The *Guide to Community Preventive Services*
A Public Health Imperative

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The *Guide to Community Preventive Services* (the *Community Guide*) promises to be a substantial and necessary tool in collective efforts to improve the public health. This supplement to the *American Journal of Preventive Medicine* (*AJPM*) is important, not only for its content, but for the example provided of this approach in practice and policymaking. Painstaking and meticulous methodology yielded extensive reviews of evidence relevant to the reduction of injuries to motor vehicle occupants by increasing child safety seat use, increasing safety belt use, and reducing alcohol-impaired driving. The evidence is then weighed, with a specified protocol, to determine if recommendations can be formulated.[1–3] Akin to the *Guide to Clinical Preventive Services*, initially issued in 1989 by the U.S. Preventive Services Task Force and aimed at prevention for the individual patient, this new guide steers an evidence-based course through the broader ocean of population-based prevention.[4,5] Although great progress has been made, as this supplement demonstrates, the future holds significant challenges for this undertaking.

In 1993, The Council on Linkages Between Academia and Public Health Practice (the Council on Linkages) (see Endnote) debated their potential involvement in developing public health practice guidelines. Enthusiasm was tempered with doubts about the effectiveness and feasibility of this initiative.[6] In addition to the issue of turf (who would promulgate the guidelines), two major questions were: (1) availability of evidence on public health interventions to support recommendations, and (2) feasibility of implementation of evidence-based recommendations dependent on acceptability to practitioners in diverse roles and geographic settings. Eight years later, major efforts of the Task Force on Community Preventive Services (the Task Force) are tackling similar areas, critical to the eventual success of the undertaking.

Support provided by the W. K. Kellogg Foundation enabled a 2-year effort by the Council on Linkages to answer the above questions. Four public health issues were chosen for study: (1) immunization of preschool children, (2) completion of treatment for tuberculosis, (3) prevention of cardiovascular disease, and (4) lead poisoning. Relevant literature was identified through searches of electronic databases, inquiries were made of experts on each topic, and queries for information were made to selected state departments of health. At a conference in Baltimore in April 1995, the expert panels concluded that: (1) public health practice guidelines are feasible, based on scientific evidence and other empirical information; and (2) the potential benefits of public health practice guidelines are immediate and far-reaching.[7] The Council on Linkages reported these findings at meetings of the Public Health Functions Group of the U.S. Public Health Service (USPHS) attended by Philip R. Lee, then Assistant Secretary for the U.S. Department of Health and Human Services; David Satcher, then Director of the Centers for Disease Control and Prevention (CDC); and representatives of the other USPHS agencies. In 1996, CDC, at the request of the USPHS, convened a 15-member independent and nonfederal Task Force on Community Preventive Services.[5]

With 5 years of activity, the Task Force and staff have made Herculean efforts to accomplish its mission. As stated by Stephanie Zaza, Chief of the Community Guide Branch, the purpose is to "improve public health practice by increasing the use of effective interventions and decreasing the use of ineffective interventions."[8] Fifteen topic areas were grouped by three categories: (1) changing risk behaviors; (2) addressing specific diseases, injuries, and conditions (including motor vehicle occupant injuries); and (3) addressing environmental and ecosystem challenges.

The potential of the *Community Guide* has already been demonstrated by the contributions on vaccine-preventable disease, tobacco use prevention and cessation, and now on prevention of injury to motor vehicle occupants with evidence-based reviews and recommendations published in the CDC *Morbidity and Mortality Weekly Reports* (MMWR).[9–11] Recommendations on vaccine-preventable disease were incorporated into other documents important to immunization policy including the Institute of Medicine Report, *Calling the Shots: Immunization Finance Policies and Practice.*[12]

The fields of immunization and the prevention of smoking and motor vehicle injury may be more amenable to evidence-based recommendations because of

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the availability of evaluative studies meeting the rigorous criteria. Insufficient evidence for interventions is a challenge faced by the Task Force. While the recommendation protocol allows for expert opinion, this option has not been used to keep guidance squarely evidence-based.[2] A potential peril is the misinterpretation by practitioners, legislators, and others that recommendations not made because of insufficient evidence are recommendations against the intervention. An associated and valuable by-product of findings of insufficient evidence is the identification of numerous public health issues requiring research.

All of the above applies to the evidence reviews and recommendations published in this supplement. Evidence for the effectiveness of strategies was identified for the great majority of interventions on reducing injuries to motor vehicle occupants. Questions for future research were also identified, including the applicability of these programs in different settings and populations. Similar to other topics investigated by the Task Force, there was little or no economic information available for many of these strategies. Sufficient evidence was available to support recommendations in the areas of child safety seat use, seat belt use, and reduction of alcohol-impaired driving.[13–16] Findings such as the strong evidence that primary safety belt laws are more effective than secondary (enforcement only in association with another offense) will aid public health policy determinations and practice.[14] A key finding of strong evidence for the effectiveness of state legislation setting .08% blood alcohol concentration (BAC) limit for driving has already made policy inroads on federal and state levels.[15]

Marguerite Pappaioanou, former Chief of Community Preventive Services Guide Development, and Caswell Evans Jr., Chairperson of the Task Force, identified the primary target audience of the *Community Guide* as "rich and diverse" composed of those "involved in the planning, funding, and implementation of population-based services and policies to improve the health at the community and state levels."[5] Field-testing of chapters and early feedback and input from the readership are seen as a priority. A primary objective of dissemination is encouraging various units within CDC and other federal agencies, such as the National Cancer Institute (NCI) and the National Highway Traffic Safety Administration (NHTSA), to implement the *Community Guide* findings among their partners and networks. (B Myers, Community Guide Branch, CDC, personal communication, 2001.)

Recommendations are to be implemented in partnerships with public health departments, managed care organizations, and employer groups.[8] Three local partnerships have been established in Detroit, Denver, and Connecticut to pilot the *Community Guide* recommendations. (B Myers, Community Guide Branch, CDC, personal communication, 2001.) Plans to improve *Community Guide* dissemination are frequently discussed at meetings of the Task Force. At the June 2001 meeting, Deborah Porterfield, North Carolina Division of Health, reported a low level of awareness among colleagues and others in the *Community Guide* target audience at a series of presentations.[17] Increased recognition of this valuable resource needs to occur for practitioners, health maintenance organizations, and policymakers. The Association of State and Territorial Health Officials (ASTHO) and the National Association of City and County Health Officials (NACCHO) can play a more active role here. Incorporation into the curricula at schools of public health and residency training programs in preventive medicine also are steps in the right direction.

The earlier *Guide to Clinical Preventive Services* has achieved a high level of awareness among practitioners, employers, and policymakers with an interest in prevention interventions directed at the individual. The *Guide to Community Preventive Services* has published chapters on vaccine-preventable disease, tobacco, prevention of motor vehicle injury (in this supplement to *AJPM*) and will publish seven additional chapters to be included in the first volume of the *Guide to Community Preventive Services* in late 2003. The Task Force is planning to add at least two chapters a year and update published chapters in the future. The breadth of the *Community Guide* and the large investment in required resources have been important issues dating to the inception of the Task Force. How is the scope of population-based prevention, with the broad array of socioenvironmental health determinants, best addressed, particularly with a rigorous and demanding methodology requiring at least 2 years to produce a chapter? A recent decision to outsource evidence reviews is a sound measure to expedite this process.

From the outset, CDC has shouldered the major responsibility for staff and for providing evidence reviews for the Task Force. As conceived, the overall effort for public health guidelines was to be assumed by the USPHS. Although some important assistance in the last 5 years has been forthcoming from these other agencies, it is increasingly clear that the magnitude and vital nature of this undertaking demands increased involvement and investment by other USPHS entities including the National Institutes of Health. The *Community Guide* must continue to move forward, for its success is vital to all of our collective efforts to improve public health.

Beyond the work of the Task Force itself lie several critical issues that must be faced before the *Community Guide* can claim its share of the success of prevention. First is the issue of social commitment. As has been the case for many years for lead poisoning prevention in children, enough is known about how to improve vehicle occupant safety and reduce the vehicle occupant death toll substantially across the United States

without further delay. What is lacking is the political will to bring to scale the myriad of "demonstration projects" and small, competitive awards that are scattered nonsystematically in health departments and traffic safety programs around the country. Perhaps one of the difficulties with eliciting this political will lies in the second issue—economics. Few question the moral and social value of saving lives, but our ability to translate these moral and social values to economic values needs more attention. From which agencies will funds be sought to support nationwide prevention efforts? Are these the agencies that will reap the savings when injuries are prevented? If not, how will they justify the expenditures? Can public health leaders help create a coalition of insurance carriers, medical care provider organizations, government payers, auto manufacturers, and others that would be willing to pay for the prevention efforts up front?

Third is the issue of public health infrastructure. There are few injury prevention interventions ready to be implemented nationwide. Several of those that are available now are described in this supplement to *AJPM*. But how many health departments are ready now to accept funds; create or strengthen their partnerships with law enforcement, traffic safety, alcohol prevention, and medical care agencies; and launch new initiatives to reduce vehicle-related injuries? Again, sadly, the answer is "precious few."

A final point is the broader issue of the context in which people use vehicles in the first place. Perhaps this is an issue of "exposure" to the "vector." Certainly, motor vehicles are destined to be the way most Americans move from place to place for years to come, making the prevention interventions described in this supplement vital now. But who thought 50 years ago that Americans would feel the way they do today about smoking? Not many. Public health and transportation leaders must be in the forefront of the changes that will take place to reduce people's risk of injuries from automobile crashes by reducing automobile trips as a percentage of total person-trips in communities all over the country. With the high proportion of serious injuries, disabilities, and deaths that occur from vehicle-related injuries within so few miles of home, we would all be safer and healthier in so many ways if we could walk to school, the supermarket, the tavern, and the movie theatre, or at least not have to drive a car there.

Efforts like those of the Task Force will go a long way toward achieving our prevention goals by making it possible to be selective about the priorities we establish, the partnerships we build, and the methods we choose as we shepherd scarce resources to make prevention a priority.

Endnote:

In 1993, the Council on Linkages was composed of representatives of the Association of State and Territorial Health Officials (ASTHO), the National Association of County Health Officials (NACCHO), American Public Health Association (APHA), Association of Schools of Public Health (ASPH), American College of Preventive Medicine (ACPM), Centers for Disease Control and Prevention (CDC), and the Health Resources Services Administration (HRSA). One of the authors (LN) was Chair of the Council (1993-1996) and has been a consultant to the Task Force since 1996.

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