annual expenses from alcohol-related crashes were estimated to be more than $51 billion in 2000.[21]

Tribal Police Apply Task Force Recommendations to Increase Safe Driving

In 2004, Arizona's San Carlos Apache Tribal Police Department received funding from CDC to implement Task Force recommendations aimed at reducing alcohol-impaired driving and increasing safety belt use. Media campaigns, sobriety checkpoints, enhanced police enforcement, and local community events were important components of their program. In 2007, the San Carlos Tribal Council passed a primary seat belt law and a 0.08% blood alcohol concentration law. From 2004 to 2009, driving under the influence (DUI) arrests increased 52%, driver seat belt use increased 46%, and motor vehicle crashes decreased 29%.

The Task Force recommends nine effective strategies for reducing alcohol-impaired driving, including the establishment of sobriety checkpoints and the use of ignition interlocks (see Appendix D). A number of organizations, states, and federal agencies have cited these Task Force recommendations as evidence that informed their decision making around policy resolutions and policy action.

MADD Commends the *Community Guide* for Sobriety Checkpoint Review

Mothers Against Drunk Driving (MADD) gave *The Community Guide* Motor Vehicle review team one of its highest awards for their systematic review of the effectiveness of sobriety checkpoints in reducing alcohol-related motor vehicle crashes, injuries, and fatalities, and for working closely with MADD to disseminate information that supported implementation of sobriety checkpoints in communities across the country.

***Community Guide* in Action:** The nationwide blood-alcohol limit of 0.08% follows a Task Force recommendation. The science showed that reducing the blood alcohol limit from 0.10% to 0.08% would lower alcohol-impaired driving fatalities by a median of 7%.[22] In October 2000, just 4 years after the Task Force was formed, and citing evidence from the Task Force review and recommendation, the President signed the FY2001 transportation appropriations bill, which required states to lower the blood alcohol limit to 0.08% by Oct. 2003 or risk losing federal highway construction funds. Every state lowered its legal limit, saving an estimated 400–600 lives per year.[23]

REDUCING TOBACCO USE

The problem: Tobacco use is responsible for one in five deaths in the U.S. (about 443,000 deaths each year) and approximately 49,000 of these deaths result from secondhand smoke exposure.[24] Preventable illnesses related to tobacco have been estimated to cost $193 billion, which is composed of $96 billion in direct medical costs yearly *plus* $97 billion in lost productivity.[25]

Since 2000, the Task Force has made 12 recommendations to reduce tobacco use (see Appendix D). Task Force recommendations helped bring about a historic decline in tobacco use, especially among youth, along with a substantial increase in average life expectancy, with an annual estimated value of $300 to $700 billion.[26]

***Community Guide* in Action:** In 2002, New York City began implementing a multi-pronged tobacco control strategy consisting of key strategies recommended by the Task Force, which included: (1) increasing state and local cigarette excise taxes; (2) requiring all work-places, including restaurants and bars, to be smoke free; (3) increasing access to cessation services, including a large-scale free nicotine-patch program; (4) educating the public about the dangers of tobacco use and secondhand smoke via an aggressive mass media campaign; and (5) rigorously evaluating the results. As a result, smoking declined: among all age groups, race/ethnicities, and education levels; in both genders; among both U.S.-born and foreign-born persons; and in all 5 boroughs. From 2002 to 2009, smoking prevalence among New York City adults decreased by 27% (from 21.5% in 2002 to 15.8% in 2009); and from 2001 to 2009 smoking rates among high school students declined by almost half (from 17.5% in 2001 to 8.4% in 2009). The decline in adult smoking prevalence since 2002 is greater than that in the United States overall and represents 350,000 fewer smokers in New York City.[27]

IMPROVING CANCER SCREENING RATES IN UNDERSERVED COMMUNITIES

The problem: Cancer in the U.S. kills more than a half million people each year.[28] Early cancer detection saves lives but many people who are eligible for breast, cervical, or colorectal cancer screening do not know about effective screenings, cannot afford them, cannot get to a location that offers screening, or face other barriers. The cost of treating cancer is high—estimated at $104.1 billion in 2006—and the relative costs of treating late-stage cancer are even higher.[29]

The Task Force recommends nine strategies for helping to bring those eligible for colorectal, breast, and cervical cancer screening to the point of care—including such services and programs as reminding clients to come in and be screened, reducing structural barriers (e.g., providing scheduling assistance and transportation, offering extended hours), and reminding providers to screen their patients (see Appendix D). Many of these services have been found to be effective for underserved populations and communities that are at greatest risk for cancer.

***Community Guide* in Action:** St. James-Santee Family Health Center in McClellanville, SC provides primary and preventive healthcare to medically underserved residents of three counties as part of an effort to increase breast and cervical cancer screening in African-American communities. The Morehouse School of Medicine helped them find and use the *Community Guide*, and the Center implemented Task Force recommendations including client reminders, one-on-one education,

group education, reducing structural barriers, reducing out-of-pocket costs, and setting up reminder and assessment and feedback systems for healthcare providers. After two years, screenings for breast and cervical cancer increased 10% and women in local churches continue to have regular screenings. The Center next applied Task Force recommendations to the costly problem of missed appointments at four locations, and in just six months reduced missed appointments by 30%. These are all very impressive outcomes given the nationally recognized challenges related to increasing cancer screening rates among this underserved population.

LOOKING AHEAD TO 2012: HIGHLIGHTS

Demand for Task Force recommendations is stronger now than ever before. Policy makers, the health sector, employers, and the public recognize the imperative to keep people healthy, productive, and independent, and reduce the drag of healthcare costs on U.S. economic competitiveness. It has become clear that critical population health improvements depend not just on quality medical care but on effective community preventive services reaching Americans where they live, learn, work, worship, and play.

To meet the demand, the Task Force is:

- **Accelerating the completion of high-priority reviews**—balancing the production of new reviews with updates to existing reviews so that all Task Force recommendations remain current. Updating existing reviews will also provide the opportunity to periodically assess whether various research gaps are being filled.
- **Enhancing dissemination efforts to better meet the needs of a wide range of users**—including: refining and updating the *Community Guide* website (www.thecommunityguide.org) to streamline and simplify information access; developing additional electronic and printed materials summarizing Task Force recommendations; and using a wider range of formats and channels to provide Task Force Liaisons and other partners with timely information so they, in turn, can inform their members, constituents, and the public about effective community preventive services.
- **Increasing and refining technical assistance to decision makers and implementers who want help in selecting and implementing Task Force recommendations**—including helping Task Force Liaisons and other partners to provide hands-on technical assistance to state and local health departments, boards of health, employers, schools, health plans, and others, in selecting and implementing effective programs, services, and policies that address their specific needs, preferences, constraints, and available resources.
- **Continuing to identify and communicate important research gaps, to help policy makers, funders, and scientists optimize resources for research and evaluation**—to increase identification of effective and ineffective programs, services, and policies, and to spur increased research and evaluation surrounding their applicability to, and implementation in, priority populations and settings. This includes providing technical assistance to funders such as the National Cancer Institute, CDC, and the National Collaborative on Childhood Obesity Research as they develop funding opportunities to address these research gaps.

- **Continuing to work closely with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices**—actively seeking to complement their recommendations on effective clinical preventive services and immunization practices.
- **Preparing a second Annual Report to Congress for release in the fall of 2012**.

APPENDIX A. LIST OF CURRENT TASK FORCE MEMBERS

Jonathan E. Fielding, MD, MPH, MBA (Chair)
Director of Public Health and Health Officer, Los Angeles County Department of Public Health
Professor of Health Services and Pediatrics, Schools of Public Health and Medicine, University of California, Los Angeles

Barbara K. Rimer, DrPH (Vice-Chair)
Dean, Gillings School of Global Public Health, University of North Carolina at Chapel Hill

Ana F. Abraído-Lanza, PhD
Associate Professor, Department of Sociomedical Sciences,
Mailman School of Public Health, Columbia University
*Completed term in June 2011

Ned Calonge, MD, MPH
President and CEO, The Colorado Trust
Associate Professor of Family Medicine and Epidemiology, Schools of Medicine and Public Health, University of Colorado, Denver

John M. Clymer
Chief Strategy Officer, Alliance to Make the US Healthiest
Adjunct Assistant Professor of Health Policy and Management,
Loma Linda University School of Public Health

Karen Glanz, PhD, MPH
George A. Weiss University Professor, Schools of Medicine and Nursing,
University of Pennsylvania

Ron Z. Goetzel, PhD
Director, Institute for Health and Productivity Studies,
Rollins School of Public Health, Emory University
Vice President, Consulting and Applied Research, Thomson Reuters

Lawrence W. Green, DrPH, DSc (Hon.)
Professor, Department of Epidemiology and Biostatistics,
School of Medicine, University of California, San Francisco

Robert L. Johnson, MD, FAAP
Dean, Professor of Pediatrics, Professor of Psychiatry, and
Director of the Division of Adolescent and Young Adult Medicine,
UMDNJ-New Jersey Medical School

C. Tracy Orleans, PhD
Senior Scientist and Distinguished Fellow, Robert Wood Johnson Foundation

Nicolaas P. Pronk, PhD, MA, FACSM, FAWHP
Vice President, Health and Disease Management,
Executive Director, Health Behavior Group
Senior Research Investigator,
HealthPartners Research Foundation
Adjunct Professor of Society, Human Development and Health,
Harvard School of Public Health

Gilbert Ramirez, DrPH
Professor and Associate Dean, Academic and Student Affairs,
Robert Stempel College of Public Health and Social Work,
Florida International University

APPENDIX B. TASK FORCE LIAISON AGENCIES AND ORGANIZATIONS

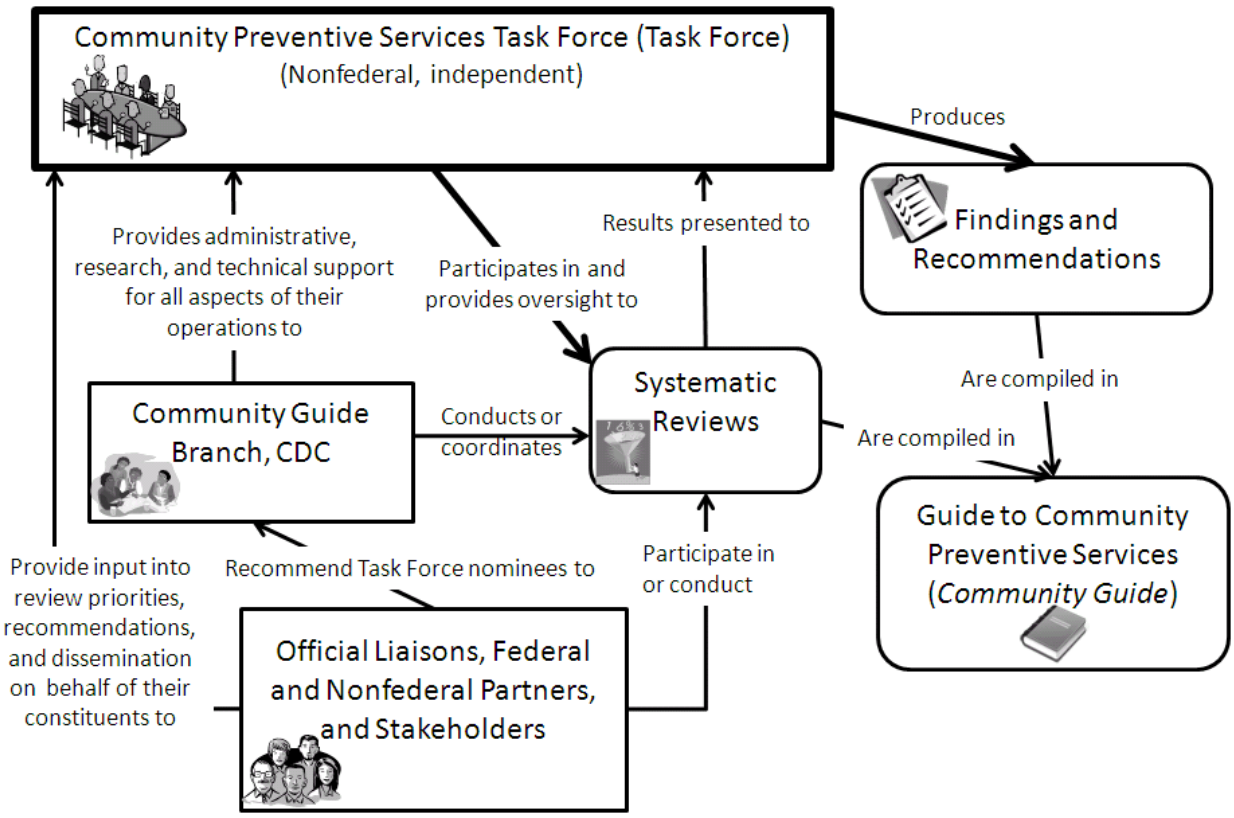
Federal Agency Liaisons

- Agency for Healthcare Research and Quality, Guide to Clinical Preventive Services
- Prevention Research Centers, Centers for Disease Control and Prevention
- Department of Health and Human Services, Office of Disease Prevention and Health Promotion
- Department of Veterans Affairs, Veterans Health Administration, Office of Patient Care Services, National Center for Health Promotion and Disease Prevention
- Health Resources and Services Administration
- Indian Health Service
- National Institutes of Health
- Substance Abuse and Mental Health Services Administration
- United States Air Force
- United States Army Public Health Command
- United States Navy Medicine

Organization Liaisons

- American Academy of Family Physicians
- American Academy of Nurse Practitioners
- American Academy of Pediatrics
- American Academy of Physician Assistants
- American College of Preventive Medicine
- American Medical Association
- American Public Health Association
- America's Health Insurance Plans
- Association for Prevention Teaching and Research
- Association of Schools of Public Health
- Association of State and Territorial Health Officials
- Center for Advancing Health
- Directors of Health Promotion and Education
- Institute of Medicine
- National Association of County and City Health Officials
- National Association of Local Boards of Health
- Public Health Foundation
- Quad Council of Public Health Nursing Organizations
- Society for Public Health Education

APPENDIX C. RELATIONSHIPS BETWEEN THE TASK FORCE, *COMMUNITY GUIDE*, CDC, LIAISONS, AND PARTNERS



APPENDIX D. LIST OF TASK FORCE FINDINGS AND RECOMMENDATIONS 1997 – 2011

Information on all findings available at www.thecommunityguide.org

Categories of Task Force Findings and Recommendations

- The Task Force uses the following terms to describe its findings:
  - **Recommended:** The systematic review of available studies provides **strong** or **sufficient** evidence that the intervention is effective.
    - The categories of "**strong**" and "**sufficient**" evidence reflect the Task Force's degree of confidence that an intervention has beneficial effects. They do not relate directly to the expected magnitude of benefits. The categorization is based on several factors, such as study design, number of studies, and consistency of the effect across studies.
  - **Recommended Against:** The systematic review of available studies provides **strong** or **sufficient** evidence that the intervention is harmful or not effective.
  - **Insufficient Evidence:** The available studies do not provide sufficient evidence to determine if the intervention is, or is not, effective. This does *not* mean that the intervention does not work. It means that additional research is needed to determine whether or not the intervention is effective. There are several reasons why the Task Force would find insufficient evidence to determine effectiveness of an intervention:
    1) There are not enough studies to draw firm conclusions;
    2) The available studies have inconsistent findings;
    3) The interventions were too varied to make an overall conclusion;
    4) The quality of the included studies was poor; or
    5) Concerns exist about applicability or potential harms of the intervention.
- Recent Task Force findings and recommendations are accompanied by a rationale statement that explains Task Force conclusions and provides other relevant information.

Topic	Finding
Adolescent Health	
Person-to-Person Interventions to Improve Caregivers' Parenting Skills	Recommended (Sufficient Evidence)
Excessive Alcohol Consumption and Related Harms	
Interventions Directed to the General Population	
Overservice Law Enhancement Initiatives	Insufficient Evidence
Responsible Beverage Service	Insufficient Evidence
Dram Shop Liability	Recommended (Strong Evidence)
Increasing Alcohol Taxes	Recommended (Strong Evidence)
Maintaining Limits on Days of Sale	Recommended (Strong Evidence)
Maintaining Limits on Hours of Sale	Recommended (Strong Evidence)
Privatization of Retail Alcohol Sales	Recommended Against (Strong Evidence)
Regulation of Alcohol Outlet Density	Recommended (Sufficient Evidence)
Interventions Directed to Underage Drinkers	
Enhanced Enforcement of Laws Prohibiting Sales to Minors	Recommended (Sufficient Evidence)

Asthma Control	
Home-Based Multi-Trigger, Multicomponent Environmental Interventions	
Home-Based Multi-Trigger, Multicomponent Interventions for Adults	Insufficient Evidence
Home-Based Multi-Trigger, Multicomponent Interventions for Children and Adolescents	Recommended (Strong Evidence)
Birth Defect Prevention	
Maternal and Infant Health Outcomes	
Community-Wide Campaigns to Promote the Use of Folic Acid Supplements	Recommended (Sufficient Evidence)
Interventions to Fortify Food Products with Folic Acid*	Recommended (Sufficient Evidence)
Cancer Prevention and Control	
Increasing Breast, Cervical and Colorectal Cancer Screening	
Client-Oriented	
Mass Media - Breast Cancer*	Insufficient Evidence
Mass Media - Cervical Cancer*	Insufficient Evidence
Mass Media - Colorectal Cancer*	Insufficient Evidence
Group Education - Cervical Cancer*	Insufficient Evidence
Group Education - Colorectal Cancer*	Insufficient Evidence
Client Incentives - Breast Cancer*	Insufficient Evidence
Client Incentives - Cervical Cancer*	Insufficient Evidence
Client Incentives - Colorectal Cancer*	Insufficient Evidence
Reducing Client Out-of-Pocket Costs - Colorectal Cancer*	Insufficient Evidence
Reducing Client Out-of-Pocket Costs - Cervical Cancer*	Insufficient Evidence
Reducing Structural Barriers - Cervical Cancer*	Insufficient Evidence
One-on-One Education - Breast Cancer*	Recommended (Strong Evidence)
One-on-One Education - Cervical Cancer*	Recommended (Strong Evidence)
Reducing Structural Barriers - Breast Cancer*	Recommended (Strong Evidence)
Client Reminders - Breast Cancer*	Recommended (Strong Evidence)
Client Reminders - Cervical Cancer*	Recommended (Strong Evidence)
Client Reminders - Colorectal Cancer*	Recommended (Strong Evidence)
Reducing Structural Barriers - Colorectal Cancer*	Recommended (Strong Evidence)
Small Media - Breast Cancer	Recommended (Strong Evidence)
Small Media - Cervical Cancer	Recommended (Strong Evidence)
Small Media - Colorectal Cancer	Recommended (Strong Evidence)
One-on-One Education - Colorectal Cancer*	Recommended (Sufficient Evidence)
Reducing Client Out-of-Pocket Costs - Breast Cancer*	Recommended (Sufficient Evidence)
Group Education - Breast Cancer*	Recommended (Sufficient Evidence)
Multicomponent Interventions	
Multicomponent Interventions	Recommended (Strong Evidence)
Provider-Oriented	
Provider Incentives*	Insufficient Evidence
Provider Reminder and Recall Systems	Recommended (Strong Evidence)
Provider Assessment and Feedback*	Recommended (Sufficient Evidence)
Informed Decision Making	
Promoting Informed Decision Making for Cancer Screening	Insufficient Evidence

Preventing Skin Cancer	
Community-Wide Interventions	
Community-Wide Multicomponent Interventions	Insufficient Evidence
Mass Media Campaigns	Insufficient Evidence
Education and Policy Approaches	
Education and Policy Approaches in Secondary Schools and Colleges	Insufficient Evidence
Education and Policy Approaches for Healthcare Settings and Providers	Insufficient Evidence
Education and Policy Approaches in Child Care Centers	Insufficient Evidence
Education and Policy Approaches in Outdoor Occupation Settings	Insufficient Evidence
Education and Policy Approaches in Outdoor Recreation Settings	Recommended (Sufficient Evidence)
Education and Policy Approaches in Primary School Settings	Recommended (Sufficient Evidence)
Interventions Targeting Parents and Caregivers	
Interventions Targeting Children's Parents and Caregivers	Insufficient Evidence
Diabetes Prevention and Control	
Healthcare System Level Interventions	
Case Management Interventions to Improve Glycemic Control	Recommended (Strong Evidence)
Disease Management Programs	Recommended (Strong Evidence)
Self-Management Education	
Diabetes Self-Management Education in the Worksite	Insufficient Evidence
Diabetes Self-Management Education in Recreational Camps	Insufficient Evidence
Diabetes Self-Management Education in School Settings	Insufficient Evidence
Diabetes Self-Management Education in the Home - Adults with Type 2 Diabetes	Insufficient Evidence
Diabetes Self-Management Education in Community Gathering Places - Adults with Type 2 Diabetes	Recommended (Sufficient Evidence)
Diabetes Self-Management Education in the Home - Children and Adolescents with Type 1 Diabetes	Recommended (Sufficient Evidence)
Health Communication and Social Marketing	
Health Communication Campaigns That Include Mass Media and Health-Related Product Distribution	Recommended (Strong Evidence)
HIV/AIDS, Other Sexually Transmitted Infections, and Pregnancy	
Interventions for Adolescents	
Group-Based Abstinence Education Interventions for Adolescents	Insufficient Evidence
Youth Development Behavioral Interventions Coordinated with Sports or Club Participation to Reduce Sexual Risk Behaviors in Adolescents	Insufficient Evidence
Youth Development Behavioral Interventions Coordinated with Work or Vocational Training to Reduce Sexual Risk Behaviors in Adolescents	Insufficient Evidence

Group-Based Comprehensive Risk Reduction Interventions for Adolescents	Recommended (Sufficient Evidence)
Youth Development Behavioral Interventions Coordinated with Community Service to Reduce Sexual Risk Behaviors in Adolescents	Recommended (Sufficient Evidence)
Interventions for Men Who Have Sex with Men	
Group-Level Behavioral Interventions for Men Who Have Sex With Men	Recommended (Strong Evidence)
Individual-Level Behavioral Interventions for Men Who Have Sex With Men	Recommended (Strong Evidence)
Community-Level Behavioral Interventions for Men Who Have Sex With Men	Recommended (Sufficient Evidence)
Partner Counseling and Referral Services	
Partner Notification by Contract Referral to Identify HIV-Positive People	Insufficient Evidence
Partner Notification by Patient Referral to Identify HIV-Positive People	Insufficient Evidence
Partner Notification by Provider Referral to Identify HIV-Positive People	Recommended (Sufficient Evidence)
Mental Health and Mental Illness	
Depressive Disorders	
Community-Based Exercise Interventions Among Older Adults	Insufficient Evidence
Collaborative Care for the Management of Depressive Disorders*	Recommended (Strong Evidence)
Home-Based Depression Care Management Among Older Adults	Recommended (Strong Evidence)
Clinic-Based Depression Care Management Among Older Adults	Recommended (Sufficient Evidence)
Motor Vehicle-Related Injury Prevention	
Alcohol-Impaired Driving	
School-Based Programs: Peer Organization	Insufficient Evidence
Designated Driver Promotion Programs: Incentive Programs	Insufficient Evidence
Designated Driver Promotion Programs: Population-Based Campaigns	Insufficient Evidence
School-Based Programs: Social Norming Campaigns	Insufficient Evidence
Sobriety Checkpoints	Recommended (Strong Evidence)
Multicomponent Interventions with Community Mobilization	Recommended (Strong Evidence)
Ignition Interlocks	Recommended (Strong Evidence)
0.08% Blood Alcohol Concentration (BAC) Laws	Recommended (Strong Evidence)
Maintaining Current Minimum Legal Drinking Age (MLDA) Laws	Recommended (Strong Evidence)
Intervention Training Programs for Servers of Alcoholic Beverages	Recommended (Sufficient Evidence)
Lower BAC Laws for Young or Inexperienced Drivers	Recommended (Sufficient Evidence)
Mass Media Campaigns	Recommended (Sufficient Evidence)
School-Based Programs: Instructional Programs	Recommended (Sufficient Evidence)

Child Safety Seats	
Education Programs When Used Alone	Insufficient Evidence
Laws Mandating Use	Recommended (Strong Evidence)
Distribution and Education Programs	Recommended (Strong Evidence)
Incentive and Education Programs	Recommended (Sufficient Evidence)
Community-Wide Information and Enhanced Enforcement Campaigns	Recommended (Sufficient Evidence)
Safety Belts	
Enhanced Enforcement Programs	Recommended (Strong Evidence)
Laws Mandating Use	Recommended (Strong Evidence)
Primary (vs. Secondary) Enforcement Laws	Recommended (Strong Evidence)
Nutrition	
School-Based Programs Promoting Nutrition and Physical Activity	Insufficient Evidence
Obesity Prevention and Control	
Interventions in Community Settings	
Mass Media Interventions to Reduce Screen Time	Insufficient Evidence
School-Based Programs	Insufficient Evidence
Worksite Programs*	Recommended (Strong Evidence)
Behavioral Interventions to Reduce Screen Time	Recommended (Sufficient Evidence)
Technology-Supported Interventions: Multicomponent Coaching or Counseling Interventions to Maintain Weight Loss	Recommended (Sufficient Evidence)
Technology-Supported Interventions: Multicomponent Coaching or Counseling Interventions to Reduce Weight	Recommended (Sufficient Evidence)
Provider-Oriented Interventions	
Multicomponent Interventions with Client Interventions	Insufficient Evidence
Multicomponent Provider Interventions	Insufficient Evidence
Provider Education	Insufficient Evidence
Provider Education with a Client Intervention	Insufficient Evidence
Provider Feedback	Insufficient Evidence
Provider Reminders	Insufficient Evidence
Oral Health	
Dental Caries (Cavities)	
Statewide or Community-Wide Sealant Promotion	Insufficient Evidence
Community Water Fluoridation	Recommended (Strong Evidence)
School-Based or -Linked Sealant Delivery Programs	Recommended (Strong Evidence)
Oral and Facial Injuries	
Population-Based Interventions to Encourage Use of Helmets, Facemasks, and Mouthguards in Contact Sports	Insufficient Evidence
Oral and Pharyngeal Cancers	
Population-Based Interventions for Early Detection	Insufficient Evidence
Physical Activity Promotion	
Behavioral and Social Approaches	
Classroom-Based Health Education to Reduce TV Viewing and Video Game Playing	Insufficient Evidence
College-Based Physical Education and Health Education	Insufficient Evidence
Family-Based Social Support	Insufficient Evidence

Enhanced School-Based Physical Education	Recommended (Strong Evidence)
Individually-Adapted Health Behavior Change Programs	Recommended (Strong Evidence)
Social Support Interventions in Community Settings	Recommended (Strong Evidence)
Campaigns and Informational Approaches	
Classroom-Based Health Education Focused on Providing Information	Insufficient Evidence
Campaigns and Informational Approaches to Increase Physical Activity: Mass Media Campaigns*	Insufficient Evidence
Community-Wide Campaigns	Recommended (Strong Evidence)
Environmental and Policy Approaches	
Transportation and Travel Policies and Practices	Insufficient Evidence
Creation of or Enhanced Access to Places for Physical Activity Combined with Informational Outreach Activities	Recommended (Strong Evidence)
Point-of-Decision Prompts to Encourage Use of Stairs	Recommended (Strong Evidence)
Community-Scale Urban Design and Land Use Policies and Practices	Recommended (Sufficient Evidence)
Street-Scale Urban Design and Land Use Policies and Practices	Recommended (Sufficient Evidence)
Social Environment	
Culturally Competent Healthcare	
Cultural Competency Training for Healthcare Providers	Insufficient Evidence
Culturally Specific Healthcare Settings	Insufficient Evidence
Programs to Recruit and Retain Staff who Reflect the Community's Cultural Diversity	Insufficient Evidence
Use of Interpreter Services or Bilingual Providers	Insufficient Evidence
Use of Linguistically and Culturally Appropriate Health Education Materials	Insufficient Evidence
Early Childhood Development Programs	
Comprehensive, Center-Based Programs for Children of Low-Income Families	Recommended (Strong Evidence)
Housing	
Mixed-Income Housing Developments	Insufficient Evidence
Tenant-Based Rental Assistance Programs	Recommended (Sufficient Evidence)
Tobacco Use Prevention and Control	
Decreasing Tobacco Use Among Workers	
Incentives and Competitions to Increase Smoking Cessation	Insufficient Evidence
Incentives and Competitions to Increase Smoking Cessation Combined with Additional Interventions	Recommended (Strong Evidence)
Smoke-Free Policies to Reduce Tobacco Use	Recommended (Sufficient Evidence)
Increasing Tobacco Use Cessation	
Mass Media - Cessation Contests	Insufficient Evidence
Mass Media - Cessation Series	Insufficient Evidence
Provider Assessment and Feedback	Insufficient Evidence
Provider Education When Used Alone	Insufficient Evidence
Increasing the Unit Price of Tobacco Products	Recommended (Strong Evidence)
Mass Media Campaigns When Combined with Other Interventions	Recommended (Strong Evidence)

Multicomponent Interventions That Include Client Telephone Support	Recommended (Strong Evidence)
Provider Reminders with Provider Education	Recommended (Strong Evidence)
Provider Reminders When Used Alone	Recommended (Sufficient Evidence)
Reducing Client Out-of-Pocket Costs for Cessation Therapies	Recommended (Sufficient Evidence)
Reducing Exposure to Environmental Tobacco Smoke (ETS)	
Community Education to Reduce Exposure in the Home	Insufficient Evidence
Smoking Bans and Restrictions	Recommended (Strong Evidence)
Reducing Tobacco Use Initiation	
Increasing the Unit Price of Tobacco Products	Recommended (Strong Evidence)
Mass Media Campaigns When Combined with Other Interventions	Recommended (Strong Evidence)
Restricting Minors' Access to Tobacco Products	
Sales Laws Directed at Retailers When Used Alone	Insufficient Evidence
Active Enforcement of Sales Laws Directed at Retailers When Used Alone	Insufficient Evidence
Community Education about Youth's Access to Tobacco Products When Used Alone	Insufficient Evidence
Laws Directed at Minors' Purchase, Possession, or Use of Tobacco Products When Used Alone	Insufficient Evidence
Retailer Education with Reinforcement and Information on Health Consequences When Used Alone	Insufficient Evidence
Retailer Education without Reinforcement When Used Alone	Insufficient Evidence
Community Mobilization with Additional Interventions	Recommended (Sufficient Evidence)
Vaccination to Prevent Infectious Diseases	
Targeted Vaccinations	
Enhancing Access to Vaccination Services	
Expanded Access in Healthcare Settings When Used Alone	Insufficient Evidence
Reducing Client Out-of-Pocket Costs When Used Alone	Insufficient Evidence
Increasing Community Demand for Vaccinations	
Client or Family Incentives When Used Alone	Insufficient Evidence
Client Reminder and Recall Systems When Used Alone	Insufficient Evidence
Clinic-Based Client Education When Used Alone	Insufficient Evidence
Community-Wide Education When Used Alone	Insufficient Evidence
Vaccination Requirements When Used Alone	Insufficient Evidence
Interventions Implemented in Combination	
Multiple Interventions Implemented in Combination	Recommended (Strong Evidence)
Provider- or System-Based Interventions	
Provider Assessment and Feedback When Used Alone	Insufficient Evidence
Provider Education When Used Alone	Insufficient Evidence
Standing Orders When Used Alone	Insufficient Evidence
Provider Reminders When Used Alone	Recommended (Strong Evidence)

Universally Recommended Vaccines	
Community-Based Interventions Implemented in Combination*	Recommended (Strong Evidence)
Enhancing Access to Vaccination Services	
Expanded Access in Healthcare Settings When Used Alone	Insufficient Evidence
Home Visits to Increase Vaccination Rates*	Recommended (Strong Evidence)
Reducing Client Out-of-Pocket Costs*	Recommended (Strong Evidence)
Vaccination Programs in Schools and Organized Child Care Centers*	Recommended (Strong Evidence)
Vaccination Programs in WIC Settings*	Recommended (Strong Evidence)
Increasing Community Demand for Vaccinations	
Client-Held Paper Immunization Records*	Insufficient Evidence
Clinic-Based Education When Used Alone*	Insufficient Evidence
Community-Wide Education When Used Alone*	Insufficient Evidence
Monetary Sanctions*	Insufficient Evidence
Vaccination Requirements for Child Care, School and College Attendance*	Recommended (Strong Evidence)
Client Reminder and Recall Systems*	Recommended (Strong Evidence)
Client or Family Incentive Rewards*	Recommended (Sufficient Evidence)
Provider- or System-Based Interventions	
Provider Education When Used Alone*	Insufficient Evidence
Immunization Information Systems	Recommended (Strong Evidence)
Provider Assessment and Feedback*	Recommended (Strong Evidence)
Provider Reminders*	Recommended (Strong Evidence)
Standing Orders When Used Alone*	Recommended (Strong Evidence)
Healthcare System-Based Interventions Implemented in Combination*	Recommended (Strong Evidence)
Violence Prevention	
Early Childhood Home Visitation	
Early Childhood Home Visitation	Recommended (Strong Evidence)
Firearms Laws	
"Shall Issue" Concealed Weapons Carry Laws	Insufficient Evidence
Bans on Specified Firearms or Ammunition	Insufficient Evidence
Child Access Prevention (CAP) Laws	Insufficient Evidence
Combinations of Firearms Laws	Insufficient Evidence
Firearm Registration and Licensing of Firearm Owners	Insufficient Evidence
Restrictions on Firearm Acquisitions	Insufficient Evidence
Waiting Periods for Firearm Acquisition	Insufficient Evidence
Zero Tolerance of Firearms in Schools	Insufficient Evidence
Reducing Psychological Harm Among Children and Adolescents From Traumatic Events	
Cognitive Behavioral Therapy	
Group Cognitive-Behavioral Therapy	Recommended (Strong Evidence)
Individual Cognitive-Behavioral Therapy	Recommended (Strong Evidence)
Other Therapies	
Art Therapy	Insufficient Evidence
Pharmacological Therapy	Insufficient Evidence
Play Therapy	Insufficient Evidence
Psychodynamic Therapy	Insufficient Evidence

Psychological Debriefing	Insufficient Evidence
School-Based Programs	
School-Based Programs to Prevent Violence	Recommended (Strong evidence)
Therapeutic Foster Care	
Therapeutic Foster Care for the Reduction of Violence by Children with Severe Emotional Disturbance	Insufficient Evidence
Therapeutic Foster Care for the Reduction of Violence by Chronically Delinquent Adolescents	Recommended (Sufficient Evidence)
Youth Transfer to Adult Criminal System	
Policies Facilitating the Transfer of Juveniles to Adult Justice Systems	Recommended Against (Strong Evidence)
Worksite Health Promotion	
Assessment of Health Risk with Feedback (AHRF)	
Assessment of Health Risks with Feedback (AHRF) Alone	Insufficient Evidence
AHRF plus Health Education with or without Other Interventions	Recommended (Strong Evidence)
Flu Vaccines	
Interventions with Actively Promoted, Off-Site Vaccinations Among Healthcare Workers	Insufficient Evidence
Interventions with Actively Promoted, Off-Site Vaccinations Among Non-Healthcare Workers	Insufficient Evidence
Interventions with On-Site, Free, Actively Promoted Seasonal Influenza Vaccinations Among Healthcare Workers	Recommended (Strong Evidence)
Interventions with On-Site, Reduced Cost, Actively Promoted Seasonal Influenza Vaccinations Among Non-Healthcare Workers	Recommended (Sufficient Evidence)

* Updated review

ENDNOTES

[1] Tandon A, Murray C, Lauer J, Evans D. *Measuring Overall Health System Performance for 191 Countries*. GPE Discussion Paper Series, No. 30, World Health Organization. <http://www.who.int/healthinfo/paper30.pdf> (accessed September 23, 2011).

[2] Centers for Medicare and Medicaid Services, Office of the Actuary. "National Health Expenditures, by Source of Funds and Type of Expenditure: Calendar Years 1960-2009." <https://www.cms.gov/nationalhealthexpenddata/downloads/tables.pdf> (accessed September 18, 2011).

[3] McGinnis JM, Russo P, Knickman JR. "The case for more active policy attention to health promotion." *Health Affairs* 21, no. 2 (2002): 78-93; some estimates are even higher: see Booske BC, Athens JK, Kindig DA et al. *Different Perspectives for Assigning Weights to Determinants of Health. County Health Rankings Working Paper*. University of Wisconsin Population Health Institute, February 2010. <http://uwphi.pophealth.wisc.edu/publications/other/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf > (accessed September 22, 2011).

[4] Olshansky SJ, Passaro DJ, Hershow RC et al. "A potential decline in life expectancy in the United States in the 21st century." *New England Journal of Medicine* 352, no. 11 (2005): 1138–1145; and Reither EN, Olshansky SJ, Yang Y. "New forecasting methodology indicates more disease and earlier mortality ahead for today's younger Americans." *Health Affairs* 30, no. 8 (2011): 1562-1568.

[5] McGinnis JM, Foege WH. "Actual causes of death in the United States." *Journal of the American Medical Association* 270, no. 18 (1993): 2207-2212; and Mokdad AH, Marks JS, Stroup DF, Gerberding JL. "Actual causes of death in the United States, 2000." *Journal of the American Medical Association* 291, no. 10 (2004): 1238-1245, corrections 293, no.3 (2005): 298; World Health Oganization. *Global Status Report on Noncommunicable Diseases, 2010*. Geneva: World Health Organization, 2011. <http://www.who.int/nmh/publications/ncd_report2010/en/index.html> (accessed September 23, 2011).

[6] Trust for America's Health. *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*. Washington, DC: Trust for America's Health, February 2009. <http://healthyamericans.org/reports/prevention08/Prevention08.pdf > (accessed September 23, 2011).

[7] Milstein B, Homer J, Briss P et al. "Why behavioral and environmental interventions are needed to improve health at lower cost." *Health Affairs* 30, no. 5 (2011): 823-832.

[8] See, for example, Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2007*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, October 2007. *Reprinted with corrections.* <http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm> (accessed September 23, 2011); Keener D, Goodman K, Lowry A et al. (2009). *Recommended Community Strategies and Measurements to Prevent Obesity In the United States: Implementation and Measurement Guide.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. <http://www.cdc.gov/obesity/downloads/community_strategies_guide.pdf> (accessed September 23, 2011).

[9] Cawley J, Ruhm C. *The Economics of Risky Health Behaviors.* National Bureau of Economic Research Working Paper No. 17081, May 2011; Goetzel RZ, Kowlessar N, Roemer EC et al. "Workplace Obesity Programs." Chapter 8 in *The Oxford Handbook of the Social Science of Obesity*, edited by Cawley, J. New York: Oxford University Press, Inc., 2011; Goetzel RZ, Ozminkowski RJ. "The health and cost benefits of work site health-promotion programs." *Annual Review of Public Health* 29, (2008): 303-323; Stiglitz JA, Sen A, Fitoussi J-P. 2009. *Report by the Commission on the Measurement of Economic Performance and Social Progress.* Paris, France: Commission on the Measurement of Economic and Social Progress. <http://www.stiglitz-sen-fitoussi.fr/documents/rapport_anglais.pdf> (accessed September 23, 2011).

[10] Fielding JE, Teutsch SM. "Integrating clinical care and community health: delivering health." *Journal of the American Medical Association*, 302, no. 3 (2009): 317-319; Ockene JK, Edgerton EA, Teutsch SM et al., "Integrating evidence-based clinical and community strategies to improve health." *American Journal of Preventive Medicine* 32, no.3 (2007): 244-252; See also the discussion of tobacco cessation interventions in Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2007.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, October 2007. *Reprinted with corrections.* <http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm> (accessed September 23, 2011).

[11] Mission: Readiness. *Too Fat to Fight: Retired Military Leaders Want Junk Food Out of America's Schools*. Washington, DC: Mission Readiness, 2010. <http://cdn.missionreadiness.org/MR_Too_Fat_to_Fight-1.pdf> (accessed September 23, 2011).

[12] Trust for America's Health. *Ready or Not? Protecting the Public's Health from Diseases, Disasters, and Bioterrorism.* Washington, DC: Trust for America's Health, September 2011. <http://healthyamericans.org/assets/files/TFAH911Anthrax10YrAnnvFINAL.pdf> (accessed September 23, 2011).

[13] Brownson RC, Baker EA, Leet TL et al. *Evidence-Based Public Health, 2nd ed.* New York: Oxford University Press, Inc., 2011; Fielding JE, Hopkins DP. "An introduction to evidence on worksite health promotion." Chapter 9 in *American College of Sports Medicine's Worksite Health Handbook: A Guide to Building Healthy and Productive Companies*, edited by Pronk NP, 75-81. Champaign, Illinois: Human Kinetics, 2009.

[14] http://www.cdc.gov/physicalactivity/downloads/PA_State_Indicator_Report_2010_Indicators.pdf.

[15] U.S. Department of Health and Human Services. *2008 Physical Activity Guidelines for Americans.* Washington, DC: Department of Health and Human Services, 2008. < http://www.health.gov/paguidelines/guidelines/default.aspx> (accessed October 7, 2011).

[16]Goetzel RZ, Ozminkowski RJ. "The health and cost benefits of work site health-promotion programs." *Annual Review of Public Health* 29, (2008): 303-323.

[17] Henke RM, Goetzel RZ, McHugh J, Isaac F. "Recent experience in health promotion at Johnson & Johnson: Lower health spending, strong return on investment." *Health Affairs*, 30, no. 3 (2011): 490-499.

[18] Thygeson NM, Gallagher JM, Cross KK, Pronk NP. "Employee health at BAE Systems: An employer-health plan partnership approach." Chapter 36 in *American College of Sports Medicine's Worksite Health Handbook: A Guide to Building Healthy and Productive Companies*, edited by Pronk NP, 75-81. Champaign, Illinois: Human Kinetics, 2009.

[19] U.S. Department of Transportation, National Highway Traffic Safety Administration (NHTSA). *Traffic Safety Facts 2009: Alcohol-Impaired Driving.* Washington, DC: National Highway Traffic Safety Administration, 2010. <http://www-nrd.nhtsa.dot.gov/Pubs/811385.PDF> (accessed October 7, 2011).

[20] U.S. Department of Transportation, National Highway Traffic Safety Administration (NHTSA). *Traffic Safety Facts 2009: Alcohol-Impaired Driving.* Washington, DC: National Highway Traffic Safety Administration, 2010. <http://www-nrd.nhtsa.dot.gov/Pubs/811385.PDF> (accessed October 7, 2011).

[21] Blincoe L, Seay A, Zaloshnja E et al. *The Economic Impact of Motor Vehicle Crashes, 2000.* Washington, DC: Department of Transportation (US), National Highway Traffic Safety Administration, 2002.

[22] Shults RA, Elder RW, Sleet DA et al. "Reviews of evidence regarding interventions to reduce alcohol-impaired driving." *American Journal of Preventive Medicine*, 21, no. 4S (2001): 66S–88S.

[23] Mercer SL, Sleet DA, Elder RW et al. "Translating evidence into policy: Lessons learned from the case of lowering the legal blood alcohol limit for drivers." *Annals of Epidemiology*, 20, no. 6 (2010): 412-420.

[24] Centers for Disease Control and Prevention. "Annual smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 2000–2004." *Morbidity and Mortality Weekly Report*, 57 no. 45 (2008): 1226–1228.

[25] Centers for Disease Control and Prevention. "Annual smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 2000–2004." *Morbidity and Mortality Weekly Report*, 57 no. 45 (2008): 1226–1228.

[26] Chaloupka F, Peck RM. "The value of the 1964 Surgeon General's Report." Chapter 19 in *Handbook of Research on Cost-Benefit Analysis*, edited by Elgar E, 513-526. Cheltenham, UK: Edward Elgar, 2009.

[27] Centers for Disease Control and Prevention. "Decline in smoking prevalence—New York City, 2002--2006." *Morbidity and Mortality Weekly Report*, 56, no. 24 (2007): 604-608; and Centers for Disease Control and Prevention. "CDC Grand Rounds: Current opportunities in tobacco control." *Morbidity and Mortality Weekly Report*, 59 no. 16 (2010): 487-492.

[28] U.S. Cancer Statistics Working Group. *United States Cancer Statistics: 1999–2007 Incidence and Mortality Web-based Report.* Atlanta: Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2010. <http://www.cdc.gov/uscs > (accessed October 7, 2011).

[29] National Cancer Institute. "Costs of cancer care." *Cancer Trends Progress Report—2009/2010 Update.* Bethesda, MD: National Cancer Institute, National Institutes of Health, Department of Health and Human Services, April 2010. <http://progressreport.cancer.gov/doc_detail.asp?pid=1&did=2007&chid=75&coid=726&mid> (accessed October 7, 2011).

www.thecommunityguide.org

The Centers for Disease Control and Prevention provides administrative, research, and technical support for the Community Preventive Services Task Force.