# PROGRESS REVIEW

## Educational and Community-Based Programs

**DEPARTMENT OF HEALTH & HUMAN SERVICES ■ PUBLIC HEALTH SERVICE ■ November 3, 1999**

The Assistant Secretary for Health and Surgeon General chaired the third and final review of progress in achieving Healthy People 2000 objectives for Educational and Community-Based Programs. The review was organized by the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA), the co-lead agencies for this priority area. The presentations and discussion addressed four settings: schools, work-sites, health care facilities, and communities. Through a satellite broadcast, participants were linked with viewers at remote sites, who were able to submit questions by telephone and fax. Of the 14 objectives in priority area **8**, discussion at the progress review focused on the following:

**8.2** For the total population aged 18-24 years, the rate of high school completion was 86 percent in 1997, the same as the 1992 baseline. For blacks aged 18-24 years, the rate was 82 percent in 1997, also the same as the 1992 baseline. The high school completion rate among Hispanics aged 18-24 years increased from 62 percent in 1992 to 67 percent in 1997, moving toward the year 2000 target of 90 percent for this objective.

**8.3** The percentage of eligible children aged four enrolled in Head Start decreased from 47 percent in 1990 to 40 percent in 1997, moving away from the year 2000 target of 100 percent. The proportion of 5-year-old low-income children receiving one year of Head Start services prior to entering first grade decreased from 58 percent in 1992 to 49 percent in 1996. The proportion of disabled children aged 3-5 years enrolled in preschool increased from 56 percent in 1991 to 63 percent in 1995.

**8.4** The year 2000 target for this objective is to increase to at least 75 percent the proportion of elementary and secondary schools that provide eight specific elements constituting a comprehensive school health education. As of 1994, three out of four schools provided at least one required health class, and two-thirds of the schools had evaluated their health education program during the preceding two years. However, only 53 percent had teachers adequately trained in health education and less than a third reported involvement of parents, health officials, and other concerned members of the community. Only 2 percent of schools met all eight of the criteria.

**8.5** Data from 1995 indicate that a majority of college students aged 18-24 received information at some time during their college career on preventing alcohol and other drug abuse (59 percent), STDs (53 percent) and HIV/AIDS (58 percent). The proportion of students who received information about other health topics was as follows: tobacco, 32 percent; violence prevention, 38 percent; injury prevention and safety, 26 percent; suicide prevention, 21 percent; pregnancy prevention, 34 percent; dietary behaviors and nutrition, 34 percent; and physical activity and fitness, 40 percent. The year 2000 target is 50 percent.

**8.6** The proportion of work-sites with 50 or more employees that offer health promotion programs increased from 65 percent in 1985 to 90 percent in 1997, surpassing the year 2000 target of 85 percent.

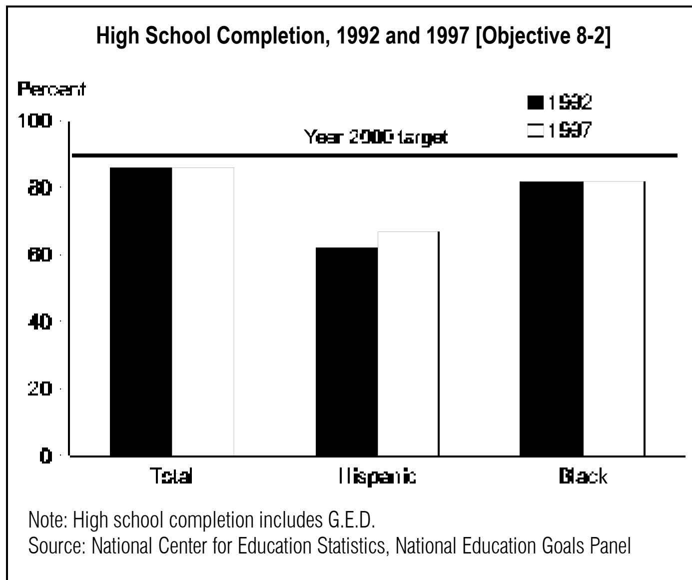
**8.8** Preliminary data from 1998 indicate that 12 percent of people aged 65 and over participated in health promotion programs, the same proportion as in 1995. The year 2000 target is 90 percent.

**8.9** In 1994, the proportion of people aged 10 and older who discussed health issues with family members at least once during the preceding month was 83 percent, exceeding the year 2000 target of 75 percent. The percentages of those who discussed specific health topics were as follows: nutrition, 67 percent; physical activity, 66 percent; sexual behavior, 39 percent; tobacco 47 percent; alcohol, 38 percent; illegal drugs, 33 percent; and safety, 50 percent.

**8.11** This objective aims to increase to at least 50 percent the proportion of counties with community health promotion programs that are culturally and linguistically appropriate for racial and ethnic minority populations in those jurisdictions. In 1996-97, the proportion of counties with significant minority populations that provided such health promotion/disease prevention services ranged from 13 percent for occupational safety and health to 48 percent for immunization and infectious diseases.

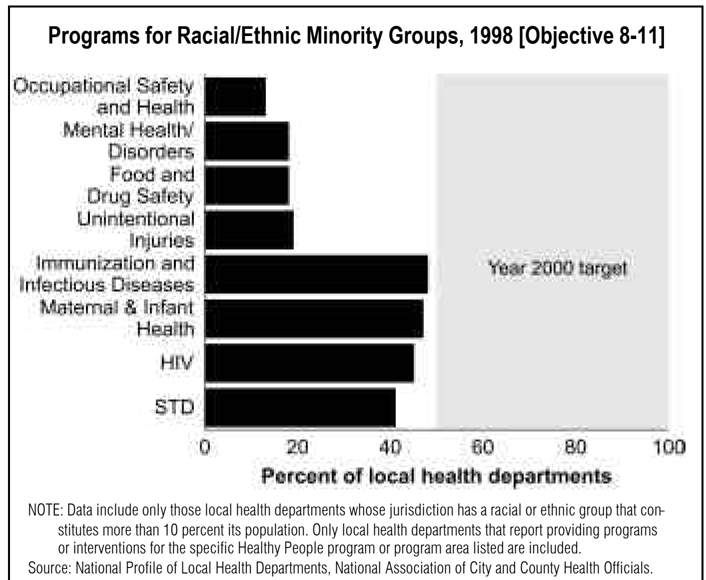
### DEVELOPMENTS

- The Departments of Health and Human Services, Education, and Justice jointly fund the Safe Schools/Healthy Children pilot program in 54 communities.
- The CDC-funded Healthy Schools Network brings together policymakers, health educators, and school staff in 11 States to coordinate efforts that enhance the health of youth.
- Parental involvement is strongly associated with the academic success of children in schools. A recent report by the College Board demonstrates that education is a principal indicator of life-long health status.
- The Benchmarking Best Programs Study identified seven characteristics of successful work-site health promotion programs: linkage to organizational goals, effective communications with employees, sharing of evaluations with management and employees, incentives to increase participation, a supportive culture, support by top management, and a generous budget.
- Work-site health promotion programs commonly produce a five-to-one return on investment in terms of productivity and a three-to-one return in terms of reduced health care costs.
- Corporate entities are increasingly implementing family outreach programs. Two-thirds of employee medical costs are incurred by spouses and children.
- HRSA provides $300 million to increase minorities in the health professions.
- CDC's Racial and Ethnic Approaches to Community Health (REACH) 2010 initiative funds 30 communities to identify strategies for reducing health disparities.
- The WHO/PAHO Integrated Management of Childhood Illness Initiative provides health messages for caregivers and families on a variety of health topics.




**High School Completion, 1992 and 1997 [Objective 8-2]**

Note: High school completion includes G.E.D.
Source: National Center for Education Statistics, National Education Goals Panel




**Programs for Racial/Ethnic Minority Groups, 1998 [Objective 8-11]**

NOTE: Data include only those local health departments whose jurisdiction has a racial or ethnic group that constitutes more than 10 percent its population. Only local health departments that report providing programs or interventions for the specific Healthy People program or program area listed are included.
Source: National Profile of Local Health Departments, National Association of City and County Health Officials.

**8.12** In 1990, 86 percent of registered hospitals offered community health promotion programs or patient education programs addressing the health needs of their communities, an increase from 68 percent in 1987. Among community hospitals, 77 percent provided patient education or health promotion programs in 1990, an increase from 60 percent in 1987. The proportion of health maintenance organizations offering health education increased from 75 percent in 1990 to 84 percent in 1992, while the proportion offering nutrition counseling increased from 85 percent to 87 percent during the same period. The year 2000 target is 90 percent.

**8.14** This objective aims to increase to at least 90 percent the proportion of people who are served by local health departments that are effectively carrying out the core functions of public health. A 1992-93 survey by the National Association of City and County Officials showed that 84 percent of local health departments in 43 States provided health education; 96 percent, immunizations; 64 percent, prenatal care; and 30 percent, primary care.

## FOLLOW-UP

- Build more vigorous and comprehensive health promotion partnerships among State and local health departments , community health centers, employer councils, schools, faith-based organizations, and other entities to improve the health and vitality of the communities they serve.
- Encourage greater involvement of parents in school health education programs and other activities affecting the welfare and life prospects of their children.
- Eliminate provisions of categorical funding programs that inhibit the development and expansion of community health promotion efforts.
- Explore with communities the available health data sets that can be applied locally and determine what more needs to be developed to meet their needs.
- Investigate environmental and other changes as possible intermediate indicators of long-term, population-level outcomes of health intervention strategies.
- Identify and seek to reduce eligibility requirements that block participation in Head Start and other Federal and State programs for children.
- Extend beyond the early years of life coverage for programs and activities to aid in the education and development of disabled children.
- Encourage all States to seize opportunities to incorporate mental health services into their Children's Health Insurance Programs.
- Achieve a broader integration of patient education and counseling into all facets of health care provision. Seek to increase the computer literacy of health care providers and others involved with community health promotion activities.
- Encourage reimbursement policies for clinical preventive services.
- Ensure that work-site health promotion programs are tailored to the specific needs and capabilities of management, employees, and providers.

## PARTICIPANTS

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American Journal of Health Promotion
Association of State and Territorial Directors of Health Promotion and Public Health Education
Centers for Disease Control and Prevention
Department of Education
Health Resources and Services Administration
Kaiser Permanente Foundation
Maine Bureau of Family and Community Health
Maryland Department of Health and Mental Hygiene
National Association of State Boards of Education
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