Educational and Community-Based Programs

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

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PROGRESS REVIEW

In the 25th in a series of assessments of *Healthy People 2010,* Senior Executive Advisor to the Assistant Secretary for Health Larry Fields chaired a focus area Progress Review on Educational and Community-Based Programs. Dr. Fields noted that even when best practices in the field of health care and prevention are well defined and widely accepted, their translation into practical application can be problematic. In this regard, programs that are mediated by educational and community-based settings can be said to serve at the front lines of health promotion and disease prevention efforts. Among the more effective health promotion programs are those that implement comprehensive plans with multiple intervention strategies in the fields of education, policy, and the environment within various settings, such as schools, worksites, healthcare facilities, and the community. In conducting the review, Dr. Fields 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). Also participating were representatives of other U.S. Department of Health and Human Services (HHS) offices and agencies.

The complete text for the Educational and Community-Based Programs focus area of *Healthy People 2010* is available at **www.healthypeople.gov/document/html/volume1/07ed.htm**. The meeting agenda, tabulated data for all focus area objectives, charts, and other materials used in the Progress Review can be found at **www.cdc.gov/nchs/about/otheract/hpdata2010/focusareas/fa07-ecbp.htm**.

Data Trends

Edward Sondik, Director of the CDC National Center for Health Statistics (NCHS), provided an overview of progress achieved in meeting the targets of selected objectives in the Educational and Community-Based Programs (ECBPs) focus area. Dr. Sondik characterized this focus area as providing the foundation for many others, but one that is challenged by the difficulty of collecting data to assess progress. Of the objectives in the focus area that have had updates to the baseline in the past 6 years, data show progress toward the target for two, a mixed picture for a third, and a worsening trend for a fourth.

Objective 7-2 seeks to increase the proportion of middle, junior high, and senior high schools that require courses on health education in nine areas—unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and sexually transmitted infections; unhealthy dietary patterns; inadequate physical activity; and environmental health. The only significant change with respect to any one of these topics has occurred among schools requiring courses in violence prevention—an increase from 58 percent of schools in 1994 to 73 percent in 2000 (target, 80 percent). The proportion of schools that have a ratio of at least 1 school nurse to 750 students increased from 32 percent in 1994 to 57 percent in 2000 among middle and junior high schools and, over the same period, from 26 percent to 44 percent among senior high schools. The target is 50 percent (Obj.

7-4a, b, c). In 2000, 53 percent of elementary schools had at least 1 school nurse to every 750 students. The target is 60 percent (Obj. 7-4d).

Between 1994 and 1998, the proportion of employees (age adjusted, aged 18 years and older) who participated in employer-sponsored health promotion activities decreased from 67 percent to 59 percent. In 1998, race and ethnicity, gender, and educational attainment were not significantly associated with employee participation in employer-sponsored health promotion programs. The target is 75 percent (Obj. 7-6).

Of a total of 419 local health jurisdictions responding to a 2004 survey, more than 250 jurisdictions reported that their community health promotion programs addressed 17 to 28 of the *Healthy People 2010* focus areas (Obj. 7-10). The largest proportion (c. 90 percent) of responding agencies involved at least three community sectors to define health problems, resources, perceptions, and priorities for action. Almost 80 percent involved at least three community sectors to develop targeted and measurable objectives for outcomes, risk factors, public awareness, services, and protection. Just over 60 percent reported involving at least three community sectors to monitor and evaluate processes to measure objectives. The community sectors referenced here include government, business, education, the faith community, health care, media, voluntary agencies, and the public.

Data from 1996–1997 were used to establish the baseline for Objective 7-11 to increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs. Culturally appropriate and linguistically competent programs are programs that are adapted to address the cultural differences and special language needs of racial and ethnic minorities in a population. Of the focus areas covered by the survey, health departments reported the highest proportion of culturally appropriate and linguistically competent programs for immunization and infectious diseases (48 percent), maternal and infant health (47 percent), HIV (45 percent), family planning (42 percent), and sexually transmitted infections (41 percent). Health departments reported fewer culturally appropriate and linguistically competent programs for environmental health (22 percent), mental health (18 percent), occupational safety and health (13 percent), and physical activity and fitness (21 percent). The target is 50 percent of local health departments.

In 1998, 12 percent of older adults (age adjusted, aged 65 years and older) participated in community health promotion activities, such as an exercise class or a presentation on health topics. Older adults with at least some college education participated at a rate (20 percent) that was twice that of high school graduates (10 percent) and almost 4 times the rate of those who had not completed high school (6 percent). The target is 90 percent (Obj. 7-12).

Key Challenges and Current Strategies

In the presentations that followed the data overview, the principal themes were introduced by representatives of the two co-lead agencies—Barbara Bowman, Acting Associate Director for Science of CDC's National Center for Chronic Disease Prevention and Health Promotion, and Dennis Williams, HRSA's Deputy Administrator. These agency representatives and other participants in the review identified a number of barriers to achieving the objectives and discussed activities under way to meet these challenges, including the following:

- In support of the President's *HealthierUS* initiative, HHS and the Departments of Education and Agriculture created the collaborative *Healthier Children and Youth Memorandum of Understanding* to strengthen and promote the education and health of U.S. school-aged children and youth.

- In fiscal year 2003, HHS provided $15 million through a cooperative agreement to support 23 communities to help them establish innovative community-based programs targeting the six chronic diseases and conditions that are the focus of the HHS *Steps to a HealthierUS* initiative launched in that year.
- In April 2004, the President established the position of National Coordinator for Health Information Technology (HIT), whose office is located in HHS. In pursuit of the President's overall goal of having electronic medical records for all Americans within 10 years, the HIT initiative embraces the strategy of unifying public health surveillance infrastructures and streamlining health status monitoring to achieve compatible data systems nationwide. Wide-ranging adoption of advances in telehealth technology and other aspects of HIT is expected to increase healthcare consumers' empowerment, retard the rise in the cost of health care, and reduce the prevailing disparity in health status between rural and urban populations.
- The CDC-based initiative REACH 2010 (Racial and Ethnic Approaches to Community Health) is a collaborative Federal initiative that, since its inception 5 years ago, has focused on key health areas identified in *Healthy People 2010* with the aim of eliminating disparities in health status experienced by racial and ethnic populations. The summer 2004 special issue of *Ethnicity and Disease* examines the intervention/prevention strategies implemented by 15 of the 42 communities that participate in REACH 2010, all of which address one or more of the following priority areas: cardiovascular disease, diabetes, infant mortality, breast and cervical cancer screening and management, HIV/AIDS, and child and adult immunizations.
- CDC's School Health Index is an online self-assessment and planning tool that can be tailored to an individual school's needs through a series of three steps for improving the effectiveness of health and safety policies and programs.
- Electronic recordkeeping in some community health centers now employs technology that enables clients at the end of their individual sessions to receive a computer-generated list of preventive activities to pursue in the course of a self-managed program.
- With support from CDC, the *Guide to Community Preventive Services* provides recommendations based on systematic reviews of population-based interventions that have been found to be effective in changing risk behaviors, addressing environmental challenges, and reducing the burden of disease, injury, and impairment. With the aid of the *Guide,* published articles on various health topics can be accessed by users, including public health professionals, healthcare service providers and purchasers, law and policymakers, and community-based organizations.

Approaches for Consideration

Participants in the review made the following suggestions for steps to enable further progress toward achievement of the objectives for the ECBPs focus area:

- Seek to fill gaps in research on health disparities, particularly in the areas of dissemination and diffusion of effective programs, new technologies, relationships between settings, and approaches to disadvantaged and special populations.
- Take advantage of economies of scale by building networks of community health centers to include the smaller centers that would otherwise be unable to afford to implement state-of-the-art record-keeping practices.
- Disseminate to community health centers and other facilities the lessons learned and best practices deriving from the experience of the Department of

Veterans Affairs, which has been highly successful in the diabetes and pre-diabetes prevention and treatment programs offered at its hospitals and clinics and in the application of telehealth technology, especially in rural areas.

- Make greater use of micro-grant programs, which can have a ripple effect in bringing salutary changes in the community that far exceed the minimal outlay of funds they entail.
- Promote commonality and synergy among efforts in the fields of ECBPs, health communication, and health literacy, which deal with many of the same issues and face some similar challenges, such as data collection.

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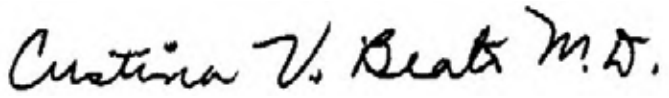
- Endeavor to share savings in healthcare costs that arise from technological advances so that healthcare payors will benefit directly and have incentives to adopt more efficient and innovative approaches in their reimbursement role.
- Seek ways to better characterize the reach, coverage, and influence of ECBPs by geographic region to identify features of the most successful programs that could be emulated more widely with enhanced public support.



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