2012

Community Preventive Services Task Force

# 2012 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 2012 Annual Report to Congress was prepared by the Community Preventive Services Task Force (Task Force) in response to the following requirement:

"…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." (, § 4003(b)(1); PHS Act § 399U(b)(6))

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

# Table of Contents

# Executive Summary

In the last year, the Community Preventive Services Task Force (Task Force) has issued or updated findings and recommendations about how to prevent and reduce the spread of pandemic influenza; prevent heart attacks, strokes, and skin cancer; increase the number of Americans who quit smoking; improve mental health; and reduce health disparities. The Task Force also

- Provided training and technical assistance on how to use Task Force recommendations to Task Force Liaisons and other health organizations and agencies; health departments, boards of health, and community-based organizations in 20 states; and Centers for Disease Control and Prevention (CDC) staff who oversee federally-funded programs.
- Improved the website where people can find Task Force findings and recommendations.
- Developed and piloted with CDC a template course on systematic review methods.
- Was recognized for authoring one of the five most cited articles in the American Journal of Preventive Medicine in 2010, "A Systematic Review of Selected Interventions for Worksite Health Promotion: The Assessment of Health Risks with Feedback."

The Task Force identified major gaps in the evidence base that limit its ability to do the following:

- Determine whether specific programs, services, and policies are effective in addressing particular populations or unique health concerns.
- Determine whether programs, services, and policies work everywhere and for everyone or only in specific places or for certain groups of people.
- Help practitioners, policy makers, and other decision makers select and put into place programs, services, and policies that meet their needs.

Using an established, transparent prioritization process, the Task Force has planned new reviews and updates to existing reviews on the following topics in 2012-14:

- Obesity prevention and control.
- Promoting good nutrition.
- Promoting physical activity.
- Addressing disparities in health status.
- Improving oral health.
- Reducing tobacco use and secondhand smoke exposure.
- Cancer prevention and control.
- Cardiovascular disease prevention and control.

When decision makers in communities, business, nonprofits, the health sector, and all levels of government need to know what works to improve and protect health, they can rely on recommendations from the Task Force (see www.thecommunityguide.org). Demand for Task Force recommendations grows stronger as the health sector, employers, the public, and policy makers recognize the imperative to keep people healthy, productive, and functioning independently, and address the rising incidence and costs of preventable diseases. To meet the increasing demand, the Task Force will take these actions:

- Accelerate the completion of highest priority reviews.
- Enhance dissemination to better meet the needs of the wide range of its users.
- Increase and refine training and technical assistance for decision makers and other users.
- Identify and communicate evidence gaps to help scientists, funders, and policy makers optimize resources for health research and evaluation.
- Work closely with the U.S. Preventive Services Task Force and Advisory Committee on Immunization Practices to expand and enhance each other's work.

# Community Preventive Services Task Force 2012 Annual Report to Congress

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

### OVERVIEW

To know what programs, services, and policies are proven to protect and improve health, decision makers in communities, companies, nonprofit organizations, health systems, and at all levels of government can rely on recommendations from the Community Preventive Services Task Force (Task Force). The Task Force bases its recommendations on systematic reviews of the scientific evidence on community preventive services. To date, the Task Force has published 225 evidence-based reviews, findings, and recommendations (Appendix A). They are compiled in the Guide to Community Preventive Services (The Community Guide) as a reference resource for decision makers, which can be found online at www.thecommunityguide.org. Task Force recommendations provide evidence-based options from which decision makers can choose what best meets their needs; they are not mandates for compliance or spending. They include programs, services, and policies that have proven effective in a variety of settings—such as worksites, schools, health plans, faith-based institutions, communities, and states—and can be used to effect these changes:

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

The Task Force outlines its methods, findings, products, and impact in this report, with particular attention to significant research gaps and priorities for future reviews and recommendations.

### BACKGROUND

The Task Force is independent, nonfederal, and unpaid. Its members (Appendix B) represent a broad range of research, practice, and policy expertise in prevention, wellness and health promotion, and public health, and are appointed by the Director of the Centers for Disease Control and Prevention (CDC). The U.S. Department of Health and Human Services established the Task Force in 1996 to identify community preventive interventions that increase healthy longevity, save lives and dollars, and improve Americans' quality of life (Appendix C). The Task Force makes recommendations about what works to improve and protect health based on a systematic review process that evaluates existing research on community-based health programs, services, and policies (Appendix D). It coordinates with the U.S. Preventive Services Task Force (USPSTF)—also independent and nonfederal—which recommends clinical preventive services shown to prevent disease and injury and improve health.

In all aspects of its work, the Task Force obtains input from partner organizations and agencies, and from individual policy makers, practitioners, and researchers (Appendix E). Many of the nation's leading public health practice and research agencies and organizations hold official

Liaison status with the Task Force (Appendix F). CDC is mandated to provide ongoing administrative, research, and technical support for all Task Force operations.

## CURRENT TASK FORCE REVIEWS AND RECOMMENDATIONS

The Task Force uses a rigorous, replicable, and systematic review process to develop evidence-based recommendations for prevention programs, services, and policies. The recommendations can be used population-wide or in selected community settings, such as schools, worksites, community centers, faith-based organizations, health plans, foundations, public health clinics and departments, clinician and public health training programs, and large, integrated healthcare systems. Each systematic review encompasses an exhaustive search for and rigorous appraisal of relevant research and evaluation studies. Task Force reviews evaluate the overall effectiveness of existing programs, services, and policies; and 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.

Evidence-based recommendations seek 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. Table 1 lists broad topic areas addressed to date by Task Force reviews.

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

- Improving Adolescent Health
- Preventing Excessive Alcohol Consumption
- Asthma Control
- Preventing Birth Defects
- Cancer Prevention & Control
- Cardiovascular Disease Prevention & Control
- Diabetes Prevention & Control
- Emergency Preparedness & Response
- Health Communication & Social Marketing
- Addressing Disparities in Health Status (Health Equity)
- Preventing HIV/AIDS, Other STIs & Pregnancy
- Improving Mental Health
- Motor Vehicle-Related Injury Prevention
- Promoting Good Nutrition
- Obesity Prevention & Control
- Improving Oral Health
- Promoting Physical Activity
- Promoting Health Through the Social Environment
- Reducing Tobacco Use & Secondhand Smoke Exposure
- Increasing Appropriate Vaccinations
- Violence Prevention
- Worksite Health Promotion

Appendix A contains all 225 current Task Force findings and recommendations for programs, services, and policies, and lists findings based on the strength of evidence:

- Strong (76) or sufficient (39) evidence of effectiveness.
- Strong (2) or sufficient (0) evidence of harm or lack of effectiveness.
- Insufficient evidence to determine effectiveness (108).

Insufficient evidence findings mean there was not enough evidence to determine whether an 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. Reasons for insufficient evidence findings are described in Appendix A.

## KEY ACCOMPLISHMENTS

In the interval between the 2011 Report to Congress and this report, the Task Force accomplished the following:

- Conducted new systematic reviews and updates to existing reviews (Table 2) resulting in 10 evidence-based findings and recommendations (see Appendix A).

**Table 2. Task Force Reviews since 2011 Report to Congress**

| Topic Area | New Reviews |
|---|---|
| Cardiovascular Disease Prevention & Control | 1. Team-Based Care to Improve Blood Pressure Control |
| Emergency Preparedness & Response | 2. School Dismissals to Reduce Transmission of Pandemic Influenza |
| Addressing Disparities in Health Status (Health Equity) | 3. Full-Day vs. Half-Day Kindergarten to Improve Health-Related Educational Outcomes for Economically Disadvantaged and Minority Students |
| Improving Mental Health | 4. Mental Health Benefits Legislation in Improving Mental Health |
| Reducing Tobacco Use & Secondhand Smoke Exposure | 5. Mobile Phone-Based Interventions in Increasing Tobacco Use Cessation<br>6. Internet-Based Interventions for Tobacco Cessation |
| | **Updates to Existing Reviews** |
| Cancer Prevention & Control—Preventing Skin Cancer | 7. Community-wide Multicomponent Interventions to Prevent Skin Cancer by Increasing UV Protective Behaviors<br>8. Mass Media Campaigns to Prevent Skin Cancer by Reducing Exposure to UV Radiation |
| Reducing Tobacco Use & Secondhand Smoke Exposure | 9. Quitline Interventions to Increase Tobacco Cessation<br>10. Reducing Out-of-Pocket Costs for Evidence-based Tobacco Cessation Treatments |

- Provided training and technical assistance on how to use Task Force recommendations to Task Force Liaisons; other professional health organizations and agencies; state and local health departments, boards of health, and community-based organizations in 20 states; and CDC staff who oversee federally-funded programs.
- Improved usability of the Community Guide website (www.thecommunityguide.org) to aid in locating Task Force findings and recommendations.
- Refined methods to expedite updates of reviews every 5 years to meet the statutory mandate.
- Received recognition for one of the five most cited articles in the American Journal of Preventive Medicine in 2010, "A Systematic Review of Selected Interventions for Worksite Health Promotion: The Assessment of Health Risks with Feedback."

## MAJOR EVIDENCE GAPS IDENTIFIED

In the 2011 Report to Congress, the Task Force identified gaps in three types of evidence (Appendix G). These gaps persist and 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. Evidence gaps can be filled by a combination of research studies and evaluations of real world programs, services, and policies. Key evidence gaps associated with each of the 10 reviews completed by the Task Force since the 2011 Report to Congress are detailed in Appendix H. Some of the most important of these evidence gaps and noteworthy patterns across the reviews are discussed below.

### 1. Evidence to determine whether programs, services, and policies are effective in addressing particular populations or unique health concerns.

The Task Force produced two insufficient findings and one split evidence finding (Appendix H) since its last Report to Congress (see Appendix A for information about "insufficient evidence").

The Task Force found insufficient evidence to determine

1) Whether or not mass media campaigns were effective in preventing skin cancer by reducing exposure to UV radiation.

2) Whether or not interventions for tobacco cessation found on the Internet were effective in helping people to quit smoking. These findings underscore the Task Force's ongoing concern with how little information is available on the effectiveness of recent technologies, including social media, that may hold potential for greater reach—and impact—at lower cost than traditional ways of reaching the public.

The Task Force made a split finding on the effectiveness of closing schools to reduce the spread of pandemic influenza, concluding a) insufficient evidence existed to determine whether closing schools would be effective when an outbreak is of moderate or low severity, but b) sufficient evidence of effectiveness existed to recommend closing schools when an outbreak is severe. The Task Force highlighted the need for information from the 2009 H1N1 pandemic to be made available to help evaluate effectiveness for low to moderate severity outbreaks, and the need to also assess the effectiveness of closing childcare settings.

### 2. Evidence to determine whether programs, services, and policies work everywhere or only in specific places or for certain groups of people.

Across the programs, services, and policies that the Task Force recommended on the basis of strong or sufficient evidence of effectiveness, the Task Force consistently found that more evidence was needed on how effective the interventions were for racial and ethnic minority populations and for populations with lower socioeconomic status (Appendix H). In some cases, information on participants' racial and ethnic status was not provided, while other studies had limited numbers of racial and ethnic minority and low income participants, or studies of racial and ethnic minorities or low income participants were few. This information is needed to address disparities in health care access, services, and outcomes. Additionally, for the reviews that relate most closely to health insurance coverage, important information was missing on the types of insurance, insurance providers, benefits and cost sharing structures, making it difficult to determine if certain scenarios were associated with greater effectiveness.

### 3. Information to help decision makers and other users select and implement effective programs, services, and policies that meet their needs, priorities, and constraints.

The Task Force consistently noted a lack of evidence about how best to devise and deliver programs, services, and policies (Appendix H). Information often was missing about duration and intensity of programs and services; how to select or adapt potential components; personnel needed; how best to promote programs, services, and policies; and how best to enhance sustainability and adherence to interventions over time. Each of these issues has important implications for staffing and resource allocation within individual communities, worksites, and other settings. Additionally, data for assessing economic efficiency and return on investment were consistently missing. Some studies included direct costs to the program, but not direct or indirect costs to participants and their families, or other stakeholders. Some studies missed significant benefits for various stakeholders. Others did not adequately account for underlying disease or health spending trends. More economic analyses are needed, especially during these fiscally challenging times.

## SETTING PRIORITIES FOR FUTURE TASK FORCE REVIEWS

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 (Appendix F) and the public. A Task Force committee oversees the process of compiling extensive background information on all proposed topics, systemically evaluating this information to rank proposed topics using predetermined prioritization criteria (Table 3), and review by the entire Task Force to identify topics of "highest," "high," "medium," and "lower" priority.

**Table 3. Criteria for Defining 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, education. 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 research to support informative systematic evidence reviews |
| • 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 programs, services, and policies within that topic allows the Task Force to achieve significant economies of scale. It also provides decision makers with a menu of effective options for addressing the topic.

The Task Force has identified the following "highest" priority topics for reviews in 2012-2013:

- Cardiovascular Disease Prevention and Control (new reviews).
- Obesity Prevention and Control (new reviews).
- Promoting Good Nutrition (new reviews).
- Worksite Health Promotion (new reviews).
- Addressing Disparities in Health Status (Health Equity) (new reviews).
- Promoting Physical Activity (new reviews and updates to existing reviews).
- Reducing Tobacco Use and Secondhand Smoke Exposure (new reviews and updates to existing reviews).
- Improving Oral Health (updates to existing reviews).
- Cancer Prevention and Control—Preventing Skin Cancer; and Increasing Appropriate Breast, Cervical, and Colorectal Cancer Screening (updates to existing reviews).

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

## HOW COMMUNITIES USE TASK FORCE RECOMMENDATIONS

With 225 Task Force findings and recommendations already available and new ones added regularly, communities, workplaces, schools, public health agencies, healthcare systems, non-governmental organizations, and all levels of government have a wide range of options for using Task Force findings. Some communities use the findings to communicate public health challenges and solutions. Others use them to address their overall health goals or a specific health problem. Still others use them as a planning tool, to help them strengthen their overall approach to improving public health practice or to optimize their resources. Specific examples of how communities across the country have used Task Force findings and recommendations to bring about healthful changes are featured in Appendix I.

## LOOKING AHEAD TO 2013

Demand for Task Force recommendations is stronger now than ever before. Policy makers, the health sector, employers, third-party payers, and the public recognize the imperative to keep people healthy, productive, and independent, and to reduce the burden of healthcare costs on governments and the private sector. It has become clear that factors affected by community preventive services have even more influence on Americans' health than does access to quality medical care.[∞]

To meet the increasing demand, the Task Force will take these actions:

- **Accelerate the completion of highest priority reviews:**
  - Balance new reviews with review updates.
  - Identify updates for expedited review.
  - Develop and test mechanisms for expanding review capacity by using external contractors for updates.
- **Enhance dissemination efforts to better meet the needs of a wide range of users:**
  - Refine access to information on The Community Guide website (www.thecommunityguide.org), including adding a searchable database.
  - Expand the range of formats and channels used in dissemination.
  - Increase the number of examples of The Community Guide in Action stories.
- **Increase and refine training and technical assistance for decision makers and other users who want help in selecting and implementing Task Force recommendations:**
  - Develop a core curriculum that can be customized for a range of audiences to provide technical assistance in using Task Force recommendations.
  - Develop a crosswalk of The Community Guide with Public Health Accreditation Board standards to help health agencies identify how they meet these standards.
- **Identify and communicate important evidence gaps, to help policy makers, funders, and scientists optimize resources for research and evaluation:**
  - Consult with researchers and funders (e.g., National Institutes of Health, Robert Wood Johnson Foundation, and CDC) on gaps in evidence.
  - Assist CDC programs in using The Community Guide in both program- and research-focused Funding Opportunity Announcements (FOAs).
  - Determine how the Task Force and The Community Guide can be useful to members of the National Prevention Council.
- **Work closely with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices:**
  - Evaluate health system supports for both USPSTF and ACIP.
  - Capitalize on opportunities to enhance or extend each other's work for strengthened health impact.
  - Coordinate in identifying critical elements of nomination and conflict of interest procedures.

[∞]McGinnis JM, Russo P, Knickman JR. "The case for more active policy attention to health promotion." *Health Affairs* 21, no. 2 (2002): 78-93.

## APPENDIX A. LIST OF TASK FORCE RECOMMENDATIONS AND OTHER FINDINGS

**Information on all recommendations and other findings available at www.thecommunityguide.org**

### Categories of Task Force Recommendations and Other Findings

- *Recommendations*—The Task Force uses the following terms to describe its recommendations:
    - **Recommended:** The systematic review of available studies provides evidence that the intervention is effective. The Task Force can recommend an intervention on the basis of
        1) **Strong evidence** of its effectiveness, or
        2) **Sufficient evidence** of its effectiveness.
            - 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 evidence that the intervention is harmful or not effective. The Task Force can recommend against an intervention on the basis of
        1) **Strong evidence** that it is harmful or not effective, or
        2) **Sufficient evidence** that it is harmful or not effective.
- *Other Findings*—When the available studies do not provide enough evidence to determine if the intervention is, or is not, effective, the Task Force arrives at a finding of **Insufficient Evidence**. 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:
    a) There are not enough studies to draw firm conclusions.
    b) The available studies have inconsistent findings.
    c) The interventions were too varied to make an overall conclusion.
    d) The quality of the included studies was poor.
    e) Concerns exist about applicability or potential harms of the intervention.

**Denotes that review is an update to an existing review.*

| Topic | Recommendations and Other Findings |
|---|---|
| **Improving Adolescent Health** | |
| Person-to-Person Interventions to Improve Caregivers' Parenting Skills | Recommended (Sufficient Evidence) |
| **Preventing Excessive Alcohol Consumption** | |
| **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) |

| Topic | Recommendations and Other Findings |
|---|---|
| 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) |
| **Preventing Birth Defects** | |
| **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 Appropriate 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 |
| Reducing Structural Barriers - Breast Cancer° | Recommended (Strong Evidence) |
| Reducing Structural Barriers - Colorectal Cancer° | Recommended (Strong Evidence) |
| One-on-One Education - Breast Cancer° | Recommended (Strong Evidence) |
| One-on-One Education - Cervical Cancer° | Recommended (Strong Evidence) |
| One-on-One Education - Colorectal Cancer° | Recommended (Sufficient Evidence) |
| Client Reminders - Breast Cancer° | Recommended (Strong Evidence) |
| Client Reminders - Cervical Cancer° | Recommended (Strong Evidence) |
| Client Reminders - 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) |

°Updated Review; Screening for breast, cervical, and colorectal cancers are reported individually within each strategy, but are part of the same review.

| Topic | Recommendations and Other Findings |
|---|---|
| Group Education - Breast Cancer° | Recommended (Sufficient Evidence) |
| Reducing Client Out-of-Pocket Costs - 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** | |
| Multicomponent Community-Wide Interventions* | Recommended (Sufficient Evidence) |
| Mass Media* | 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 |
| **Cardiovascular Disease Prevention and Control** | |
| Team-Based Care in Improving Blood Pressure Control | Recommended (Strong 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 |

°Updated Review; Screening for breast, cervical, and colorectal cancers are reported individually within each strategy, but are part of the same review.

| Topic | Recommendations and Other Findings |
|---|---|
| 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) |
| **Emergency Preparedness and Response** | |
| School Dismissals to Reduce Transmission of Pandemic Influenza | Severe Pandemic: Recommended (Sufficient Evidence) |
| | Moderate to Low Severity Pandemic: Insufficient evidence |
| **Health Communication and Social Marketing** | |
| Health Communication Campaigns That Include Mass Media and Health-Related Product Distribution | Recommended (Strong Evidence) |
| **Addressing Health Disparities (Health Equity)** | |
| Full-Day Kindergarten | Recommended (Strong Evidence) |
| **Preventing 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 Contact 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) |

| Topic | Recommendations and Other Findings |
|---|---|
| **Improving Mental Health** | |
| 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) |
| Mental Health Benefits Legislation | Recommended (Sufficient Evidence) |
| **Motor Vehicle-Related Injury Prevention** | |
| **Alcohol-Impaired Driving** | |
| School-Based Programs: Peer Organization | Insufficient Evidence |
| School-Based Programs: Social Norming Campaigns | Insufficient Evidence |
| Designated Driver Promotion Programs: Incentive Programs | Insufficient Evidence |
| Designated Driver Promotion Programs: Population-Based 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) |
| **Promoting Good Nutrition** | |
| School-Based Programs Promoting Nutrition and Physical Activity | Insufficient Evidence |

| Topic | Recommendations and Other Findings |
|---|---|
| **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 |
| **Improving 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 |
| **Promoting Physical Activity** | |
| **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 |

| Topic | Recommendations and Other Findings |
|---|---|
| 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) |
| **Promoting Health Through the 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) |
| **Reducing Tobacco Use and Secondhand Smoke Exposure** | |
| **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** | |
| Internet-Based Interventions | Insufficient Evidence |
| 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) |
| Provider Reminders with Provider Education | Recommended (Strong Evidence) |
| Quitline Interventions* | Recommended (Strong Evidence) |
| Reducing Out-of-Pocket Costs for Evidence Based Tobacco Cessation Treatments* | Recommended (Strong Evidence) |
| Mobile Phone-Based Interventions | Recommended (Sufficient Evidence) |
| Provider Reminders When Used Alone | Recommended (Sufficient Evidence) |
| **Reducing Secondhand Smoke Exposure** | |
| Community Education to Reduce Exposure in the Home | Insufficient Evidence |
| Smoking Bans and Restrictions | Recommended (Strong Evidence) |

| Topic | Recommendations and Other Findings |
|---|---|
| **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) |
| **Increasing Appropriate Vaccinations** | |
| **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) |

| Topic | Recommendations and Other Findings |
|---|---|
| **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** | |

| Topic | Recommendations and Other Findings |
|---|---|
| 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) |

## APPENDIX B. LIST OF CURRENT TASK FORCE MEMBERS

Jonathan E. Fielding, MD, MPH, MBA (Chair)
Director of Public Health and Health Officer, County of Los Angeles 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, MPH (Vice-Chair)
Dean, Gillings School of Global Public Health, University of North Carolina at Chapel Hill

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
Executive Director, National Forum for Heart Disease & Stroke Prevention;
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, MA
Director, Institute for Health and Productivity Studies,
Rollins School of Public Health, Emory University;
Vice President, Consulting and Applied Research, Truven Health Analytics

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, MA, PhD, FACSM, FAWHP
Vice President and Health Science Officer
Senior Research Investigator,
HealthPartners Research Foundation;
Adjunct Professor of Society, Human Development and Health,
Harvard School of Public Health

Gilbert Ramirez, DrPH
Senior Associate Dean for Academic Affairs and Educational Effectiveness,
School of Public Health,
West Virginia University

## APPENDIX C. THE UTILITY OF COMMUNITY PREVENTIVE SERVICES

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] the factors that influence health are as follows: behaviorial factors (40%), genetics (30%), social circumstances (15%), medical care (10%) and environmental conditions (5%).[3] Community preventive efforts can effect these changes:

- ***Increase healthy 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 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]

[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 July 27, 2012).

[2] Centers for Medicare and Medicaid Services, Office of the Actuary. "National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Change: Selected Calendar Years 1960-2010." <https://www.cms.gov/nationalhealthexpenddata/downloads/tables.pdf> (accessed July 27, 2012).

[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/different-perspectives-for-assigning-weights-to-determinants-of-health.pdf> (accessed July 27, 2012).

[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 July 27, 2012).

[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 July 27, 2012).

[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 July 27, 2012).

[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 July 27, 2012).

[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 July 27, 2012).

[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 July 27, 2012).

[12] Trust for America's Health, Robert Wood Johnson Foundation. *Remembering 9/11 and Anthrax: Public Health's Vital Role in National Defense*. Washington, DC: Trust for America's Health, September 2011. <http://healthyamericans.org/assets/files/TFAH911Anthrax10YrAnnvFINAL.pdf> (accessed July 27, 2012).

[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.

# APPENDIX D. THE WORK OF THE COMMUNITY PREVENTIVE SERVICES TASK FORCE AND RELATIONSHIP TO U.S. PREVENTIVE SERVICES TASK FORCE

## How the Community Preventive Services Task Force Conducts its Work and Makes its Recommendations

The Task Force meets three times annually in person and communicates throughout the year by phone and through email to carry out these activities:

- Set priorities for selecting topics for systematic review.
- Participate in developing and refining systematic review methods.
- Assign members to serve on each systematic review team.
- Assess the findings of each review and makes recommendations for policy, practice, and research.
- Identify key research and evidence gaps and recommend new research to be conducted in critical areas.
- Help 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.

The Task Force bases its recommendations on a rigorous, replicable, and systematic review process that includes these steps:

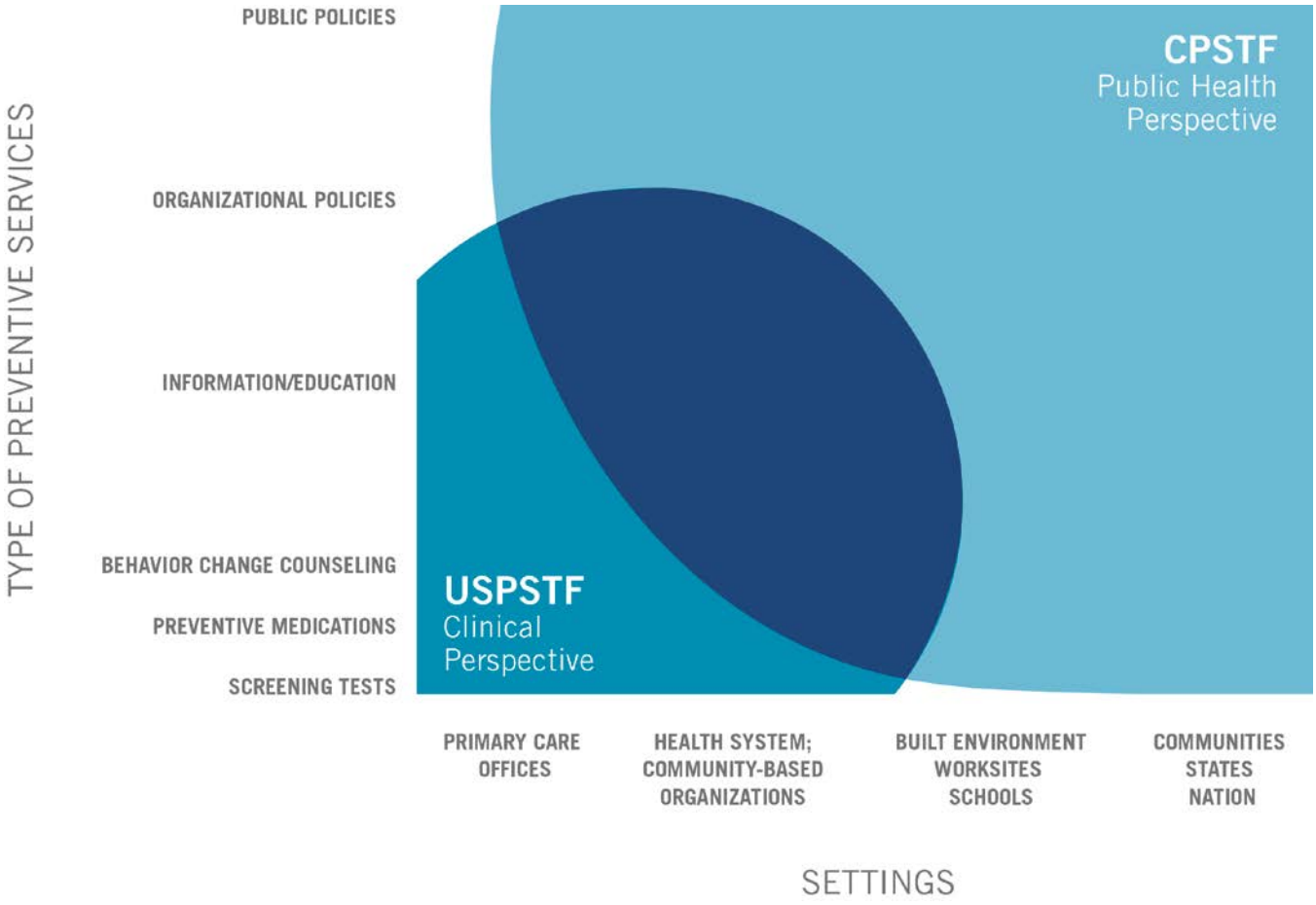
- Evaluate the strength and limitations of existing research evidence on community-based health promotion and disease prevention programs, services, and policies in high-priority topic areas.
- Assess whether the programs, services, and policies are effective in promoting health and preventing disease, injury, and disability.
- Examine 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).
- Conduct 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.

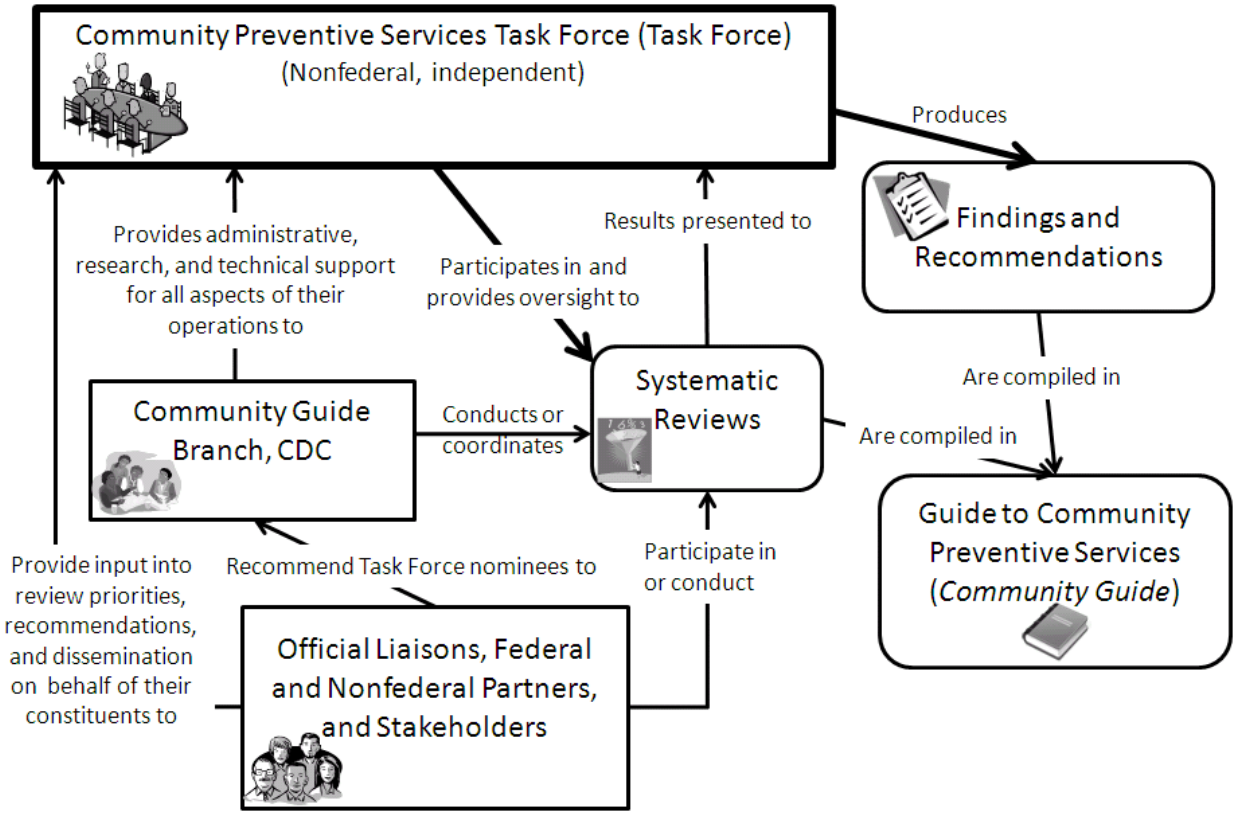
## How the Community Preventive Services Task Force Relates to its Sister Task Force—the U.S. Preventive Services Task Force

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 below. 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.




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

## APPENDIX E. RELATIONSHIPS BETWEEN THE TASK FORCE, COMMUNITY GUIDE, CDC, LIAISONS, AND PARTNERS



## APPENDIX F. TASK FORCE LIAISON AGENCIES AND ORGANIZATIONS

Liaisons participate in meetings of the Task Force and represent the views, concerns, and needs of their organizations and constituents by contributing as follows:

- Helping the Task Force identify the most pressing current public health priorities.
- Serving on and recommending other participants for systematic review teams.
- Providing input while the Task Force examines the systematic review findings to reach its recommendations.
- Disseminating the Task Force recommendations and implementation guidance, and helping their members and constituents translate evidence-based recommendations into action.
- Conveying 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 following agencies and organizations have official Liaison status with the Task Force:

| Federal Agency Liaisons | Organization Liaisons |
|---|---|
| • Agency for Healthcare Research and Quality (as staff support to United States Preventive Services Task Force)<br>• Department of Health and Human Services, Office of Disease Prevention and Health Promotion<br>• Department of Veterans Affairs, Veterans Health Administration, Office of Patient Care Services, National Center for Health Promotion and Disease Prevention<br>• Health Resources and Services Administration<br>• Indian Health Service<br>• National Institutes of Health<br>• Prevention Research Centers, Centers for Disease Control and Prevention<br>• Substance Abuse and Mental Health Services Administration<br>• United States Air Force<br>• United States Army Public Health Command<br>• United States Navy Medicine | • American Academy of Family Physicians<br>• American Academy of Nurse Practitioners<br>• American Academy of Pediatrics<br>• American Academy of Physician Assistants<br>• American College of Preventive Medicine<br>• American Medical Association<br>• American Public Health Association<br>• America's Health Insurance Plans<br>• Association for Prevention Teaching and Research<br>• Association of Schools of Public Health<br>• Association of State and Territorial Health Officials<br>• Center for Advancing Health<br>• Directors of Health Promotion and Education<br>• Institute of Medicine<br>• National Association of County and City Health Officials<br>• National Association of Local Boards of Health<br>• Public Health Foundation<br>• Quad Council of Public Health Nursing Organizations<br>• Society for Public Health Education |

## APPENDIX G. MAJOR EVIDENCE GAPS IDENTIFIED ACROSS REVIEWS

As described in its first Report to Congress in 2011, The Task Force has identified three types of evidence gaps that are routinely seen across Community Guide reviews and that limit the Task Force's ability to provide user audiences with all of the information they need to assist in deciding whether the programs, services, and policies recommended by the Task Force will meet the needs, and preferences of their populations, settings, and contexts, and whether they have adequate resources, capacity, and infrastructure to implement them. Community Guide findings and recommendations highlight specific evidence gaps identified within a review and provide guidance to researchers and research sponsors on future research and evaluation studies.

### 1. Evidence gaps where there is insufficient evidence to determine whether or not specific programs, services, and policies are effective in addressing particular populations or unique health concerns.

As shown in Appendix A, when 108 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. These 108 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. For example, Internet-based health behavior change programs hold the potential for greater reach at lower cost than face-to-face community and organizational programs. Likewise, emerging social media technologies (e.g., Internet, mobile devices, Facebook©, Twitter©) hold great potential to improve the reach and effectiveness of mass media community campaigns. Electronic health records hold unparalleled potential to benefit medically and socio-demographically high-risk populations, and to assist people living in hard-to-reach inner-city and rural settings. 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; supporting healthful lifestyles; or increasing health-related quality of life.

### 2. Evidence 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 115 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 in populations at particularly high risk of disease, disability, or injury, or in settings with fewer resources than were available in the research or evaluation studies. .

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.

### 3. Evidence 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 needs, 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 constrained 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. 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.

## APPENDIX H. KEY EVIDENCE GAPS IDENTIFIED IN REVIEWS COMPLETED SINCE THE LAST REPORT TO CONGRESS

| Topic and Review | | Type of Evidence Gap | | |
|---|---|---|---|---|
| **Intervention Review** | **Type of Review and Task Force Finding** | **Evidence Gap Type 1 – Need More Evidence on:** | **Evidence Gap Type 2 – Need More Evidence on:** | **Evidence Gap Type 3 – Need More Evidence on:** |
| **Cancer Prevention & Control – Preventing Skin Cancer** | | | | |
| Community-Wide Multicomponent Interventions to Prevent Skin Cancer by Increasing UV Protective Behaviors | Update<br><br>Recommended (Sufficient Evidence) | | • **Effectiveness for:**<br>o **Long term**<br>o **Additional outcomes**<br>▪ Skin cancer incidence<br>o **Different settings**<br>o **Different populations**<br>▪ Children<br>▪ Caregivers<br>▪ Race/ethnicity<br>▪ Skin type | • **Critical elements of program delivery:**<br>o Scope<br>o Intensity<br>o Specific components and how to best combine them<br>• **Economic data**<br>(currently being evaluated) |
| Mass Media Campaigns to Prevent Skin Cancer by Reducing Exposure to UV Radiation | Update<br><br>Insufficient Evidence | • Effectiveness of mass media campaigns to reduce UV<br>o More appropriate:<br>▪ Study designs<br>▪ Comparison groups | | • **Critical elements of program delivery:**<br>o Intensity<br>o Informational vs. persuasive messages<br>o Types of channels or combinations of channels<br>o Use of social media |
| **Cardiovascular Disease Prevention and Control** | | | | |
| Team-Based Care (TBC) to Improve Blood Pressure Control | New Review<br><br>Recommended (Strong Evidence) | | • **Effectiveness for:**<br>o **Additional outcomes**<br>▪ Patient satisfaction<br>▪ Adherence to healthy behaviors<br>▪ Sustainability<br>o **Different populations:**<br>▪ Large populations<br>▪ Race/ethnicity<br>▪ Socioeconomic status<br>▪ Income<br>▪ Education<br>▪ Insurance status | • **Critical elements of program delivery:**<br>o Other types of team members:<br>▪ Community health workers<br>▪ Dieticians<br>o Communication within team<br>o Use of technology<br>• **Economic data**<br>(currently being evaluated) |

| Topic and Review | | Type of Evidence Gap | | |
|---|---|---|---|---|
| **Intervention Review** | **Type of Review and Task Force Finding** | **Evidence Gap Type 1 – Need More Evidence on:** | **Evidence Gap Type 2 – Need More Evidence on:** | **Evidence Gap Type 3 – Need More Evidence on:** |
| School Dismissals to Reduce Transmission of Pandemic Influenza | New Review<br><br>Split Finding:<br>1) Severe Pandemic – Recommended (Sufficient Evidence)<br><br>2) Moderate or Low Severity Pandemic – Insufficient Evidence | • Findings of 2009 H1N1 pandemic—to compare with existing modeling and economic data<br>• Modeling for organized childcare settings | • **Effectiveness for:**<br>o **Additional outcomes**<br>▪ Clinical severity<br>o **Different contexts**<br>▪ Threshold margins of effectiveness (where benefits to costs tradeoffs change) based on:<br>♦ Differences in pandemic impact<br>♦ Differences in transmission<br>♦ Presence or absence of other community mitigation actions | • **Critical elements of program delivery:**<br>o School dismissal timing<br>o Duration (Value of shorter dismissals to reduce peak burden on health care resources)<br>• **Economic data**<br>o Child care costs and arrangements<br>o Parents missing work, loss of pay<br>o Costs to schools of maintaining payroll and facilities during closure<br>o School funding when tied to days of instruction<br>o Economic impact on low income households |
| **Addressing Disparities in Health Status (Health Equity)** | | | | |
| Full-Day vs. Half-Day Kindergarten to Improve Health-Related Educational Outcomes for Economically Disadvantaged and Minority Students | New Review<br><br>Recommended (Strong Evidence) | | • **Effectiveness for:**<br>o **Long term**<br>▪ Influence of:<br>♦ Post-kindergarten education<br>♦ Boosters<br>♦ Family conditions<br>♦ Community characteristics<br>o **Different settings**<br>▪ Urban, suburban, rural<br>o **Different populations**<br>▪ Race/ethnicity<br>▪ Socioeconomic status | • **Economic data**<br>o Cost-benefit from societal perspective<br>o School:<br>▪ Transportation savings<br>▪ Curricula Costs<br>▪ Staff training costs<br>o Parents:<br>▪ Childcare savings<br>▪ Employment possibilities |

| Topic and Review | | Type of Evidence Gap | | |
|---|---|---|---|---|
| **Intervention Review** | **Type of Review and Task Force Finding** | **Evidence Gap Type 1 – Need More Evidence on:** | **Evidence Gap Type 2 – Need More Evidence on:** | **Evidence Gap Type 3 – Need More Evidence on:** |
| **Improving Mental Health** | | | | |
| Mental Health Benefits Legislation in Improving Mental Health | New Review<br><br>Recommended (Sufficient Evidence) | | • **Effectiveness for:**<br>o **Long term**<br>o **Additional outcomes**<br>▪ Reduced symptoms<br>▪ Relapse prevention<br>▪ Remission<br>▪ Recovery<br>▪ Mortality<br>▪ Quality of life<br>o **Different populations:**<br>▪ Race/ethnicity<br>▪ Socioeconomic status<br>▪ Different types of mental illness<br>o **Different settings:**<br>▪ Public insurance<br>▪ Inpatient versus outpatient | • **Critical elements of delivery:**<br>o Legislation with more parity requirements<br>• **Economic data**<br>o Inflation rates<br>o Drug innovations<br>o Prescription patterns<br>o Trends in diagnosis and treatment<br>o Business perspective<br>▪ Effects on offer of health benefits as part of compensation<br>▪ Businesses of different sizes |
| **Reducing Tobacco Use and Secondhand Smoke Exposure** | | | | |
| Internet-Based Interventions for Tobacco Cessation | New Review<br><br>Insufficient Evidence | • Effectiveness using full range of available interactive web content and social support | • **Effectiveness for:**<br>o **Different populations** | • **Critical elements of delivery:**<br>o Best web content and social support<br>o Strategies to increase use and adherence<br>• **Economic data**<br>o Costs of sustained promotion, recruitment, retention |
| Mobile Phone-Based Interventions in Increasing Tobacco Use Cessation | New Review<br><br>Recommended (Sufficient Evidence) | | • **Effectiveness for:**<br>o **Different populations**<br>▪ Within US<br>o **Different settings:**<br>▪ Within US<br>▪ Comparative effectiveness and use across:<br>♦ Health departments, organizations<br>♦ Health care systems<br>♦ Quitline services | • **Economic data**<br>o In US settings and situations<br>▪ Overall economic efficiency<br>▪ Comparative economic efficiency across:<br>♦ Health departments, organizations<br>♦ Health care systems<br>♦ Quitline services<br>o Costs of sustained promotion, recruitment |

| Topic and Review | | Type of Evidence Gap | | |
|---|---|---|---|---|
| **Intervention Review** | **Type of Review and Task Force Finding** | **Evidence Gap Type 1 – Need More Evidence on:** | **Evidence Gap Type 2 – Need More Evidence on:** | **Evidence Gap Type 3 – Need More Evidence on:** |
| **Reducing Tobacco Use and Secondhand Smoke Exposure (continued)** | | | | |
| Quitline Interventions to Increase Tobacco Cessation | Update<br><br>Recommended (Strong Evidence) | | • **Effectiveness for:**<br>o **Different populations:**<br>▪ High rates of tobacco use<br>▪ Tobacco-related diseases<br>▪ Limited access to health care, evidence-based cessation treatments | • **Critical elements of program delivery:**<br>o How to increase awareness, use, and impact of quitlines<br>▪ Reactive vs. proactive counseling<br>▪ Quitline +/- promotion<br>▪ Digital media via mobile phones to add text messages or web-based social support<br>• **Economic data**<br>o Cost effectiveness with, without digital media<br>o Current cost data<br>o More information on benefits |
| Reducing Out-of-Pocket Costs for Evidence-based Tobacco Cessation Treatments (ROPC) | Update<br><br>Recommended (Strong Evidence) | | • **Effectiveness for:**<br>o **Additional outcomes**<br>▪ Awareness, use of covered benefits<br>▪ Total number of tobacco users who successfully quit, not just differences in quit rates<br>▪ Quit attempts<br>▪ Total quits<br>o **Different populations:**<br>▪ Age<br>▪ Gender<br>▪ Socioeconomic status<br>▪ Education level<br>▪ Race/ethnicity<br>o **Different settings:**<br>▪ Clarify who is covered in setting<br>▪ Types of coverage provided by different insurers:<br>♦ Private health system<br>♦ Public<br>♦ Large employer | • **Critical elements of program delivery:**<br>o Efforts to promote awareness and use of cessation benefits<br>o Barriers to use and efforts to reduce barriers<br>▪ Benefit requirements that discourage use<br>o Thresholds for benefit use based on out of pocket costs to tobacco users<br>• **Economic data**<br>o Consider total number of tobacco users who successfully quit |

## APPENDIX I. THE COMMUNITY GUIDE IN ACTION: EXAMPLES OF COMMUNITIES USING TASK FORCE FINDINGS AND RECOMMENDATIONS

The following table lists a number of specific examples, by location and topic area, of how Task Force findings and recommendations have helped communities across the country to bring about healthful changes. It is not an exhaustive compilation, but rather an illustrative overview. To read the full stories, click on the links provided in the table. You can also access them from the home page of the Community Guide website at www.thecommunityguide.org.

| Title* | Location | Finding / Recommendation Topic Area(s) | Link to full story |
|---|---|---|---|
| Black Corals: A Gem of a Cancer Screening Program in South Carolina | South Carolina – St. James-Santee Family Health Center | Cancer Screening | http://www.thecommunityguide.org/CG-in-Action/CancerScreening-SC.pdf |
| Blueprint for Success in Reducing Tobacco Use | Nebraska – City of Lincoln and Lancaster County | Tobacco | http://www.thecommunityguide.org/CG-in-Action/Tobacco-NE.pdf |
| Community-Wide Effort to Make Florida Tobacco Free | Florida – Jefferson & Madison County Health Departments | Tobacco | http://www.thecommunityguide.org/CG-in-Action/TobaccoFree-FL.pdf |
| Creating Walkable Communities in Rural North Carolina | North Carolina – Granville County | Obesity<br>Physical Activity | http://www.thecommunityguide.org/CG-in-Action/PhysicalActivity-NC.pdf |
| An Evidence-Based Approach to Montana's Health Landscape | Montana – Department of Public Health and Human Services | Asthma<br>Tobacco<br>Vaccines | http://www.thecommunityguide.org/CG-in-Action/PublicHealth-MT.pdf |
| Evidence-Based Recommendations Get Minnesotans in the Groove | Minnesota – Blue Cross and Blue Shield | Obesity<br>Physical Activity<br>Schools<br>Worksite | http://www.thecommunityguide.org/CG-in-Action/PhysicalActivity-MN.pdf |
| A Good Shot: Reaching Immunization Targets in Duval County | Florida – Duval County Health Department, Jacksonville | Vaccines | http://www.thecommunityguide.org/CG-in-Action/Vaccinations-FL.pdf |

| Title* | Location | Finding / Recommendation Topic Area(s) | Link to full story |
|---|---|---|---|
| Lowering Legal Blood Alcohol Limits Saves Lives | National | Alcohol<br>Motor Vehicle Injury | http://www.thecommunityguide.org/CG-in-Action/BAC.pdf |
| Maryland Businesses Support Worksite Wellness Effort to Combat Chronic Disease | Maryland – Department of Health and Mental Hygiene | Diabetes<br>Obesity<br>Worksite | http://www.thecommunityguide.org/CG-in-Action/Worksite-MD.pdf |
| Mobilizing Funding Support to Battle Overweight and Obesity | Maryland – Western Maryland Health System | Obesity | http://www.thecommunityguide.org/CG-in-Action/Obesity-MD.pdf |
| Planning a Strategy: Changing the Way a County Health Department Addresses Health Conditions | California – Los Angeles County Department of Public Health | Cardiovascular Disease(CVD)<br>Obesity<br>Tobacco | http://www.thecommunityguide.org/CG-in-Action/LACounty.pdf |
| Rural Community Works Together to Stay "Fun and Fit" | Alaska – Hoonah community and Alaska Department of Health and Social Services | Nutrition<br>Obesity<br>Physical Activity<br>Schools | http://www.thecommunityguide.org/CG-in-Action/FunandFit-AK.pdf |
| Screening New Yorkers to Save Lives | New York - New York State Department of Health Cancer Services Program | Cancer Screening | http://www.thecommunityguide.org/CG-in-Action/CancerScreening-NY.pdf |
| *All examples can also be accessed from The Community Guide website at www.thecommunityguide.org or by clicking on the "In Action" image on the right side of the homepage. | | | |

www.thecommunityguide.org

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