Educational and Community-Based Programs

U.S. Department of Health & Human Services • Public Health Service

December 9, 2008

PROGRESS REVIEW

In the 28th session of the second series of assessments of *Healthy People 2010*, Deputy Assistant Secretary for Health (Science and Medicine) Anand Parekh chaired a Progress Review on Educational and Community-Based Programs. He was assisted by staff of the co-lead Agencies for this *Healthy People 2010* focus area, the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS). Dr. Parekh stressed the importance to the Nation's collective health status of education and other social determinants that are addressed by many of the focus area objectives, usually in one of the great variety of non-clinical settings in which people spend their lives.

The complete November 2000 text for the Educational and Community-Based Programs focus area of *Healthy People 2010* is available online at **www.healthypeople.gov/document/html/volume1/07ed.htm**. Revisions to the focus area chapter that were made at the January 2005 Midcourse Review are available at **www.healthypeople.gov/data/midcourse/html/focusareas/fa07toc.htm**. For comparison with the current state of the focus area, the report on the first-round Progress Review (held on December 15, 2004) is archived at **www.healthypeople.gov/data/2010prog/focus07/2004fa07.htm**. The meeting agenda, tabulated data for all focus area objectives, charts, and other materials used in the Progress Review can be found at a companion site maintained by the CDC National Center for Health Statistics (NCHS): **www.cdc.gov/nchs/about/otheract/hpdata2010/focusareas/fa07-ecbp2.htm**. That site has a link to **wonder.cdc.gov/data2010**, which provides access to detailed definitions for the objectives in all 28 *Healthy People 2010* focus areas and periodic updates to their data.

Data Trends

Richard Klein, Chief of the NCHS Health Promotion Statistics Branch, presented an overview of data related to the Educational and Community-Based Programs focus area. He noted that one's education level is a powerful predictor of physical and mental health and longevity. Schools can play a critical role in providing information, tools, and practical strategies to help students adopt healthy lifestyles. Of the focus area objectives and subobjectives that were retained after the 2005 *Healthy People 2010* Midcourse Review, one has met its target, six are improving, one is getting worse, nine show little or no change, and four have baseline data only. Mr. Klein then provided a more detailed examination of objectives the focus area workgroup selected to highlight at the Progress Review:

(Obj. 7-1): In 2006, 88 percent of persons aged 18 to 24 years had completed high school, compared with 85 percent in 1998. By racial and ethnic group for whom data were available, the proportions of people in this age group in 2006 who had completed high school were as follows: non-Hispanic Asians and Pacific Islanders,

96 percent; non-Hispanic whites, 93 percent; persons of two or more races, 90 percent; non-Hispanic blacks, 85 percent; and Hispanics, 71 percent (a significant improvement from 63 percent in 1998). The target for all population groups is 90 percent.

Among some population groups, the likelihood of high school completion is strongly influenced by the recency of immigration. In 2006, 57.7 percent of Hispanics born outside, but resident in, the United States had completed high school, compared with 81.9 percent of first-generation Hispanics, and 83.5 percent of Hispanics who were at least of the second generation. Self-assessed health status appears to improve with the level of education achieved. In 2007, only 38.2 percent of persons with less than high school education reported themselves to be in excellent or very good health, compared with 52.5 percent of high school graduates, 59.9 percent of persons who had some college education, and 73.9 percent of college graduates. In contrast, 28.2 percent of persons with less than high school education reported themselves to be in fair or poor health, compared with 16.3 percent of high school graduates, 13.2 percent of persons who had some college education, and only 6.2 percent of college graduates. Also, the occurrence of negative mood is associated inversely with the level of education achieved. In 2007, 3.7 percent of persons with less than high school education reported feelings of hopelessness in the preceding month, compared with 2.8 percent of high school graduates, 1.7 percent of persons who had some college education, and only 0.7 percent of college graduates. The feeling during the preceding month that everything required an effort occurred among 7.1 percent of persons with less than high school education, 5.9 percent of high school graduates, 5.0 percent of persons who had some college education, and only 2.2 percent of college graduates.

(Obj. 7-2a-i): In 2006, the proportions of middle, junior high, and senior high schools that provided school health education on specific topics were as follows: all priority areas, 44 percent (33 percent in 1994)—target, 83 percent; unintentional injury, 80 percent (66 percent in 1994)—target, 90 percent; violence, 77 percent (58 percent in 1994)—target, 80 percent; suicide, 63 percent (58 percent in 1994)—target, 80 percent; tobacco use and addiction, 87 percent (86 percent in 1994)—target, 95 percent; alcohol and other drug use, 87 percent (90 percent in 1994)—target, 95 percent; unintended pregnancy, HIV/AIDS, and STD infection, 67 percent (65 percent in 1994)—target, 90 percent; unhealthy dietary patterns, 84 percent (the same in 1994)—target, 95 percent; and inadequate physical activity, 79 percent (78 percent in 1994)—target, 90 percent.

(Obj. 7-4a-d): In 2006, the proportions of schools that had at least one nurse for every 750 or more students were as follows: all middle, junior high, and senior high schools, 45 percent (28 percent in 1994)—target, 50 percent; senior high schools, 38 percent (26 percent in 1994)—target, 50 percent; middle and junior high schools, 50 percent (32 percent in 1994)—the target of 50 percent was met; and elementary schools, 45 percent (42 percent in 2000)—target, 48 percent.

(Obj. 7-10): In 2007, 97 percent of the States and U.S. Territories included local health service areas or jurisdictions that had established community health promotion programs addressing two or more *Healthy People 2010* focus areas. Also, the Kickapoo Native American tribe had received block grant funding for a program on substance abuse and the Santee Sioux tribe had funding for a program on accessing health care.

Key Challenges and Current Strategies

Kurt Greenlund, Associate Director for Science in the Division of Adult and Community Health of the CDC National Center for Chronic Disease Prevention and Health Promotion, and Lyman Van Nostrand, Director of the HRSA Office of Planning and Evaluation, made presentations on the principal themes of the Progress Review. Their statements, the discussion that ensued, and Progress Review briefing materials prepared by an interagency workgroup identified a number of barriers to achieving the objectives, as well as activities under way to meet these challenges, including the following:

Barriers

- According to the U.S. Department of Commerce, high school dropouts are more likely to be unemployed and, when they are employed, earn less than those who completed high school.
- A continuing problem facing efforts to address educational and community-based program needs is assuring at all levels the competency of the workforce required for evaluating, communicating, and translating health promotion programs.
- In many areas of concern, dissemination mechanisms for delivering evidence-based programs are inadequate, in terms of not only the number of health promotion programs but also in the amount of exposure to these programs.
- Increasing budget pressures at the Federal, State, and local levels limit the amount of resources available for school health education and for school nursing staff.
- Too often, community health promotion strategies lack the firm basis in evidence of their results that would allow them to be replicated in other settings.
- Additionally, communities often have lacked the appropriate tools and resources to translate effectively evidence-based programs into community practice that suits local needs.
- Surveys that are the sources of data by which objectives can be tracked are sometimes conducted only once when funding is available for a relatively short period (for example, the survey supporting the objective for worksite health promotion) and not repeated again in a timely enough fashion to make updating possible during the decade.
- It is increasingly difficult to measure progress for some objectives in the focus area. Some data sources used to establish measures were not continued or ceased collecting the data needed to support tracking.

Activities and Outcomes

- CDC's *Racial and Ethnic Approaches to Community Health Across the United States* (REACH U.S.) program has produced improvements in health and reductions in health disparities in communities that face serious community health problems. REACH U.S. provides training, technical assistance, and support to community coalitions that design, implement, evaluate, and disseminate community-driven strategies to eliminate health disparities in key health areas. In fiscal year 2007, CDC launched Centers for Excellence in the Elimination of Health Disparities to disseminate innovative strategies developed in REACH U.S. communities to train and mentor new communities. CDC has a Web site at **www.cdc.gov**.
- HRSA's Area Health Education Centers (AHEC) program offers cooperative agreements to accredited schools of medicine and nursing to encourage the establishment and maintenance of community-based training programs in off-campus rural and underserved areas. The AHEC program provides other community-based training

for health professions students and practicing healthcare providers and exposes students in grades 9 to12 to health career activities. Other program activities include the mentoring of students in medically underserved and unserved communities from kindergarten through grade 12. Between fiscal year 2003 and fiscal year 2006, a total of 203,253 high school students received AHEC health career training of more than 20 hours. HRSA has a Web site at **www.hrsa.gov**.

- CDC has published a series of guidelines documents that identify the school health program strategies most likely to be effective in promoting healthy behaviors among young people. Based on extensive reviews of research literature, the guidelines were developed by CDC in collaboration with other Federal Agencies, State agencies, universities, voluntary organizations, and professional organizations. Included in the series are guidelines for programs to prevent unintentional injury and violence, promote lifelong healthy eating, promote lifelong physical activity among young people, and prevent tobacco use and addiction.
- In 2004, HRSA developed the *Take a Stand. Lend a Hand. Stop Bullying Now!* national public awareness and prevention campaign directed at young people aged 9 to 13 years. The campaign's message to kids is: You can play a key role in stopping bullying at schools and in other social environments. The campaign Web site **www.stopbullyingnow.hrsa.gov** receives up to 20,000 visitors in an average week. Since the campaign began, HRSA has distributed more than 20,000 resource kits to parents, educators, and other adults interested in bullying prevention.
- One resource designed to facilitate disease prevention and health promotion planning in colleges and universities is *Healthy Campus 2010: Making It Happen*. The manual helps local health workers assess campus and community health needs in their area.
- CDC's *Steps* program implements prevention and health promotion activities to address chronic diseases and related risk behaviors. The program has moved into a new phase that will spread effective local strategies to bring change in communities across the Nation on an ongoing basis. The growing successes of *Steps* communities are being continuously translated into Action Guides, mentorship networks, tools for community change, and Action Institutes which will provide structured guidance, support, training, and state-of-the-art models for replication in hundreds of communities in all regions of the country.
- To assist schools in the implementation of quality health programs, CDC recently developed the Physical Education Curriculum Analysis Tool (PECAT) at **www.cdc.gov/healthyyouth/pecat/index.htm**. PECAT provides guidance that allows local school districts to meet local needs and interests and increase the likelihood of improving students' knowledge, skills, and health behaviors.
- The National Center on School-Based Health Care (NCSBHC), which receives funding from HRSA, provides up-to-date, evidence-based information, resources, and technical assistance to school-based and school-linked health clinics to improve and enhance their service capabilities and quality of care. NCSBHC interacts with approximately 1,700 school-based/linked health clinics in the United States, as well as with schools and communities interested in developing this model of health care.
- CDC's Health Education Curriculum Analysis Tool (HECAT) at **www.cdc.gov/healthyyouth/hecat/index.htm** can help school districts, schools, and others conduct a clear, complete, and consistent analysis of health education curricula based on

the National Health Education Standards and CDC's Characteristics of Effective Health Education Curricula. With the HECAT results in hand, schools are better able to select or develop appropriate and effective health education curricula and improve the delivery of health education. The HECAT can be customized to meet local community needs and conform to the curriculum requirements of the State or school district.

- A resource designed to increase disease prevention and health promotion activities in the workplace is *Healthy Workforce 2010: An Essential Health Promotion Sourcebook for Employers, Large and Small*, prepared by the Partnership for Prevention (**www.prevent.org**). This publication educates employers on how health promotion helps businesses function more effectively and efficiently. In addition, it provides strategies for developing and maintaining worksite health promotion programs and activities.
- To provide guidance for designing and implementing policy and environmental change interventions that affect large segments of the population, the Directors of Health Promotion and Education (DHPE), with support from CDC, has developed *Policy and Environmental Change: New Directions for Public Health*. Another DHPE report, *State Health Promotion Capacity*, describes the perceived health promotion capacities of those carrying out programs in State health agencies, priority needs for professional development, and actions that might be undertaken to strengthen health promotion activities and programs conducted by State and local public health agencies.
- CDC's *Guide to Community Preventive Services* (**www.thecommunityguide.org**) provides evidence-based recommendations for programs and policies to promote population health in 16 principal subject areas. Users of the guide include public health professionals, legislators and policymakers, community-based organizations, providers of healthcare services, researchers, and employers and other purchasers of healthcare services.
- HRSA developed a Web-based health communications training tool designed to improve interaction between healthcare providers and their patients. The training aid helps toward achieving Objective 7-11 (Increase the proportion of local health departments that have established culturally appropriate and linguistically competent health promotion and disease prevention programs). This Unified Health Communication Tool addresses health literacy, cultural competency and limited English proficiency in a five-part, self-paced interactive training format available at **www.hrsa.gov/healthliteracy/training.htm**. The last module in the series allows participants to apply information learned in previous modules to test their ability to communicate effectively with patients.
- The second version of Community Health Status Indicators (CHSI) is now in the final stages of preparation by a consortium that includes HRSA, CDC, other HHS Agencies, associations of public health professionals, and partners in the private sector. (See **www.communityhealth.hhs.gov**.) CHSI II will provide an overview of key health indicators for local communities and is intended to encourage dialogue about actions that can be taken to improve a community's health. With more than 200 measures for each of the 3,141 U.S. counties, community profiles can be displayed on maps or downloaded in brochure format. The CHSI mapping capability will allow users to compare their own county visually with similar, as well as adjacent counties.

What Needs To Be Done

Participants in the Progress Review made the following suggestions for public health professionals and policymakers to consider as steps to enable further progress toward achieving the objectives for Educational and Community-Based Programs:

- Ensure that the interests and expertise of active and potential Federal Healthy People partners, such as the HHS Administration on Children and Families and the U.S. Department of Education, are reflected in any iteration of the Healthy People initiative, specifically in any continuation in whatever form of objectives in focus area 7 of *Healthy People 2010*.
- Strive to instill a sense of ownership in and advocacy for the subjects of focus area 7 in Federal staff, State partners, and citizens groups whose interests are most closely allied to and affected by Educational and Community-Based Programs.
- Seek to profit by the experience of other *Healthy People 2010* focus areas in planning for the transition of focus area 7 content into the milieu of Healthy People 2020.
- Examine all sides of the issue of whether to continue focus area 7 in much the same form in which it currently exists or to pursue an alternative strategy, such as amalgamation with other focus areas.
- Explore alternatives for increasing rates of response to public surveys and assess whether data can be collected from other national data sources not currently used for this focus area.
- Seek to expand community intervention strategies among young children, for whom such strategies are often more effective in the long run.
- Consider a process for Healthy People 2020 that can accommodate a changing field, such as community health and educational programs, in which there have been substantial positive developments that may not be reflected in the objectives developed several years earlier.

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[Signed February 3, 2009]

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