Integrating Evidence-Based Clinical and Community Strategies to Improve Health

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Abstract: Multiple and diverse preventive strategies in clinical and community settings are necessary to improve health. This paper (1) introduces evidence-based recommendations from the U.S. Preventive Services Task Force sponsored by the Agency for Healthcare Research and Quality and the Community Task Force sponsored by the Centers for Disease Control and Prevention, (2) examines, using a social-ecologic model, the evidence-based strategies for use in clinical and community settings to address preventable health-related problems such as tobacco use and obesity, and (3) advocates for prioritization and integration of clinical and community preventive strategies in the planning of programs and policy development, calling for additional research to develop the strategies and systems needed to integrate them.

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Introduction

Unhealthy lifestyle behaviors and risk factors, poor delivery of clinical and community preventive services, and environments not conducive to health increase the risk of disease and injury and contribute to the leading causes of death (Table 1).[1,2] (We use the term "clinical" to include primary care in healthcare systems as well as solo practices, and the term "community" to include a range of geopolitical units from small-community interconnected groups to entire countries, continents, and the globe.) Tobacco use, poor diet, and physical inactivity alone contribute to more than a third of the premature deaths in the United States.[1,2]

Disease and injury are not inevitable. A growing body of evidence-based preventive strategies is available to reduce the preventable burden of disease, that is, the amount of disease that could be averted if preventive and therapeutic services were universally delivered.[3] Parts of the burden can be prevented through the delivery of appropriate clinical preventive services, through community-level interventions, and through appropriate treatment (see lower bar on Figure 1). The remainder is unavoidable at present due to the limits of current knowledge and will require additional research.

Clinical, medical, and community interventions have contributed to reducing the burden of illness; the impact of these interventions is illustrated in Figure 1 (see top bar) as what has been prevented. The gap between what is avoidable through these interventions, and what we currently achieve represents the translation gap, that is, the failure to translate effective clinical and community-level services into practice. This information can be used to guide efforts to improve preventive care. The relative balance and prioritization of interventions should be based on a clear understanding of what can be achieved–the preventable burden attributable to each, and their relative value–cost effectiveness along with important qualitative factors to ensure successful implementation. Although Figure 1 portrays the clinical and community interventions as discrete, as we discuss below, they should be viewed as synergistic and integratable.[4,5]

Two established national expert panels, the U.S. Preventive Services Task Force (USPSTF) and the Community Task Force (CTF) (henceforth Task Forces), specifically recommend evidence-based preventive strategies in clinical and community settings, respectively, in order to reduce the preventable burden of

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Table 1. The leading and actual causes of death, United States, 2000

Leading cause of death	Rate/100,000	Actual cause of death	*n* (%)
Heart disease	258.2	Tobacco	435,000 (18.1)
Malignant neoplasm	200.9	Poor diet and physical activity	400,000 (16.6)
Cerebrovascular disease	60.9	Alcohol consumption	85,000 (3.5)
Chronic lower respiratory tract disease	44.3	Microbial agents	75,000 (3.1)
Unintentional injuries	35.6	Toxic agents	55,000 (2.3)
Diabetes mellitus	25.2	Motor vehicle	43,000 (1.8)
Influenza and pneumonia	23.7	Firearms	29,000 (1.2)
Alzheimer disease	18.0	Sexual behavior	20,000 (0.8)
Nephritis, nephrotic syndrome, and nephrosis	13.5	Illicit drug use	17,000 (0.7)
Septicemia	11.3		
Other	181.4		
Total	**873.1**	**Total**	**1,159,000 (48.2)**

Source: Mokdad et al.[1,2]

disease. Their recommendations are made on the basis of rigorous review of research-generated evidence and provide essential information for selecting and prioritizing effective preventive strategies. Members of both Task Forces are nonfederal experts drawn from academia, state and local governments, and the private sector, and both Task Forces work closely with a range of federal and nonfederal experts in science, program, and policy. The USPSTF and CTF are convened and supported by the Agency for Healthcare Research and Quality and the Centers for Disease Control and Prevention, respectively.

This paper provides an overview of the work of the two Task Forces, discusses the complementary nature of their recommendations (Table 2), and notes the importance of prioritizing and integrating clinical and community efforts for achieving optimal disease prevention and control. A social-ecologic framework[7] (Figure 2) is used to include both perspectives and to organize examples of clinical and community evidence-based interventions. An example (tobacco) is provided where both clinical and community strategies have strong evidentiary support. Another example (obesity) is provided in which the primary challenge is integration where there are identified gaps in studies and syntheses. This example illustrates opportunities for improvement and research. Finally, some of the resources needed to address challenges to integration are considered.

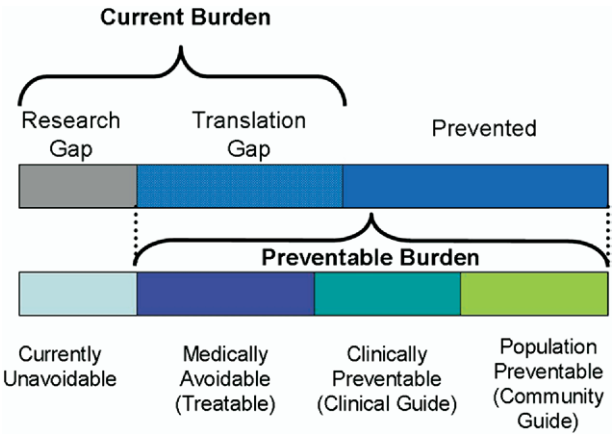

Figure 1. Burden of disease, preventability, and research and translation gaps.

Evidence-Based Recommendations for Preventive Services

The USPSTF and the CTF use evidence-based methodologies to assess the benefits and harms of preventive interventions. The USPSTF focuses on clinical preventive services primarily delivered at the level of the individual patient in primary care settings, while the CTF focuses on preventive services targeted to communities/populations (Table 2). Many high-burden, high-interest health topics have been considered by both Task Forces including tobacco use, motor vehicle occupant injuries, physical activity, diabetes, and obesity. The USPSTF assesses the evidence for benefits and harms of screening, counseling, and preventive medication, and makes recommendations for services where evidence is sufficient to determine that benefits exceed harms. It also publishes clinical considerations that provide guidance for the delivery of recommended services. Current recommendations and clinical considerations are published annually as *The Guide to Clinical Preventive Services*. The current clinical guide and other clinical preventive services products can be accessed at

Table 2. Clinical and community guides review of complementary interventions

Prevention strategy	Task Force
Clinical	U.S. Preventive Services Task Force
Screening, counseling, preventive medication	
Health system change	Task Force on Community Preventive Services
Community	
Group education	
Policy change	
Environmental change	

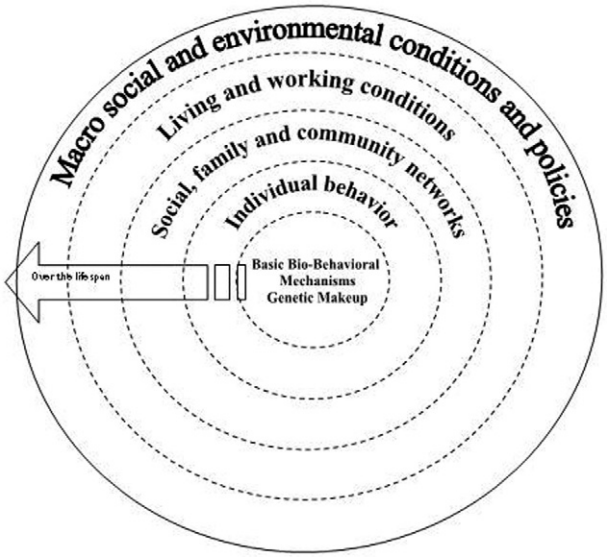

Figure 2. Social-ecologic framework: levels of influence on behavior. (From the Institute of Medicine, 2002.[7])

www.preventiveservices.ahrq.gov. The findings of the USPSTF are disseminated in both medical and public health journals.

The CTF assesses the evidence for preventive interventions targeted at the level of a community/population. Interventions include various types of service delivery, improvements in systems, education, policy, and environmental changes. Interventions considered in *The Guide to Community Preventive Services* (henceforth *Community Guide*) can be targeted at healthcare systems including clinicians' offices as well as at schools, worksites, other organizations, or the entire community. The CTF communicates recommendations in the *Community Guide*, journals, and other products that can be accessed at www.thecommunityguide.org.

The recommendations of both Task Forces are regularly used by organizations to support decisions about selecting and funding interventions and related research. The work also is used as a core set of recommendations that can then be tailored for particular audiences. Examples of use include the following: recommendations made by the USPSTF form the core set of clinical preventive services that have been prioritized by the National Commission on Prevention Priorities on the basis of their clinically preventable burden and cost effectiveness (www.prevent.org/content/view/48/103/). USPSTF recommendations also have been used by the National Committee for Quality Assurance (NCQA) in developing its Health Plan Employer Data and Information Set (HEDIS) measures, and by the National Business Group on Health in developing its *Employer's Guide to Health Improvement and Preventive Services* (www.businessgrouphealth.org/services/index.cfm), which provides practical advice to employers about structuring health benefits. Work by the CTF has been used by Institute of Medicine (IOM) committees to inform national efforts to achieve and maintain high levels of immunization coverage,[8] and by public health programs (e.g., STEPS to a Healthier US, www.healthierus.gov/steps/) to inform ongoing public health activities. Work of both Task Forces has contributed to the effective state and national efforts to reduce tobacco use,[9] and is therefore considered fundamental to evidence-based cancer control. The latter has caused an IOM committee addressing strategies to fulfill the potential for cancer early detection and control[10] to call for the U.S. Congress to provide sufficient appropriations to the U.S. Department of Health and Human Services for the USPSTF and the CTF to conduct timely assessments of the benefits, harms, and costs associated with screening tests and other preventive interventions.

Complementary Approaches to Prevention

Although some problems of ill health may be addressed in clinical or community settings, many are likely to benefit from the complementary and coordinated efforts of clinical and community-based interventions to take full advantage of the opportunities for prevention. The IOM has articulated the need to address major health threats and concerns from a multi-level perspective, building partnerships across health systems, communities, academia, business, and the media, in order to effectively improve the health of the population.[7] It is likely that integration of effective clinical and community services eventually will lead to greater gains than either type of service used by itself.

Social–Ecologic Perspective

Integration of complementary preventive services into a comprehensive approach is consistent with a social-ecologic perspective that recognizes that behaviors and health are influenced by multiple levels from the individual to families to larger systems and groups and then to the broadest levels, the population and ecosystem.[11] A framework (Figure 2) based on this perspective can serve as a guide or blueprint for intervention strategies needed to address specific clinical and public health challenges. The multiple levels of influence on behavior and health are categorized within this framework[11] providing a structure for targeting strategies at the discrete but inter-related levels of influence on health and behavior.[12] A strong evidence base demonstrates that there are effective intervention strategies available to target each level of the ecologic model.[13,14] When intervention strategies are available at each level of influence, treatment access and support are provided for people at many different points (e.g., schools, clinics, worksites), thereby expanding their reach. In addition, by integrating them and creating a pathway from one level to another, resources can be leveraged

making them more available and better utilized.[15] There are reinforcing effects when a comprehensive coordinated approach is used, enhancing behavior change and influencing health.[16,17]

Levels of Intervention

Individual-level interventions involve one-to-one interactions between a patient and a provider, often within a clinical environment (clinician's office or clinic). However, clinical services can also extend to most proximal large systems (e.g., the family), and are well suited for addressing the health needs of the individual and the family. Social, family, and community network interventions are oriented to close social groups and primarily target behavior change and social support. These mostly occur in community settings including "Y"s, workplaces, schools, places of worship, and other venues. Interventions include strategies such as educational and skill building programs and workplace competitions. One-to-one interactions also can occur in programs based in the community such as in a workplace health program or tobacco quitlines. Community-level interventions that influence living and working conditions include interventions that target specific communities defined by geography, race, ethnicity, gender, illness, or other health conditions. Additionally these interventions target groups and systems that have a common interest including health or service agencies, organizations, workplaces, schools, healthcare or public health practitioners, or policymakers. They include environmental interventions such as water fluoridation, creation of walkable communities, and availability of nutritious foods and recreation facilities in neighborhoods.

The highest stage of community-level interventions generally involves large geographic communities and includes broad changes, especially at the policy level, in sectors such as the environment, criminal justice, healthcare regulation, agriculture, transportation, urban planning, and fiscal policy. At this level there are policy interventions that restrict or support behavior through laws and regulations such as requirements to ensure clean indoor air, ensure patients' access rights to their personal health information, and preclude driving legally with an excessive specific level of blood alcohol.

Interventions targeting the family, social networks, and the community are needed for changing the context in which individuals live, and for supporting behavioral changes that they make at the individual level.

Case Studies

Two examples are used to examine the evidence base and potential synthesis or integration of preventive strategies in clinical and community settings that are implemented at multiple levels of influence in the social-ecologic model. In the first specific example, tobacco control, relevant information about effective clinical and community-level strategies is plentiful and interventions have been implemented at multiple levels contributing to improvements in important behavioral and possibly health outcomes. In the second example, obesity prevention and control, there are gaps in evidence regarding what works at each of the levels of influence and in the synthesis and integration of the evidence. This example is presented to highlight the need for additional evidence as well as possibilities that exist for strategic coordination of preventive strategies.

Tobacco Control

Coordinating services on multiple levels. Tobacco use accounted for over 435,000 deaths per year in 2000 (Table 1).[1,2] The current prevalence of tobacco use among adults in the U.S. is 20.9%,[18] reduced by more than one-half from 42.4% in 1965.[19] Tobacco-cessation efforts demonstrate the importance of incorporating complementary activities at each level of influence in clinical and community settings.

Both the USPSTF and the CTF have considered the issue of reducing tobacco use and have issued recommendations for its prevention and treatment.[20] Much of the same evidence was used by the Centers for Disease Control and Prevention for developing their recommendations noted in *Best Practices for Comprehensive Tobacco Control Programs*[21] and by the Public Health Service (PHS) noted in *Treating Tobacco Use and Dependence: Clinical Practice Guideline*.[9] Recommendations in each of these documents suggest the need for comprehensive tobacco treatment programs that identify smokers, advise them to quit, and provide brief counseling and a full range of treatment services including pharmaceutical aids, more intensive behavioral counseling, and follow-up visits. Optimal success in reducing tobacco-use prevalence has occurred when, in addition to clinical services, community-level interventions such as mass media efforts and legislation raising the price of tobacco products and reducing exposure to environmental tobacco smoke have been used, and quitlines have been made accessible and available.[14] The success of tobacco control intervention has benefited from the dissemination of the evidence-based findings of clinical and community practice to all levels of the social-ecologic model.

Clinical preventive services. In 2003 (www.ahrq.gov/clinic/uspstf/uspstbac.htm), the USPSTF recommended that:

- Clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products
- Clinicians screen all pregnant women for tobacco

use and provide augmented pregnancy-tailored counseling to those who smoke

Community preventive services. In 2000/2001,[20] the CTF recommended the following:

- Smoking bans and restrictions
- Increasing the unit price for tobacco
- Media campaigns with intervention
- Provider reminder systems
- Provider reminder systems with provider education
- Reducing patient costs for treatment
- Quitter telephone support with interventions

An example of a comprehensive coordinated tobacco treatment and control program is the statewide Massachusetts Tobacco Control Program (MTCP).[16] Recognized by the Centers for Disease Control and Prevention (CDC) and others as a "best practice" program from its inception in 1993 through 2002, MTCP has incorporated clinical and community strategies, combining and connecting activities of clinical settings, the media, community agencies, academic institutions, and local and state policymakers. It included (1) an innovative media campaign to change public opinion and community norms around tobacco use, (2) community mobilization to change local laws and health regulations, and (3) comprehensive tobacco treatment programs based in clinics and community settings modeled after CDC and PHS guidelines to reduce tobacco use.

A comparison of Massachusetts data to data from 40 U.S. states that had not had state programs in place through 1999 (Figure 3)[17] shows a more rapid decline in smoking prevalence in Massachusetts than in comparison states. Although funding for the MTCP program was withdrawn in 2002, a special tobacco treatment program, QuitWorks,[22,23] still exists. QuitWorks coordinates clinical and community-based efforts by linking patients, clinicians, and a proactive telephone counseling quitline through the use of forms faxed to the quitline. Funded by the Massachusetts Department of Public Health, it was created in collaboration with all the major health plans in the state. Studies have demonstrated the importance and feasibility of developing pathways or linkages between clinical settings and community-based settings.[15,24,25]

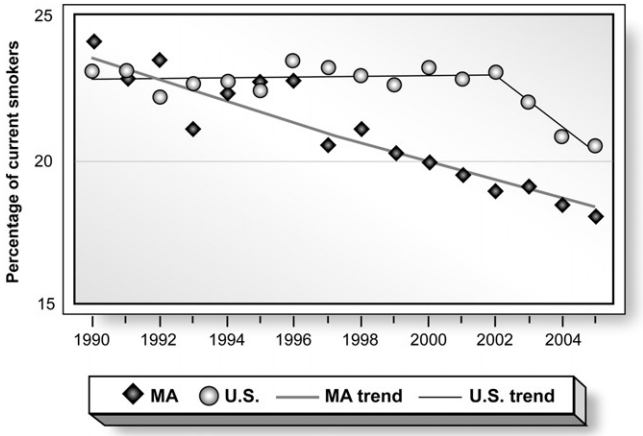

Figure 3. Percentage of adult current smokers, Massachusetts (MA) and U.S., 1990–2005

Trend is statistically significant ($p < 0.05$)
40 U.S. states that had not had state programs in place through 1999
Source: Massachusetts BRFSS
Prepared by: Health Survey Program

Although the MTCP did not set out to base its program on the recommendations of the USPSTF and the CTF, it did use a social-ecologic framework to map out the types of services needed (MTCP, unpublished document, 1992), and has contributed to the evidence base illustrating that complementary coordinated efforts are possible and that these efforts have beneficial effects. Other studies and programs also have demonstrated that such coordinated efforts are possible and beneficial, and can work.[6,26] Studies in progress funded by the Agency for Healthcare Research and Quality (AHRQ) and Robert Wood Johnson Foundation as part of the Prescription for Health program also are exploring the feasibility and effectiveness of linkages between clinical settings and community-based settings.[27]

While tobacco control has been largely a success story, there are still large gaps in utilization and application of clinical interventions in primary care settings. This is especially true where organizational, community and statewide programs, policies, and resources are not available to support clinicians.[6]

Obesity: Example of Gaps in Evidence and Incomplete Synthesis of Available Evidence for Intervention Recommendations

Obesity, an important contributor to morbidity and mortality in the U.S.,[1,2] is a result of complex interactions of factors on several levels of influence, including genetic, physiologic, behavioral, cultural, social, and environmental.[28] An estimated 30% of American adults aged ≥20 years old or older—over 60 million people—are currently obese (body mass index [BMI] ≥30), compared to 23% in 1994. Sixteen percent of children and adolescents aged 6 to 19—over 9 million—are overweight (BMI for age at or above the 95th percentile) and the percentage of overweight children has tripled during the past decade.[29,30]

In contrast to the situation with tobacco, the available evidence regarding effective interventions to prevent obesity and promote weight loss in clinical and community settings is incomplete. Programs, services, and guidelines needed to address obesity and weight loss are in an earlier stage of development than programs targeting the multiple levels of influence demonstrated to be effective in reducing tobacco use.

Both the USPSTF and the CTF have issued recommendations regarding obesity in adults and children based on evidence of the effectiveness of options for obesity prevention and promotion of weight loss in primary care (USPSTF) and community settings (CTF) and others are in progress.

Clinical preventive services. In 2003,[31] the USPSTF recommended that clinicians:

- Screen all adult patients for obesity using a patient's BMI (weight in kilograms divided by height in meters squared).
- Offer obese patients—those whose BMI is ≥30—intensive counseling and behavioral interventions to promote sustained weight loss. A high-intensity intervention was defined as one that offers more than one person-to-person (individual or group) session per month for at least the first 3 months of the intervention. There was insufficient evidence to determine whether some settings, persons, or teams were preferable to others in delivering these services.
- Refer obese patients to programs that offer intensive counseling and behavioral interventions for optimal weight loss.

The USPSTF found insufficient evidence to recommend for or against moderate- or low-intensity counseling with behavioral interventions for obese patients, or for screening and counseling overweight adults (BMI 25 to 29) or for routine screening for overweight in children and adolescents as a means to prevent adverse health outcomes.[32,33] The USPTF also has found insufficient evidence to make recommendations regarding two other related preventive services—routine behavioral counseling in primary care settings to promote a healthy diet[2,34,35] and to promote physical activity.[34–37] More research is needed in these areas.[38]

Community preventive services. The CTF has issued findings based on evidence available through 2001 on interventions in two community settings—schools and worksites—to promote healthy weight. A systematic review of published studies available through 2001 found that interventions in the worksite that combine nutrition and physical activity are effective in helping adult employees lose weight and keep it off in the short term.[39] Based on this review, the CTF recommends use of these multicomponent interventions to help employees control overweight and obesity. It determined that there was insufficient evidence to recommend in favor of or against school-based programs for children and adolescents.[39]

Although specifically relevant work from the *Community Guide* is currently limited, additional reviews for promoting healthy nutrition and promoting physical activity are completed or ongoing (Table 3). In addition, the previous obesity reviews are being updated

Table 3. Recommendations relevant to reducing obesity from *Guide to Community Preventive Services* through March 2006

Intervention	Finding
RECOMMENDATIONS TO PROMOTE PHYSICAL ACTIVITY	
Informational approaches to increasing physical activity	
Community-wide campaigns	Recommended (strong evidence)
"Point-of-decision" prompts	Recommended (sufficient evidence)
Classroom-based health education focused on information provision	Insufficient evidence to determine effectiveness
Mass media campaigns	Insufficient evidence to determine effectiveness
Behavioral and social approaches to increasing physical activity	
Individually adopted health behavior change	Recommended (strong evidence)
School-based physical education	Recommended (strong evidence)
Non-family social support	Recommended (strong evidence)
Health education with TV/video game turnoff component	Insufficient evidence to determine effectiveness
College-age physical education/health education	Insufficient evidence to determine effectiveness
Family-based social support	Insufficient evidence to determine effectiveness
Environmental and policy approaches to increasing physical activity	
Creation and/or enhanced access to places for PA combined with informational outreach activities	Recommended (strong evidence)
Transportation and infrastructure changes promote nonmotorized transit	Insufficient evidence to determine effectiveness
Urban planning approaches—zoning and land use—community scale interventions	Recommended (sufficient evidence)
Urban planning approaches—zoning and land use—street scale interventions	Recommended (sufficient evidence)
RECOMMENDATIONS TO PROMOTE HEALTHY NUTRITION (www.thecommunityguide.org)	
Multicomponent school-based nutrition programs	In progress
Community approaches to increase fruit and vegetable intake	In progress
Food and beverage advertising to children	In progress
Food and beverage availability, price, portion size, and labeling in restaurants	In progress

with new literature available since 2001 and new reviews have been conducted to include community and healthcare settings.[40]

There are other potentially important interventions to influence healthy diet, nutrition, and physical activity related to agricultural and transportation policies, design of the built environment, and availability of affordable healthy foods. Relevant data that meet CTF criteria are likely to be sparse, but these interventions have the potential to have large effects. The CTF has only begun to address these issues.

Obesity is a major and growing health problem and most communities will not wait for ideal information before taking action. The challenge is to implement programs in the face of the paucity of evidence on which interventions work; at a minimum this will require considering the evidence-based resources that exist and implementing them if they are consistent with community needs and resources, considering additional conceptually reasonable strategies, and acting at multiple levels in the social-ecologic model. More obesity research is needed to investigate interventions at each level of the social-ecologic model and their potential incremental benefits as different combinations are used. This research can be included in future systematic reviews of program effectiveness so that better guidance through evidence-based recommendations can be provided to communities and practitioners.

A Call for Integration of Clinical and Community-Based Strategies

Integration of effective clinical and community-based strategies across the multiple levels of a social-ecologic framework expands the availability of services at the levels of influence that may be most accessible to different individuals, thus making utilization of available services more likely. Increased utilization of services of demonstrated effectiveness such as quitlines also makes it more likely that they will be more cost effective and not disappear because of under-utilization.[15]

The tobacco case study demonstrates that effective clinical and community strategies can be developed, identified, and integrated, thereby increasing utilization and effectiveness. Approaches for linking clinical and community services include such things as computer-linked systems where referrals are automatically made from a clinician to a community-based program and vice versa, or a fax referral system that links providers with community-based quitlines and vice versa.[15,24,25]

Obesity represents a continuing unmet challenge. The AHRQ-sponsored USPSTF and the CDC-sponsored CTF are working together to support integrated approaches to the evidence-based preventive strategies that exist, such as the Steps to a Healthier US initiative (see sidebar).[41] However, there are large gaps in our knowledge of effective strategies for obesity treatment and prevention. Of the effective strategies available, questions remain as to which ones are feasible and cost effective.

In order to facilitate integration of services in all areas of prevention there are key issues to consider. Substantial financial resources and policies are needed to transform existing systems or create entirely new systems that link resources into an efficient network.[27] Appropriate training for implementation and maintenance of these systems is also needed. Based on evidence, cost effectiveness, and acceptability and support of consumers, clear priorities for strategies need to be agreed upon across the clinical/community spectrum. Each requirement is a challenge at the clinical and community levels.

Addressing the abovementioned challenges requires leaders who are willing to advocate for creating and integrating effective clinical and community interventions, and for the financial resources and policies needed. Also needed are curricula for health professionals in which the value of a collaborative approach between clinical and community services to address major health problems is strengthened. In health education curricula, the focus has largely been on expertise within the specialty discipline. There is a growing recognition of the need to prepare health professionals to work collaboratively to plan, implement, and evaluate health strategies to target major health issues.[42]

In addition to the USPSTF and the CTF, there are efforts at the national level to evaluate potential

SIDEBAR

Steps to a Healthier US

The U.S. Department of Health and Human Services initiative, Steps to a HealthierUS,[33] funds 40 communities across the country to implement and evaluate chronic disease prevention projects focused on reducing the burden of diabetes, overweight, obesity, and asthma. Participating communities are working with healthcare providers and community-based organizations to strengthen the linkages between these two sectors. The core of the program is based on the evidence-based recommendations of the Community Task Force.

The Steps to a HealthierUS initiative is being evaluated at the national and local levels. It is anticipated that the information gathered will help guide communities and clinicians in developing and implementing effective interventions and partnerships.

strategies/interventions to inform decision makers. The National Commission on Prevention Priorities adds important cost-effectiveness and magnitude-of-impact information to the evidence-based clinical services recommendations to guide decision makers in setting priorities for policy-level actions. The ranking of clinical preventive services combined with information about their utilization in the population can be used to establish priorities to drive active translation efforts. A similar initiative that compares the value of the population-based preventive services–that is, the cost effectiveness of interventions from the societal, individual, and healthcare system perspectives–could help policymakers determine the appropriate mix of clinical and population-based support for improving the health of the population. These priorities along with the evidence-based strategies to achieve them could be reflected in our forthcoming national health goals (Healthy People 2020). Integration of delivery systems in the clinical and community setting is the next essential step. Promoting the integration and collaboration of these well-established and functioning systems preserves the strengths of the two systems and maximizes existing structures.

Conclusion

Major improvements in health have occurred as a result of effective health care and clinical and community-based preventive interventions. Although the current burden of disease and injury remains high, improvements can be made through effective prevention strategies (Table 2). To continue improvement in the health of the people in the United States we need to use the complete array of effective prevention tools at our disposal, increase their effectiveness and utilization by connecting them where possible, and systematically apply them at all levels of influence on behavior.

Resources/Contacts

Task Force on Community Preventive Services—www.thecommunityguide.org/about/

The Guide to Community Preventive Services—www.thecommunityguide.org

U.S. Preventive Services Task Force—www.preventiveservices.ahrq.gov

The Guide to Clinical Preventive Services—www.ahrq.gov/clinic/pocketgd.htm

The findings and conclusions in this report are those of the authors and do not necessarily represent the views of the Agency for Healthcare Research and Quality and the Centers for Disease Control and Prevention.

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