TABLE OF CONTENTS

APPENDIX II

WHAT WORKS: STRATEGIES FOR IMPROVING THE HEALTH AND QUALITY OF LIFE OF A POPULATION

Background

The sponsors of this project requested that, as a part of our literature review, we do a scan of the issues surrounding health and quality-of-life problems for populations in general in areas of particular interest to the steering committee. The committee was interested in approaches and strategies that had been tried elsewhere that might be useful to explore further for possible adaptation within Montgomery County.

We searched Web resources and literature databases available through the Temple University Library system (such as Ovid, Lexis-Nexis). While the review served as useful background for us in completing the report, given the time constraints, however, we could touch only the surfaces of the large and complex problem areas identified by the steering committee. Here we present a brief summary of the problems, possible solutions, and Web and literature resources we identified that may be helpful to others not already directly involved in these areas and who wish to explore them in more depth.

I. Improving the Environment

As a cost-effective strategy for improving the health and quality of life of a population, improving the environment trumps changing behavior and providing access to services. Cleaner air, water, and better nutrition were responsible for most of the dramatic improvement in life expectancy in the United States in the 20th century. The specific interventions that have had the most clear, measurable, beneficial impact to health have been environmental ones: for example, requirements for lead reduction in gasoline and reductions in lead levels in children, the introduction of childproof medicine bottles and reductions in accidental poisonings, the temporary dramatic reduction of respiratory admissions to hospitals in Atlanta that took place with the ban on automobiles in the city when it was hosting the summer Olympic games.

We focus the application of this tried-and-true public health approach to a more expansive vision of the environment that includes all the physical, organizational, and interpersonal influences a population is exposed to and to the specific areas of concern suggested by the steering committee of this project.

Reducing Urban Sprawl

Problem

The health and quality-of-life costs of urban sprawl are enormous. As outlined in a recent review, those costs include ones directly related to expanded use of automobiles and ones indirectly related through the influence of such use on land use. There is a well-established relationship between lower-density development and greater automobile travel. More automobile travel means more automobile and pedestrian fatalities and more air pollution. More automobile travel also translates into the absorption of more land into highways and less availability of paths and sidewalks for local trips providing exercise. Adult populations in counties in the United States with a higher degree of urban sprawl report of less physical activity, more obesity, and more hypertension. The use of lands for highway expansion reduces vegetation, creates a “heat island effect” in urban areas, and threatens regional water quality and supply. The adverse mental health effects of sprawl are substantial. Nationally, the stress of automobile commuting has increased incidences of road rage, and that same stress is bound to spill over into home and family life and into physical symptoms such as back pain. The impact

on the social capital of communities of the time-pressed suburban-sprawl commuter culture is substantial, producing civic decay and an erosion of trust in communities. All of these effects of urban sprawl, however, tend to disproportionately affect low-income persons and racial and ethnic minorities, particularly in terms of air pollution, heat effects, and pedestrian fatalities. They raise fundamental issues of fairness and environmental justice.

Solutions

Solutions range from the easy ones, such as planting trees or constructing safe bike and pedestrian paths to school or to work, using funding provided for in the Transportation Equity Act for the 21st Century [TEA-21, enacted June 9, 1998 as Public Law 105-178. See http://www.fhwa.dot.gov/tea21/index.htm] to the more difficult and costly ones of changing regional patterns of development and investment in the expansion of public transportation. The 25-year plan of the Delaware Valley Regional Planning Commission provides a blueprint for what has been described as "smart growth" (higher density, more contiguous development, preserved green space, mixed land use, walk able neighborhoods and a more balanced approach to transportation investment). The case for such "smart growth" in this region has been persuasively presented. Those who have been involved public health and community health issues have yet to be effectively engaged in these regional planning struggles and could be helpful in shifting the balance. The barriers to such effective regional planning are substantial and may involve elimination of the economic incentives that have driven sprawl (for example, property-tax-dependent local financing of services and mortgage interest exemptions on personal income taxes).

Reducing Social and Economic Disparities

Problem

In general, the most powerful predictor of the health of an individual or a population, once one has controlled for age, are income and education. Nations, states, counties, minor civil divisions, and individual families with higher income and education levels tend to be healthier. However, once a threshold of per capita income is reached, as it has in most developed nations, increases in average per capita income have little effect on health. For example, while the United States ranks fourth in the world in gross national income per capita ($37,600 in 2003, just behind Luxembourg, Norway, and Switzerland), it ranks 23rd in male life expectancy at birth (67 years in 2002, tied with Portugal and Slovenia, which have less than one third its gross national income per capita). The evidence suggests that what matters more, particularly in the United States, is income inequality. For example, differences in earnings inequality of metropolitan areas in the United States produces an estimated difference of 23 and 33 deaths per 100,000 in the working- age population. The weight of the evidence suggests that it is not just those in abject poverty that produce this effect: greater income inequality increases mortality rates for all income groups. Whether the health effect of income inequality is the result of an individual income effect (increasing incomes at the high end has essentially no effect on increasing health, while increasing the income of those of the low end does), a psychosocial environmental effect (more stress and isolation and less trust, for example) or material condition effect (fewer physical amenities in public spaces, cultural opportunities, and the like) is debated. The bottom line, however, is that reducing social and income inequalities could probably do more to improve the overall health of a community than would any other environmental change.

Solutions

Solutions range the from relatively easy and partly symbolic ones (such as eliminating reimbursement of first class airfares for executives and tiered health insurance benefits by employers) to the controversial and difficult (such as changing minimum wage policies, tax, retirement income and health benefit structures). Major improvements could take place without changing the income distribution just by dampening its effect of income on the work environment, health insurance, retirement security, where one lives, the schools their children attend and the services they receive. Much could be done just through policies that would reduce economic residential segregation (for example, greater dispersion of low-income housing). Some examples of what national and local efforts in other countries (Canada,

the United Kingdom, and Sweden, for example) suggest that it is possible to make progress. A report produced by the Minnesota Department of Health provides a framework for what is possible in addressing these issues in the United States. Others reviewing this issue, however, have questioned how much can be accomplished through voluntary efforts if there is a lack of an underlying political will to change.

Reducing the Social and Economic Costs of the Criminal Justice System

Problem

Criminal incarceration rates measure more than just the failure of individuals to be law-abiding citizens: they measure the failure of families, informal social networks, faith communities, schools, employers, and the social and health services systems. High incarceration rates are a strong indicator of the poor health and quality of life of a population, and the United States performs more poorly on this indicator than on any other. The number of people imprisoned in the United States has grown sixfold in the last 30 years to more than two million. Incarceration rates in this country are now the highest in the world—702 per 100,000 population—outstripping the next two highest nations (Russia 628 and South Africa 400) and more than six times higher than Canada and other developed nations. However, overall victimization rates derived from surveys in 17 industrialized countries puts the United States in the midrange, suggesting that the higher incarceration rates are not just the result of more crime. The major exception are homicide rates, which, despite a 40-percent drop over the last decade, are still about four times higher than those of most nations in western Europe. (If one excludes firearm homicides, the difference in rates drops to only about two times as high).

If the "correctional" system "corrected" individuals, the United States' distinctive reliance on this system would not be as troubling. The most recent national study of recidivism found that 67.5 percent of released prisoners were arrested for a new crime within three years and that rate represents an increase from a decade earlier. Any school or healthcare institution with such a failure rate would be closed or taken over by the state.

Part of the growth of the prison population reflects the cost shifting and abandonment of people by the educational, social service, health, and mental health systems. The growth in accommodations in prisons mirrors the decline, over the last three decades, in beds for inpatient mental health and drug and alcohol treatment. The majority of the prison population in the United States has a history of substance abuse and/or mental illness. Major mental illnesses are four times as likely in the prison than in the general population. More persons with serious mental health problems are now housed in our prison system than are hospitalized in psychiatric hospitals in the United States. Eighty percent of inmates in state correctional institutions report prior illicit drug use. At least one in six prisoners in a six-state study of federal prisons had heart problems. The growth of medical problems will increase as the prison population ages and, increasingly substitutes for long-term care facilities. The services in these facilities are generally woefully inadequate to care for the needs of this population, and the costs per year, per inmate now exceed that cost of a year at a top-flight private university.

Unfortunately, as with everything else, incarceration is not evenly distributed across the population. Rates of incarceration in Pennsylvania are more than 10 times higher for blacks than whites. Pennsylvania has the seventh highest disparity among the states between black and white incarceration rates. One of every 14 African American children in the United States has a parent in prison, and one out of every eight black males age 25 to 29 are currently incarcerated.

Solutions

Many of the solutions overlap those for schools, drug and alcohol, and mental health. The "prison pipeline," which includes schools, courts, and the lack of adequate rehabilitation resources for inmates and recently discharged prisoners, needs to be interrupted. The Harvard Civil Rights project anticipates releasing a resource guide for altering the role of schools in the prison pipeline and diverting financial resources from prisons to schools [See http://www.civilrightsproject.harvard.edu/research.php ; contact Daniel J. Losen, dlosen@law.harvard.edu]. In a recent intervention study on Pennsylvania's state prison system, conducted by Temple University

faculty, with support from the Pennsylvania Commission on Crime and Delinquency, participation in a "therapeutic community" drug treatment program in prison reduced the likelihood of re-incarceration, but so did post-release employment.

Improving Housing

Problem

Homeownership and rental costs have risen more rapidly than family incomes in the United States, and the pubic resources available for subsidized housing has not kept up with the increased need. The generally accepted definition of affordable housing is that a household should not pay more than 30 percent of its annual income on housing. Currently, one in three American households pay more than that 30 percent, and one and eight households pay more than 50 percent. An estimated 12 million households in the United States pay more than 50 percent of their incomes for housing. Twenty eight million households in the bottom half of the income distribution spend more than 30 percent of their incomes on housing. Even these statistics understate the magnitude of the problem, given the tradeoffs families have to make to hold down their housing costs. Two-and-a-half million families live in crowded or structurally inadequate housing units. In addition, in order to find affordable housing, many spend more on transportation and more time commuting to work.

Various tax subsidies have failed to stem the loss of affordable rental units. Rent vouchers, the principle strategy for relieving housing cost burdens, are in short supply, involve long waiting lists, and offer no guarantees that eligible households will ever receive assistance. The growing affordable housing shortage most adversely affects the low-income population and particularly low-income minorities, who tend to be concentrated in a region's poorest communities. The substandard housing in these areas frequently exposes residents to mold, cockroach dust, and lead, which contribute to high rates of respiratory illnesses and other health problems. These same disadvantaged neighborhoods, while lacking in easy access to recreational activities, fresh wholesome, and inexpensive foods, and other healthy amenities, typically have easier access to alcohol, tobacco, and junk foods than do more affluent neighborhoods.

Poor and deteriorating neighborhoods have higher rates of gonorrhea, premature death in general, and death from cardiovascular disease and homicide. However, in equally poor neighborhoods where there was a greater sense of collective efficacy, a willingness to help out for the collective good, these rates were lower.

Solutions

The gap between what people can reasonably afford to pay and the cost of housing has to be bridged and it is unlikely to be bridged by policies that would dramatically improve wages of the working poor. A current Brookings Institution and Urban Institute review outlines the various public policy approaches that have been taken and the lessons learned from them. These have included expanding low-income rental housing (stimulating production and providing rental subsidies with vouchers), expanding low-income home ownership (financing production, providing homebuyers with tax deductions, and other assistance) and land use regulations (low-income housing quotas, rent stabilization, and the like). Voluntary efforts such as those that include contributions of sweat equity of the owners have enjoyed small but very tangible successes, for example, those facilitated by Habitat for Humanity and their local partnerships [see http://www.habitat.org/]. Others have proposed that employers in low-income communities in partnerships with cities join in assisting the financing of housing for their employees.

Chicago's Gautreaux mobility program was the first and one of the only successful initiatives to racially desegregate and reduce the concentration of poverty through a metropolitan area low-income housing program. It was created as a result of a suit by residents against the Chicago Housing Authority and HUD. A decision by the Supreme Court in favor of the plaintiffs in 1976 created the program. The Leadership Council for Metropolitan Open Communities (emerging out of Martin Luther King's Chicago initiative in the 1960s) was selected to administer the remedy. Over the next 20 years, through a counseling, voucher, and placement program, it helped over 7,000 families to relocate to suburban, predominantly white, low-poverty Chicago areas. Children making the transfer with their parents, despite poor-quality education before the move, were more likely than their city counterparts to take

college-track classes in high school, enter four-year colleges, and be employed in higher-pay jobs.

The Gautreaux mobility program has served as a model for more recent HUD initiatives and more than 50 other housing mobility programs across the country. Most, however, have either ignored the goal of reducing racial segregation or have been less successful in insisting on placement in predominantly white, low-poverty areas.

Assuring Adequate Nutrition

Problem

Going hungry. The following items can be found on America's Second Harvest Web site:

> The Number of People Seeking Emergency Food Assistance is Rising.
>
> America's Second Harvest's Hunger in America 2001 report found that 23.3 million people sought and received emergency hunger relief from its network of charities in 2001. The study also found that between 1997 and 2001, demand for emergency food assistance through the America's Second Harvest network has risen 9 percent since 1997. [See http://www.secondharvest.org/site_content.asp?s=59]
>
> The Number of Americans Food Insecure and Hungry is Rising:
>
> In 2001, the number of Americans who were food insecure, or hungry or at risk of hunger, was 33.6 million, a rise over 2000, when 33.2 million Americans were food insecure. The number of individuals who are suffering from hunger rose from 8.5 million in 2000 to 9 million in 2001.
>
> The number of food insecure households with children has also risen since 2000 by 10,000 to 6.18 million. [Source: U.S. Department of Agriculture's Economic Research Service, Household Food Security in the United States, 2001].
>
> The Life Science Research Office's definitions of food insecurity and hunger are the following:
>
> Food Insecurity exists whenever the availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain.
>
> Hunger, in its meaning of the uneasy or painful sensation caused by a lack of food, is in this definition a potential although not necessary, consequence of food insecurity. [See Cornell Cooperative Extension Web site, http://www.cce.cornell.edu/programs/food/staff/expfiles/topics/olson/olsonoverview.html]
>
> Source: Life Sciences Research Office, Federation of American Societies of Experimental Biology: "Core Indicators of Nutritional State for Hard to Measure Populations," The Journal of Nutrition, v. 120 (November 1990 Supplement): 1575-76.

Unhealthy eating practices across the county. Eating five servings of fruits or vegetables is one of the U.S. government's recommendations for healthy eating practices. [See Dietary Guidelines for Americans 2005 at http://www.healthierus.gov/dietaryguidelines/]

According to the Centers for Disease Control, only 22 percent of children eat this recommended amount, and adults consume even fewer daily servings. [See "Physical Activity and Good Nutrition: Essential Elements to Prevent Chronic Diseases and Obesity" at http://www.cdc.gov/nccdphp/aag/aag_dnpa.htm]

Solutions

Going hungry. In the United States, hunger is addressed through a combination of government, and nonprofit agency and religious organization providers.

Government. The three primary government programs are food stamps; the women, infants and children (WIC) program; and school meal programs. Rules under these programs require new immigrants to wait five years after becoming permanent residents before they may receive food stamps and limit childless adults to three months of food stamps. Also, for a variety of reasons, many who are eligible for these programs do not participate in them. [See Rosenbaum, D. and Neuberger, Z. "Food and Nutrition Programs: Reducing Hunger, Bolstering Nutrition." Center and Budget and Policy Priorities Web site, at http://www.cbpp.org/7-19-05fa.htm].

Private agencies. Private providers are comprised of numerous national and local organizations, with varying degrees of coordination. The National Anti-Hunger Organization (NAHO), a coalition of 13 large providers, issued a report in July 2004 entitled "Blueprint to End Hunger in America." The NAHO blueprint outlines the key investments in the resources and improvements in the national nutrition safety net necessary to reduce hunger and food insecurity by fifty percent in the United States by 2010 and to end both by 2015 [See "Blueprint to End Hunger. 2004," America's Second Harvest Web site, at http://www.secondharvest.org/more_files/blueprint_final.pdf.; see

http://www.fightinghunger.org/pages/press%20releases/Blueprintpr.PDF]

The largest nonprofit provider in the United States is America's Second Harvest. At local levels, there typically is found a loosely coordinated group of food servers and agencies that provide foods to those servers.

An example of a government service is the Illinois Department of Aging Elderly Nutrition Program, which provides meals served in group settings and delivered to people's homes. The group site meals are served weekdays in over 625 sites throughout the state, including senior centers, churches, senior housing facilities, and community buildings. [See Illinois Department of Aging Web site at http://www.state.il.us/aging/1athome/nutrition.htm]

An example of a private provider that supplies food to food servers is Second Harvest Food Bank of Northwest Pennsylvania. From the Web site: "Our Food Bank, which has 29,000 square feet of space, solicits, receives, inventories, stores, and distributes food and grocery products to 245 member agencies in 11 counties in northwest PA."[See Second Harvest Food Bank of Northwest Pennsylvania website: http://www.eriefoodbank.org/background.htm]

An example of the service of a private provider is the Ecumenical Hunger Program of East Palo Alto, California, which provides boxes of food to meet basic nutritional needs of families and individuals experiencing temporary emergency needs or special circumstances, such as long term illness. The food boxes are nutritionally balanced, containing vegetables, protein, grains and cereals, as well as canned goods. They are prepared with an understanding of the cultural and ethnic preferences of each family. In 1997, EHP distributed a total of 2,950 food boxes. A total of 5,352 unduplicated individuals were served. [See VolunteerMatch Web site at http://www.volunteermatch.org/orgs/org15267.html]

Approaches outside the United States. A somewhat broader approach is taken by the Canadian organization CHEP, a nonprofit group in the Canadian province of Saskatchewan. It provides for basic food needs for children, and low-cost food for adults, with an emphasis on fresh foods. CHEP also provides cooking and nutrition education for children, as well community gardening programs. [See CHEP Web site at http://www.chep.org/]

Changing unhealthy eating practices. The Centers for Disease Control and Prevention (CDC) has developed a set of detailed guidelines for promoting healthy eating habits in children. [See Guidelines for School Health Programs to Promote Lifelong Healthy Eating. CDC, "Morbidity and Mortality Weekly Report." June 14, 1996 / Vol. 45 / No. RR-9 at http://www.cdc.gov/mmwr/PDF/RR/RR4509.pdf]

The CDC has also developed a set of recommendations for school health programs promoting healthy eating. [See Guidelines for School Health Programs to Promote Lifelong Healthy Eating. CDC "Morbidity and Mortality Weekly Report." June 14, 1996 / 45(RR-9):1-33, at http://www.cdc.gov/mmwr/preview/mmwrhtml/00042446.htm]

Concerning obesity and lack of exercise:

> "Students from schools participating in a coordinated program that incorporated recommendations for school-based healthy eating programs exhibited significantly lower rates of overweight and obesity, had healthier diets, and reported more physical activities than students from schools without nutrition programs." [See Veuglers, P. J. and Fitzgerald, A. "Effectiveness of School Programs in Preventing Childhood Obesity: A Multilevel Comparison." *American Public Health Association, Inc.* Volume 95(3), March 2005: 432-435.]

The most effective school-based integrated programs cited in this study were the Annapolis Valley Health Promoting Schools programs, implemented in seven primary schools in Nova Scotia, Canada. These schools integrated healthy eating programs with exercise and parent and student involvement. [See http://www.hpclearinghouse.ca/features/AVHPSP.pdf]

A recent study from a researcher at the University of Texas at Austin discusses effective nutritional practices and policies for childbearing and childrearing women. This work specifically addresses methods for promoting healthy eating among low-income pregnant women. [See Reifsnider, E. "Effective Nutritional Practices and Policies for Childbearing and Childrearing Women." April 4, 2003, at http://www.excellence-earlychildhood.ca/ documents/ReifsniderANGxp.pdf.]

The State of Hawaii sponsors the Nutrition Education for Wellness program, which is a statewide "umbrella concept" program that facilitates consumer foods and nutrition education. Some of its features include the following goals:

- To provide educational programs that increase the likelihood of healthy food choices
- To provide practical foods and nutrition education training
- To safeguard the health and well-being of limited income households by promoting skills building and access to a healthy diet.[See University of Hawaii College of Tropical Agriculture and Human Resources Web site at http://www.ctahr.hawaii.edu/NEW/]

Providing a Better Infrastructure for Volunteerism

Problem

The sponsors of this assessment confront many issues with respect to volunteer initiatives. Among these are program development, recruitment and marketing, screening, training, transportation, risk management, and organization. Below we outline some of the approaches to these problems that have been tried elsewhere and that may provide some guidance to local efforts. The sections on transportation and child literacy are particularly comprehensive and relevant for the sponsors.

Solutions

Program development. A1999 study from the California Council of Churches and Catholic Charities of California assesses ways to increase quality childcare services: "the project was designed to work through the faith community by building on this strong commitment to the care and early childhood development of children." The council produced a guide that offers a variety of ways to increase quality childcare services locally. An assessment tool is included to help identify community needs and congregational assets, along with a step-by-step list and related resources for each type of child care service a congregation might choose to support. [See http://www.calchurches.org/CCBooklet.pdf]

The Canadian government sponsors a national program of employer-based volunteering. Among the components of the program are designing volunteer programs; recruiting volunteers; interviewing, screening, and training; and managing volunteers. The government provides manuals for step-by-step procedures for developing these programs. [See Giving and Volunteering Web site at http://www.nsgvp.org/]

Recruitment, screening, training, and supervision. Based upon a 2003 study from the Canadian Centre for Philanthropy, the Huntington Society of Canada produced a comprehensive manual that provides effective formalized procedures for: recruitment, screening, training, and supervision. [See http://www.hsc-ca.org/english/pdf/VTIIIIVolunteerRecruitment.pdf]

Transportation. The Beverly Foundation and the AAA Foundation for Traffic Safety produced in 2001 a report of a comprehensive study of Supplemental Transportation Programs (STP); a follow-up study was conducted in 2004. STPs are community-based transportation programs for seniors. These programs are predominantly nonprofit, with budgets ranging from modest volunteer efforts to ones with budgets of as much as $10 million. Some use volunteers, others paid staff. The two reports provide reviews of several components of these programs, including organization, recruitment, financing, and risk management. Case studies are provided. [See 2001 study at http://www.seniordrivers.org/research/stp.pdf ; 2004 study at http://www.aaafts.org/pdf/STP2.pdf]

Child literacy programs.

"Experience Corps is a national literacy program that mobilizes … older adults who work in teams providing reading and literacy support to children in Philadelphia elementary schools."

The Philadelphia Experience Corps program is the largest of 12 national Corps sites and has been designated as the lead site for a large-scale national expansion initiative. All Experience Corps members go through a comprehensive screening process. Candidates complete a program application and interview, criminal and child abuse background clearances and reference checks. Members also receive 20 hours of pre-service training and an in-school orientation before being carefully matched with students. [See Philadelphia Experience Corps Web site at http://www.temple.edu/cil/ec/inside.asp]

Increasing Access to Fluoridated Water Supplies

Problem

Several surveys conducted in the last decade of the efficacy of communal water fluoridation in reducing dental caries [a progressive destruction of bone or tooth; especially: tooth decay] have shown that water fluoridation significantly reduces the incidence of caries:

> The efficacy is greatest for the deciduous dentition [first set of teeth], with a range of 30-60 percent less caries in fluoridated communities. In the mixed dentition (ages 8 to 12), the efficacy is more variable, about 20-40 percent less caries. In adolescents (ages 14-17), it is about 15-35 percent less caries. Current data on caries prevalence in adults and seniors are extremely limited and include several populations living in communities with higher than optimal fluoride levels. For these adults and seniors, a range of 15-35 percent less caries would also apply. Newburn, E. *Journal of Public Health Dentistry,* 1989, 49 (5 Spec No): 279-89. [See http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=2681730&dopt=Citation]

> In the United States during 2000, approximately 162 million persons (65.8 percent of the population served by public water systems) received optimally fluoridated water compared with 144 million (62.1%) in 1992 . . . This report presents state-specific data on the status of water fluoridation in the United States and describes a new surveillance system designed to routinely produce state and national data to monitor fluoridation in the public water supply. The results of this report indicate slow progress toward increasing access to optimally fluoridated water for persons using public water systems.
>
> Percentage of the population receiving optimally fluoridated water through public water systems (PWS) in Pa. in 2000 was 54.2%; in 1992 it was 50.9%. This is a change of 3.3%.
>
> This report … describes a new surveillance system designed to routinely produce state and national data to monitor fluoridation in the public water supply. The results of this report indicate slow progress toward increasing access to optimally fluoridated water for persons using public water systems. CDC, "Morbidity and Mortality Weekly Report" February 22, 2002 / Vol. 51 / No. 7 [See http://www.cdc.gov/mmwr/PDF/wk/mm5107.pdf]

The CDC lists 41 water systems in Montgomery County. These communities vary in size from townships to a 75-person apartment complex. Only the Borough of Pottstown Municipal water system, serving a population of about 36,000, fluoridates its water. [See "My Water's Fluoride," CDC Web site: http://apps.nccd.cdc.gov/MWF/SearchResultsV.asp]

The CDC, in the surgeon general's 2004 "Statement on Community Water Fluoridation," states that an economic analysis has determined that in most communities, every $1 invested in fluoridation saves $38 or more in treatment costs. [See Surgeon General's Statement on Community Water Fluoridation, 2004, CDC Web site, at http://www.cdc.gov/oralhealth/waterfluoridation/fact_sheets/sg04.htm]

Solutions

A goal of the Healthy People 2000 Initiative is that 75 percent of residents receive fluoridated water. [See "Fluoridation of Public Water Supplies," on the American Academy of Family Physicians Web site at http://www.aafp.org/x1585.xml]

A working group commissioned by the CDC provides a comprehensive analysis of the efficacy of fluoride in reducing tooth decay, and several modalities available for administering fluoride (communal water, tooth paste, and the like). Among the groups recommendations: a collaboration to educate health care professionals and public professional health care organizations, public health agencies, and suppliers of oral-care products to in turn educate health-care professionals and trainees and the public regarding the recommendations in this report [increased fluoridation of communal water supplies]. Broad collaborative efforts to educate health-care professionals and the public and to encourage behavior change can promote improved, coordinated use of fluoride modalities. [See CDC, "Weekly Morbidity and Mortality Report." August 17, 2001 / 50(RR14):1-42 on the CDC Web site at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5014a1.htm]

In its report "The Effective Use of Fluorides in Public Health," the World Health Organization (WHO) provides a case study of fluoride promotion in the State of California. In 1992 the water of 16 percent of state citizens was fluoridated. In 1995, state legislation mandated mandatory communal water fluoridation for communities with more than 10,000 water connections. As of the publication of the report in 2005, 28 percent of California citizens were receiving fluoridated water. [See "Bulletin of the World Health Organization." September 2005, 83 (9) at the WHO Web site, http://www.who.int/entity/bulletin/volumes/83/9/670.pdf.]

The Pennsylvania Department of Health provides an Oral Health Strategic Plan, with several recommendations for fluoride promotion in the commonwealth. Among these are promotion, information, opposition to legislation that opposes fluoridation, and funding. [See "Oral Health Care Programs" on the Pennsylvania. Department of Health Web site, at http://www.dsf.health.state.pa.us/health/cwp/view.asp?a=174&q=232221&healthPNavCtr=|#4675]

II. Reducing Behavioral Risks

It is estimated that 1,159,000 deaths, or 48.2 percent of all deaths, in the United States in 2000 were caused by modifiable individual behavioral risks. Tobacco use remained the major cause of such deaths (435,000), but poor diet and lack of physical exercise caused an estimated 400,000 deaths and, since it is the only behavioral cause of death to increase in terms of its share of all deaths in the last decade, will soon eclipse tobacco for the number one spot. While these estimates by the CDC are a source of ongoing debate and refinement, the message is clear. Individual behavior is responsible for about half the deaths, half the illness, and perhaps about half the medical and indirect economic costs of illness that now exceed one trillion dollars a year. Federal, state and local public health efforts, private employers, health insurance plans, and private foundations have invested substantial resources towards changing people's behavior, with some modest successes. Changing behavior is not easy, and some of the work has amounted to little more than moralistic pronouncements about individuals taking responsibility for their own health in order to avoid collective responsibility. Following, we survey some of the key pockets of need and targets of opportunity for behavioral change.

Reducing Violence

Problem

According to the surgeon general, arrests for youth violence declined from about 525 per 100,000 in 1994, to 350 per 100,000 in 1999. [See "Youth Violence: A Report of the Surgeon General," at http://www.surgeongeneral.gov/library/youthviolence/chapter2/sec1.html#measuring] The Web site also provides assessment of risk factors, and interventions.

The number of arrests involving juveniles in 2000 was 13 percent lower than it was in 1994. Arrests for many of the most serious offenses fell even more sharply. [See Butts, J. and Travis, J. "The Rise and Fall of American Youth Violence: 1980–2000," at the

Urban Institute Web site, http://www.urban.org/UploadedPDF/410437.pdf]

> "Although the 1999 arrest rate for violent crimes was the lowest in this decade, it is still 15 percent higher than the 1983 rate (Snyder, unpublished). As seen in Figure 2-2 the 1999 rates for homicide, robbery, and rape are below the 1983 rates; however, arrests for aggravated assault are still nearly 70 percent higher than 1983 rates." [From "Youth Violence: A Report of the Surgeon General," (Chapter 2) at http://www.surgeongeneral.gov/library/youthviolence/chapter2/sec1.html#arrests]
>
> "The reasons for the decline are complex and not well understood, but they do involve changes in the carrying and use of guns in violent encounters (Blumstein & Wallman, 2000). The explanations most often given are a decline in youth involvement in the crack market and in gang involvement in crack distribution, police crackdowns on gun carrying and illegal gun purchases, longer sentences for violent crimes involving a gun, a strong economy, and expanded crime and violence prevention programs. After reviewing these and other potential explanations for the drop in violence, Blumstein and Wallman (2000) concluded that no single factor was responsible; rather, the decrease in violence resulted from the combination of many factors." [From "Youth Violence: A Report of the Surgeon General," (Chapter 2) at http://www.surgeongeneral.gov/library/youthviolence/chapter2/sec1.html#arrests]

According to a 2001 Report from the Office of Disease Prevention and Health Promotion (Health and Human Services):

> Estimating the Cost of Youth Violence:
>
> The Surgeon General's report provides the best estimate but it is based on data nearly a decade old: Violence costs the United States an estimated $425 billion in direct and indirect costs each year. Of these costs, approximately $90 billion is spent on the criminal justice system, $65 billion on security, $5 billion on the treatment of victims, and $170 billion on lost productivity and quality of life. Youth Violence is a Public Health Problem. [See http://odphp.osophs.dhhs.gov/pubs/prevrpt/01spring/Spring2001PR.htm]

Solutions

Information. The American Psychological Association and the American Academy of Pediatrics have collaborated to produce a brochure of recommendation to reduce violence in youth. [See "Raising Children to Resist Violence: What You Can Do," at http://www.apa.org/pubinfo/apa-aap.html]

School. Virginia. Commonwealth University, and Virginia's departments of health and education produce a Web site that lists youth violence-reduction best practices and assesses programs that follow each of the listed best practices. [See "Virginia. Best Practices in School-Based Violence Prevention" at http://www.pubinfo.vcu.edu/vabp/best_practice_lists.asp; note that accessing information does not require registration]

Comprehensive state/community programs (such as domestic violence shelters, advocacy, counseling, education). A Woman's Place provides comprehensive services to victims of domestic violence in Bucks County, Pennsylvania. This organization provides a children's program that offers counseling to young witnesses of domestic violence and education in non-violent approaches to conflict; volunteer training; a shelter; school-based education programs; legal advocacy. [See http://www.awomansplace.org/awp2004.pdf]

The Sexual Assault and Trauma Resource Center of Rhode Island is a state agency that deals with issues of sexual assault as a community concern. It employs 32 staff members. In addition, over 70 volunteers are highly trained in dealing with issues of sexual assault and domestic violence, serving as counselor/advocates throughout the state. Among services provided are counseling, legal advocacy, and prevention education and professional training. [See http://www.satrc.org/programs.htm]

Communities That Care (CTC) is a less comprehensive program that provides communities with a process to mobilize the community, identify risk and preventive factors, and develop a comprehensive prevention plan. It is sponsored by the

Pennsylvania Commission on Crime and Delinquency, which provides funding, and development, training, and evaluation techniques. [See http://www.pccd.state.pa.us/pccd/cwp/view.asp?a=3&Q=571154]

Therapeutic interventions. Research at the National Institutes of Mental Health has determined two therapeutic interventions to reduce violence in youth. [See "Child and Adolescent Violence Research at the National Institutes of Mental Health" at http://www.nimh.nih.gov/publicat/violenceresfact.cfm]

Reducing Smoking

Problem

From the CDC's "Health Effects of Cigarette Smoking" fact sheet, February 2004:

> The adverse health effects from cigarette smoking account for 440,000 deaths, or nearly 1 of every 5 deaths, each year in the United States. More deaths are caused each year by tobacco use than by all deaths from human immunodeficiency virus (HIV), illegal drug use, alcohol use, motor vehicle injuries, suicides, and murders combined.
>
> **Cancer**
>
> The risk of dying from lung cancer is more than 22 times higher among men who smoke cigarettes, and about 12 times higher among women who smoke cigarettes compared with never smokers.
>
> Cigarette smoking increases the risk for many types of cancer, including cancers of the lip, oral cavity, and pharynx; esophagus; pancreas; larynx (voice box); lung; uterine cervix; urinary bladder; and kidney.
>
> Rates of cancers related to cigarette smoking vary widely among members of racial/ethnic groups, but are generally highest in African-American men.
>
> **Cardiovascular Disease (Heart and Circulatory System)**
>
> Cigarette smokers are 2–4 times more likely to develop coronary heart disease than nonsmokers.
>
> Cigarette smoking approximately doubles a person's risk for stroke.
>
> Cigarette smoking causes reduced circulation by narrowing the blood vessels (arteries). Smokers are more than 10 times as likely as nonsmokers to develop peripheral vascular disease.
>
> **Respiratory Disease and Other Effects**
>
> Cigarette smoking is associated with a ten-fold increase in the risk of dying from chronic obstructive lung disease. About 90% of all deaths from chronic obstructive lung diseases are attributable to cigarette smoking.
>
> Cigarette smoking has many adverse reproductive and early childhood effects, including an increased risk for infertility, preterm delivery, stillbirth, low birth weight, and sudden infant death syndrome (SIDS).
>
> Postmenopausal women who smoke have lower bone density than women who never smoked. Women who smoke have an increased risk for hip fracture than never smokers.

[See http://www.cdc.gov/tobacco/factsheets/HealthEffectsofCigaretteSmoking_Factsheet.htm]

Solutions

Smoking prevalence rates among adults aged 18 years and older decreased from 42.4 percent in 1965 to 24.7 percent in 1997.

An estimated 1.6 million deaths were postponed because of gains against cigarette smoking, saving more than 33 million person-years of life. Deaths from heart disease have decreased from 307.4 per 100,000 in 1950 to 134.6 per 100,000 in 1996.

[See "Achievements in Public Health: Tobacco Use—United States 1900-1999." MMWR Highlights. November 5, 1999 / Vol. 48 / No. 43 at the CDC Web site, http://www.cdc.gov/tobacco/news/achievements99.htm.]

The CDC has produced a report that "draws upon 'best practices' determined by evidence-based analyses of comprehensive State tobacco control programs. Among the recommendations: Community and State-wide initiatives; chronic disease programs; school programs; enforcement; counter-marketing; and cessation programs." [See Centers for Disease Control and Prevention. "Best Practices for Comprehensive Tobacco Control Programs—August 1999." Atlanta GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, August 1999, found at http://www.cdc.gov/tobacco/research_data/stat_nat_data/bestprac-execsummay.htm.]

> Tobacco use is the leading cause of preventable death in the United States. The majority of daily smokers (82%) began smoking before 18 years of age, and more than 3,000 young persons begin smoking each day. School programs designed to prevent tobacco use could become one of the most effective strategies available to reduce tobacco use in the United States. The following guidelines summarize school-based strategies most likely to be effective in preventing tobacco use among youth. They were developed by CDC in collaboration with experts from 29 national, federal, and voluntary agencies and with other leading authorities in the field of tobacco-use prevention to help school personnel implement effective tobacco-use prevention programs. These guidelines are based on an in-depth review of research, theory, and current practice in the area of school based tobacco-use prevention. The guidelines recommend that all schools a) develop and enforce a school policy on tobacco use, b) provide instruction about the short- and long-term negative physiologic and social consequences of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills, c) provide tobacco-use prevention education in kindergarten through 12th grade, d) provide program-specific training for teachers, e) involve parents or families in support of school-based programs to prevent tobacco use, f) support cessation efforts among students and all school staff who use tobacco, and g) assess the tobacco-use prevention program at regular intervals. [From the CDC's Morbidity and Mortality Weekly Report. "Guidelines for School Health Programs to Prevent Tobacco Use and Addiction." February 25, 1994 / Vol. 43 / No. RR-2. [See http://www.cdc.gov/tobacco/interv.htm]

Minnesota youth anti-smoking campaign:

> Comprehensive state anti-tobacco programs, especially those with strong advertising (i.e., paid media) campaigns, have contributed to the substantial decline in youth smoking since 1997.
>
> In Minnesota, annual funding for tobacco-control programs was reduced from $23.7 million to $4.6 million in July 2003, ending the Target Market (TM) campaign directed at youths since 2000.
>
> To assess the effects of cutting the state's tobacco control funding, during November–December 2003, a survey of Minnesota adolescents aged 12–17 years was conducted to determine their awareness of the TM campaign and their susceptibility to smoking, which is an important predictor of adolescent tobacco use.
>
> The percentage of adolescents who were aware of the TM campaign declined from 84.5 percent during July–August 2003 to 56.5 percent during November–December 2003, and the percentage of adolescents susceptible to cigarette smoking increased from 43.3 percent to 52.9 percent.
>
> Between the July–August 2003 and November–December 2003 surveys, a related increase in susceptibility to smoking, from 43.3 percent to 52.9 percent, occurred among youth in Minnesota. [From "Effect of Ending an Anti Tobacco Youth Campaign on Adolescent Susceptibility to Cigarette Smoking - Minnesota, 2002–2003. CDC's "Morbidity and Mortality Weekly Report." "MMWR Highlights." April 16, 2004 / Vol. 53 / No. 14." at http://www.cdc.gov/tobacco/research_data/youth/mm5314a1_highlights.htm.]

Smoking is a major cause of low-birth weight babies. Counseling is the primary treatment for smoking cessation in pregnant women. The fact that counseling is covered in only 13 states means that the primary

treatment for tobacco dependence is not available to many pregnant Medicaid enrollees. [See State Medicaid Coverage for Tobacco Dependence Treatments — United States, 1998 and 2000. "MMWR Highlights." November 9, 2001 / Vol. 50 / No. 44. at http://www.cdc.gov/tobacco/research_data/interventions/mm5044.highlights.htm]

Oregon's voter-approved measure in 1996 to increase cigarette excise taxes by $.30 (to $.68 per pack) and to implement a new comprehensive tobacco prevention and education program reduced cigarette consumption by 11.3 percent between 1996 and 1998 (two-years following the voter initiative); thus reversing a 4-year period (1993-1996) of increasing consumption prior to the measure. [See "Oregon—Reducing Cigarette Consumption through a Comprehensive Tobacco Control Program." "MMWR Highlights." February 26, 1999 / Vol. 48 / No. 7. at http://www.cdc.gov/tobacco/research_data/interventions/mm299fs.htm.

Promoting Exercise and Weight Control

Problem

Nutrition and overweight is one of the focus areas highlighted in the Healthy People 2010 program. The level of physical activity is one of the 10 leading health indicators (major health issues) in the program. [See U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health.* 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.]

According to "The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity 2001,"

- In 1995, the total costs (direct and indirect) attributable to obesity amounted to an estimated $99 billion.
- In 2000, that amount was estimated to be $117 billion ($61 billion direct and $56 billion indirect cost).
- In 1995 the direct cost alone associated with obesity was estimated to be 5.7 percent of total national health expenditures.
- Much of the costs associated with obesity are attributable to type 2 diabetes, coronary heart disease, and hypertension. [See http://www.surgeongeneral.gov/topics/obesity/ page 10, which cites Wolf A.M., and Colditz, G.A. Obesity Research.1998 6(2):97-106]

The same report cites research that observes an increase in obesity over the last two decades:

- Based on clinical height and weight measurements in the National Health and Nutrition Examination Survey (NHANES):
- In 1999, 34 percent of U.S. adults aged 20 to 74 years were overweight (BMI 25 to 29.9), and an additional 27 percent were obese (BMI > 30) [See National Center for Health Statistics (NCHS), CDC. Prevalence of Overweight and Obesity Among Adults: United States, 1999 at http://www.cdc.gov/nchs/products/pubs/pubd/hestats/obese/obse99.htm]
- This contrasts with the late 1970s, when an estimated 32 percent of adults aged 20 to 74 years were overweight, and 15 percent were obese.[See Eberhardt, M.S.et al. Urban and Rural Health Chartbook. Health, United States, 2001. Hyattsville, MD: NCHS, 2001. p. 256; see also the comprehensive study from which much of the data above was drawn: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute. NIH Publication No. 98-4083 September 1998 National Institutes of Health, at http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.htm]

Solutions

School-based, integrated physical activity and nutrition programs:

"Students from schools participating in a **coordinated program** that incorporated recommendations for school-based healthy eating programs exhibited **significantly lower rates of overweight and obesity, had healthier diets, and reported more physical activities than students from schools without nutrition programs.**" [See

Veugelers, P. J., and Fitzgerald, A. L. "Effectiveness of School Programs in Preventing Childhood Obesity: A Multilevel Comparison." American Public Health Association, Inc. Volume 95(3), March 2005: 432-435.]

The most effective school-based integrated programs cited in this study were the Annapolis Valley Health Promoting Schools programs, implemented in seven primary schools in Nova Scotia, Canada. These schools integrated healthy eating programs with exercise and parent and student involvement. [See www.hpclearinghouse.ca/features/AVHPSP.pdf]

Increasing physical activity. A private collaboration of physicians and healthcare researchers, supported by the U.S. Department of Health and Human Services, performed a systematic evaluation of existing studies of the effects of physical activity in reducing morbidity and mortality; and the effectiveness of interventions in increasing physical activity. From the report of the task force:

> "the development team focused on interventions to increase physical activity through informational, behavioral and social, and environmental and policy approaches."

"The Task Force **strongly recommended or recommended six interventions based upon an evaluation of numerous studies:**

- Two informational approaches:
  - Community-wide campaigns
  - Point-of-decision prompts to encourage using stairs
- Three behavioral and social approaches:
  - school-based physical education
  - social support interventions in community settings (e.g., setting up a buddy system or contracting with another person to complete specified limits of physical activity)
  - individually adapted health behavior change
- One environmental and policy approach: creation of or enhanced access to places for physical activity combined with informational outreach activities. [See "A Report on Recommendations of the Task Force on Community Preventive Services." Task Force on Community Preventive Services. October 1, 2001 at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5018a1.htm]

Tailored Print Interventions: Testimony of Dr. James F. Fries, MD, Joint Economic Committee of U.S. Congress. July 22, 2004. "Postponement of Illness and the Future of Medicare Costs":

> "prove our ability to achieve healthier and less costly lives … through relatively inexpensive health improvement programs costing less than $100 per year per person annually. The **most consistently effective approach has been "tailored print interventions, where each set of feedback materials to the participant is exquisitely configured for the precise characteristics and previous behaviors of that individual."**
>
> "'results of one randomized trial indicate that **investing about $100 per year per person annually … should be expected to reduce Medicare claims by about $400 per beneficiary per year, even in the first year.**' [See citations of this testimony at http://jec.senate.gov/_files/Friestestimony.pdf]
>
> [For a "how to" program: strategies, assessments, individual programs, see The Active Aging Toolkit. Phil Page, et al. The Hygenic Corporation. 2004. https://www.hsminc.com/ReadFileLink.asp?fileLinkId=170]

Walking trails. A CDC-supported exercise program, including walking trail construction.

"The program evaluation found that **42% of community residents used walking trails established through the program and that almost 60% of trail users reported increasing their physical activity**. The evaluation also found that **women and people with lower educational levels—groups at high risk for physical inactivity—may be especially responsive to walking trails."** [See www.healthierus.gov/steps/summit/prevportfolio/pa-hhs.pdf OR 0-www.cdc.gov.library.unl.edu/nccdphp/pe_factsheets/pefs_pa.pdf]

Recommended Solutions for Montgomery County:

- School-based integrated nutrition, exercise, and community involvement program. For an evaluation of the program's effectiveness and detailed "how we did it" sections on each topic area, see Dietary Guidelines for Americans at http://healthierus.gov/dietary guidelines; and Physical Activity and Good Nutrition: Essential Elements to Prevent Chronic Diseases, at http://www.cdc.gov.nccdphd/aag/aag_dnpa.htm.
- Physical activity program for seniors. The sponsoring agencies of this initiative could work with several types of community resources to implement this program. The area hospitals may be enlisted to perform the initial health assessments, and the development of the individual exercise programs. The hospitals' facilities themselves, as well as the 13 county senior centers, YMCA/YWCAs, places of worship, and other community sites may be used to localize the program; the hospitals may provide the individual assessments and individual exercise programs at either no or a discounted cost to gain access to the referral base.
- The agencies could work with local media and other avenues to communicate the need for and availability of the program. The agencies could then develop a follow-up program to inform the participants to update the individual plans. The agencies could work with some of the above-referenced facilities to provide exercise sites.
- Walking trails. A walking trails program may be particularly useful for the Norristown and Pottstown communities. The sponsoring agencies could assess the availability and condition of any local trails; work with county and state to develop and maintain trails; develop a program to promote walking among residents. [See Illinois Department of Aging at http://www.state.il.us/aging/lathome/nutrition.htm]

Reducing Drug and Alcohol Abuse

Problem

From the U.S. Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) 2001 Household Survey:

- 15.9 million Americans age 12 and older used an illicit drug in the month immediately prior to the survey interview; this was 7.1 percent of the population in 2001, compared to an estimated 6.3 percent the previous year.
- 10.8 percent of youths 12 to 17 were current drug users in 2001, compared with 9.7 percent in 2000.
- Among young adults age 18 to 25, current drug use increased between 2000 and 2001 from 15.9 percent to 18.8 percent.
- There were no statistically significant changes in the rates of drug use among adults age 26 and older.

[See SAMHSA 2001 Household Survey at http://www.whitehousedrugpolicy.gov/drugfact/nhsda01.html

From the National Institute on Drug Abuse (part of the National Institutes of Health):

> The economic cost to U.S. society of drug abuse was an estimated $97.7 billion in 1992, according to recent calculations. The new cost estimate [1992] continues a pattern of strong and steady increase since 1975, when the first of five previous cost estimates was made. The current estimate is 50 percent higher than the most recent previous estimate—which was made for 1985—even after adjustment for population growth and inflation.
>
> The parallel cost to society for alcohol abuse was estimated at $148 billion, bringing the total cost for substance abuse in 1992 to $246 billion. This total represents a cost of $965 for every person in the United States in 1992. The per-person cost for drug abuse alone was $383.
>
> These costs arise from increased costs for health services, costs of crime, lost earnings, and social welfare costs.
>
> Neil Swan. National Institute on Drug Abuse. "Research Findings." Volume 13, Number 4 (November, 1998). [See http://www.drugabuse.gov/NIDA_Notes/NNVol13N4/Abusecosts.html]

Solutions

Evaluation of effective intervention methods:

> "a policy response of reductions in prevention or treatment expenditures will have the effect of increasing rather than decreasing state costs. Furthermore, policy strategies that involve only civil or criminal justice sanctions without requiring treatment will, in the long term, raise rather than reduce state costs. By thinking about expenditures as investments, policy makers will be in a better position to demand specific results for their investments. An investment-based approach will help policy makers ensure accountability for expenditure of public funds by showing the return and the results." Foster, S.E., and Modi, D. "United Nations Office on Drugs and Crime: Estimating the Costs of Substance Abuse to State Budgets in the United States of America." Bulletin on Narcotics. Volume LII, Nos. 1 and 2, 2000. [See http://www.unodc.org/unodc/en/bulletin/bulletin_2000-01-01_1_page007.html]

The National Institute on Drug Abuse (NIDA, within the NIH) conducted a thorough study of effectiveness of drug abuse prevention strategies. The effectiveness of expanded social influence/competence enhancement [resistance skills] approaches has been tested in a number of research studies. These studies have generally produced 40 to 80 percent reductions in drug use behavior. [See NIDA. Bukowski, W. and Evans R. (eds) "Cost-Benefit/Cost-Effectiveness Research of Drug Abuse Prevention" at http://www.drugabuse.gov/pdf/monographs/monograph176/download176.html]

Provincial/state/community programs. The British Colombia Ministry of Health Services website information on best practices and programs to reduce alcohol and substance abuse in the province. [See the British Columbia Ministry of Health Web site at http://www.healthservices.gov.bc.ca/mhd/bpelementsbc.html]

The Center for Substance Abuse Prevention (in SAMHSA), provides descriptions and links to numerous community-based model programs to reduce alcohol and substance abuse. "The SAMHSA Model Programs featured on this site have been tested in communities, schools, social service organizations, and workplaces across America, and have provided solid proof that they have prevented or reduced substance abuse and other related high-risk behaviors." [See http://www.modelprograms.samhsa.gov/template.cfm?page=default]

> "The Baltimore Substance Abuse Systems (BSAS) is the agency charged with reducing the harm associated with drug addiction. Baltimore is one of only two U.S. cities attempting to insure that drug addicted individuals gain access to treatment within 48 hours of request. Researchers from three local universities evaluated the system's expansion and enhancement efforts and found that heroin use declined by 69% at 12 months after treatment entry and cocaine use declined by 48%. Furthermore, treatment participants engaged in criminal activities 64% less at 12 months after treatment entry. HIV-risk behaviors also were shown to decline significantly." [See the Open Society Institute at http://www.soros.org/initiatives/baltimore/focus_areas/drug_addiction]

III. Improving Access to Services

Access is shaped by perceived need, supply, and knowledge of available resources. It is restricted by economic, social, transportation, and convenience barriers. Since less than 20 percent of a population need and use more than 80 percent of all health and social services, and since that 20 percent is least likely to be able to afford the costs, public and/or private insurance, financing plays the central role in assuring access. That financing determines demand and supply. The less the recipient of services has to pay out of pocket the more services will be used and those out of pocket barriers will loom larger for those with less income. The more providers receive relative to their costs, the more supply will expand. The challenge is to reduce the currently existing market distortions that tend to reduce access to primary and preventive services to those that need them the most and expand

access to generally more profitable catastrophic services that increase the overall costs and produce poorer outcomes for the population as a whole.

Improving Access to Information

Problem

Residents of Montgomery County have a multitude of questions regarding matters of health. There are many informational resources available, but residents do not know how to find them.

Solutions

The internet provides one rich source of useful information that, properly supported by service providers, can assist clients in getting the resources they need.

Thorough, comprehensive information sources:

The U.S. Health and Human Services' Information and Hotline Directory: Web links and hotline telephone numbers for a menu of health needs. Links range from adoption services, cancer information, lead poisoning, through women's health and youth crisis services. [See http://www.hhs.gov/about/referlst.html]

The National Institutes of Health provides a Web site that addresses both the "how to" element of obtaining health information, as well as numerous print and Internet information sources. [See http://www.niams.nih.gov/hi/topics/howto/howto.htm]

The Food and Nutrition Information Center, a division within the U.S. Department of Agriculture (USDA), provides a Web site that contains a comprehensive list of links pertaining to nutrition. Among the topics covered are aging, community food systems, diabetes, heart health, overweight, and WIC. [See http://www.nal.usda.gov/fnic/etext/fnic.html]

The California Department of Education provides a Web site of resources for preventing violence. Some topics covered include safe schools, warning signs of youth violence, program development, hate crimes, and sources of violence statistics. [See http://www.cde.ca.gov/ls/ss/vp/ssresources.asp]

The CDC produces a Web site of resources for quitting smoking, with CDC-provided interventions, as well as links to other sources. [See http://www.cdc.gov/tobacco/how2quit.htm]

The SAMHSA produces a Web site with a comprehensive list of resources. Links include both government and non-government sources. Topics include information and interventions for alcohol and a list of drugs, as well as information for specific audiences (ethnic group, peer group, service providers, etc.). [See http://www.health.org/links/]

The strength of these sites is that they provide a wealth of information from reliable sources, such as the CDC, in a format that is easy to understand by a typical citizen. These sites generally take a "how to" approach, addressing a broad range of health concerns that citizens have, and how those citizens may answer their own questions. For example, the HHS site provides several links addressing various types of cancer. Among the topics covered are descriptions of various cancers, appropriate interventions, and the success of those interventions. Likewise, the Food and Nutrition Information Center on the USDA site provides links to local resources, with descriptions of programs, how to use these programs, as well as opportunities for volunteers and social service agencies to participate.

Use of a "professional navigator". In order to assist individuals in accessing information, the sponsors may wish to fund a "professional navigator' service. Such a service is currently operating in Montgomery County under a HRSA grant. The navigator works with people needing services, finding the right providers, negotiating with providers into granting services, providing benefits, and the like.

There may be a significant expense involved, in developing and maintaining such a site, in promoting the site, and employing the navigator. The task of coordinating the content and technical elements must also be considered. If such a service is developed well, it could provide very valuable services to a host of

different types of users, and might even serve as a pilot for the development of other such services elsewhere.

Increasing Training for Coaches and Parents of Children Involved in Sports and Physical Activity Programs

Problem

Much of children's sports activity in the United States is supervised by persons without training in medicine, coaching, or child psychology. This results, at times, in physical injury, and a sports experience that is frustrating and discouraging to children. The resources below address how to improve the safety of children's sports activities and how to improve the experience of children participating.

Solutions

The National Youth Sports Safety Foundation, Inc. (NYSSF), a nonprofit corporation established in 1989, is dedicated to reducing the number and severity of injuries youth sustain in sports activities through the education of health professionals, program administrators, coaches, parents and athletes. Its website states that it is the only such organization in the country. Resources include a clearinghouse for information, educational literature, resource center, and coaching education. [See http://www.nyssf.org/wframeset.html]

The Positive Coaching Alliance (PCA), established in 1998, is a national organization that was provides live, research-based training workshops and practical tools for coaches, parents and leaders who operate youth sports programs. PCA educates adults who shape the youth sports experience by offering partnership programs with youth sports organizations, schools, cities, and national sports governing bodies. [See http://www.positivecoach.org/default.aspx?SecID=6]

National Youth Sports Coaches Association (NYSCA) is the most widely used volunteer coach training program in the nation, having trained more than 1.8 million coaches since its inception in 1981. Its national standards for youth sports are used as a guide for operating youth sports programs. [See http://www.nays.org/TimeOut/National%20Standards.pdf; see http://www.nays.org/IntMain.cfm?Page=78&Cat=1]

The nonprofit National Alliance for Youth Sports (NAYS), founded in 1981, has certified over 1.7 million coaches who have completed their training programs. It provides training in sports coaching, as well as standards for coach conduct, and recommendations for developing community sports programs. [See http://www.nays.org/IntMain.cfm?Page=82&Cat=1]

A model for regional efforts and a source of information is Urban Youth Sports, which creates solutions that increase opportunities for sports participation and healthy development in Boston neighborhoods. Operated by Northeastern University's Center for the Study of Sport in Society, it has have created over 1,200 new sports/recreation opportunities in two years. The Web site provides program descriptions, as well as contact information for program administrators. [See http://www.sportinsociety.org/uys.html]

Christiana Care Health System provides a sports program that may provide a model for local Montgomery County hospital systems to consider. Christiana Care Physical Therapy Plus offers a sports program of customized strength and conditioning programs for athletes of all ages and abilities. Some of the sports addressed are football, soccer, tennis, bicycling, running, and golfing. [See http://www.christianacare.org/body.cfm?id=361]

Improving Prevention Strategies

Problem

In the United States, rates of immunization for children and seniors are significantly below levels recommended by the Healthy People 2010 initiative. [Children: four or more doses of diphtheria/tetanus/acellular pertussis (DTaP) vaccine; three or more doses of polio vaccine; one or more dose of measles/mumps/rubella (MMR) vaccine; three or more doses of Haemophilus influenza type b (Hib) vaccine; and three or more doses of hepatitis B (Hep B) vaccine. Seniors: influenza and pneumococcal vaccines. See http://www.healthypeople.gov/Document/HTML/uih/uih_4.htm]

Solutions

The sources described below provide methods for addressing the gaps in the health care system: immunization coverage for the reluctant or unmotivated, the uninformed, and the uninsured. The comprehensive surveying of target populations to determine immunization status allows providers to seek and treat those not inoculated. Communication strategies, particularly for minority, non-English-speaking, and senior populations, informs those who do not understand or appreciate the efficacy of immunization. And universal coverage for pediatric immunizations overcomes the barrier of inadequate financial resources.

The following regional programs offer models for Montgomery County:

In Canada, the Saskatchewan Department of Health conducts a review of all preschool records on an annual basis to identify those children who are behind in their immunization schedule. On first review, between 75 and 80 percent of children are fully immunized to current recommendations. This rises to between 93 and 95 percent by school entry as children get caught up with vaccine doses they have previously missed. The immunizations are provided by public health nurses and physicians. The sponsors might consider funding an initiative with the Pennsylvania and Montgomery County departments of health, long with area health care providers, to develop a similar program. The Pennsylvania Chapter of the American Academy of Pediatrics and the Pennsylvania Department of Health currently provide a health care provider education and child immunization program: the sponsors could supplement this program with one for greater surveying and outreach efforts.[See www.saskatoonhealthregion.ca/pdf/2000population/Section%2010.pdf]; see http://www.partnersforimmunization.org/2002nominees.html]

The Childhood Immunization Coalition of Fresno/Madera Counties works to increase immunization education to the San Joaquin Valley's Hispanic, Hmong, and African-American populations. Outreach to the Hmong community included the development and use of immunization messages in radio announcements, sponsoring a Hmong-speaking physician to talk on a regional healthcare radio shows and participation in health fairs. The coalition also developed culture-specific posters and ads to reach the African American and Hispanic communities. Local agencies assisted the coalition in distributing posters and placing ads in local newspapers. [See http://www.partnersforimmunization.org/2002nominees.html]

Iowa Adult Immunization Coalition distributed flyers at health fairs and senior events, produced and aired a television and radio commercial, and directed a press release from the governor to over 400 newspapers statewide. [See National Partnership for Immunization at http://www.partnersforimmunization.org/2002nominees.html]

The Immunization Action Coalition, a coalition of government agencies and health care professional organizations, creates and distributes educational materials for health professionals and the public that enhance the delivery of safe and effective immunization services. The coalition also facilitates communication about the safety, efficacy, and use of vaccines within the broad immunization community of patients, parents, health care organizations, and government health agencies. This organization's Web site provides a wealth of educational material, as well as methods for promoting immunization. [See http://www.immunize.org/]

The Washington State Immunization Program provides vaccines to all children under age 19, regardless of income, through a combination of state and federal funds. No child in Washington can be denied state-supplied vaccine because of an inability to pay an administration or office visit fee, and no child can be charged for state-supplied vaccine. [See Washington State Department of Health at http://www.doh.wa.gov/cfh/Immunize/vaccine4.htm]

Improving Access to Transportation

Problem

Citizens who require services, or who wish to volunteer their services, often have difficulty in getting to and from the sites where such activities occur. Obstacles to providing transportation services include funding; obtaining drivers, and managing and scheduling them; liability costs associated with

providing transportation; and promoting the availability of transportation services.

Solutions

As noted in the section above, on providing a better infrastructure for volunteerism, the Beverly Foundation and the AAA Foundation for Traffic Safety produced in 2001 a report of a comprehensive study of Supplemental Transportation Programs (STP); a follow-up study was conducted in 2004. STPs are community-based transportation programs for seniors. These programs are predominantly nonprofit, with budgets ranging from modest volunteer efforts to ones with budgets of as much as $10 million. Some use on volunteers, others paid staff. The two reports provide reviews of several components of these programs, including organization, recruitment, financing, and risk management. Case studies are provided. [See http://seniordrivers.org/research/stp.pdf; see http://www.aaafts.org/pdf/STP2.pdf]

Washington State provides funding to counties within the state to develop and operate transportation services for those not utilizing any available public transportation services. The 2000 report to the legislature from each of the counties includes descriptions of innovative and successful programs to provide such services. The report from Mason County (beginning on page 17 of the link cited) discusses the process of developing a program organizational structure and decision-making process, a county-wide transportation plan, coordination of services with the school bus system, and the raising of additional funds. [See Washington State Department of Transportation at http://www.wsdot.wa.gov/acct/library/reports-studies/2000_ACCT_Report.pdf]

The U.S. Administration on Aging provides a Web site with a wealth of sources for seniors to obtain transportation services in their area. Information is provided in nine languages. [See http://www.aoa.gov/prof/notes/notes_transportation.asp]

Accessible PA is a joint effort between Pennsylvania's departments of aging, education, health, labor and industry, and public welfare. It provides online links to various transportation services in the state. Among the populations served include seniors; Medicaid recipients; the disabled, including transportation to and from work; special needs children; and rural citizens in need of medical care. [See http://www.accessiblepa.state.pa.us/AccessiblePA/site/]

The Phoenix, Arizona city government's Reserve-A-Ride program provides specialized, door-to-door transportation for the elderly, age 60 and over; and certified disabled individuals, age 18 and over, for transportation to senior centers, medical appointments, social service agencies and shopping. All vehicles are wheelchair accessible. The city's Web site provides information on this service. [See http://phoenix.gov/PUBTRANS/reserve.html]

The Rhode Island Department of Transportation provides transportation to seniors and the disabled through FlexService, from 6:00 a.m. to 7:00 p.m., Monday through Friday. Transportation is provided in Providence and the rest of Rhode Island, using dedicated vans. Telephone appointments are used to schedule rides. [See http://www.ripta.com/ripta/search.php]

The Rensselaer County Department for the Aging, in Troy, New York, provides comprehensive services to seniors in the city. Focused on getting seniors to activity centers, transportation to other services, such as medical, banking, and shopping, is provided in coordination with this primary goal. The service uses a mixed fleet including eight 15-passenger maxi-vans, two 12-passenger vans, three minivans (used for medical trips), and a passenger car. Rensselaer uses professional drivers, many of whom are themselves retired seniors. Money for the program comes from the county, with additional contributions from the state, local governments, and federal funding through the Older Americans Act of 1965. There is a suggested contribution of $4 per trip for medical visits and 25 cents each way for other rides, but seniors who cannot afford the fare travel free. [See http://www.rensco.com/departments/departmentlist.htm]

Improving Cancer Screening

Problem

Cancer is the second leading cause of death in the United States. According to the CDC's numbers from 2002, on the three leading causes:

Heart disease: 696,947

Cancer: 557,271

Stroke: 162,672

[See http://www.cdc.gov/nchs/fastats/lcod.htm]

In 2001, the state of Connecticut determined deaths from cancer by cancer type in the state:

Lung and other respiratory: 26%

Colorectal: 10.9%

Female breast: 8%

Prostate: 5.6%

Pancreas: 5.7%

Leukemia: 3.7%

All others: 40.1%

According to the National Cancer Institute, in the United States, the chances of a woman getting breast cancer are the following:

From age 20 to age 30: 1 out of 2,000

From age 30 to age 40: 1 out of 250

From age 40 to age 50: 1 out of 67

From age 50 to age 60: 1 out of 35

From age 60 to age 70: 1 out of 28

Ever: 1 out of 8.

[See http://www.cancer.gov/cancertopics/factsheet/Detection/screening-mammograms]

Prostate is the fifth leading cause of death among men over age 45. The risk in men of being diagnosed with prostate cancer, by age:

45: 1 in 2,500

50: 1 in 476

55: 1 in 120

60: 1 in 43

65: 1 in 21

70: 1 in 13

75: 1 in 9

Ever: 1 in 6

[See http://www.cdc.gov/cancer/prostate/decisionguide/]

Several methods of colorectal cancer screening appear to be effective in reducing disease-specific mortality, but the cost-effectiveness of different strategies is unclear. [See Pignone, M. et al "Cost-effectiveness Analyses of Colorectal Cancer Screening" Annals of Internal Medicine 2002, 137(2): 96-104, at http://www.ahrq.gov/clinic/3rduspstf/colorectal/colocost1.htm

Solutions

The National Cancer Institute (NCI) recommends that all women over age 40 receive a screening mammogram every one to two years; those with certain characteristics should consult with their physicians about more frequent screening [See http://www.cancer.gov]

The CDC coordinates the National Breast and Cervical Cancer Early Detection program. This program provides screening services, including clinical breast exams and mammograms, to low-income women throughout the United States and in several U.S. territories. Contact information for local programs is available on the CDC's Web site [See http://www.cdc.gov/cancer/nbccedp/contacts.htm] or by calling the CDC at 1–888–842–6355 (select

option 7). Information on low-cost or free mammography screening programs is also available through the NCI's Cancer Information Service (CIS) at 1–800–4–CANCER (1–800–422–6237).

The HealthyWoman Program in Pennsylvania is the Breast and Cervical Cancer Early Detection program funded by the CDC. The state coordinates with eight contractors, who in turn subcontract with over 200 service delivery sites for mammograms, Pap tests, and other required services. This organization provides a wealth of services addressing breast cancer: promoting legislation and research; treatment informational services; support services; and programs for cancer patients. [See http://www.dsf.health.state.pa.us/health/cwp/view.asp?A=174&Q=198271]

Pennsylvania. recently enacted legislation creating the Pennsylvania Breast and Cervical Cancer Early Screening Act, making free mammograms available to eligible uninsured and underinsured women 40 to 49 (effective July 1, 2006). This complements the current program available for women 50 to 64. Under this legislation, women whose family income does not exceed 25 percent of the federal poverty level and with no other access to health insurance qualify for screenings. The legislation was strongly promoted by the Pennsylvania Breast Cancer Coalition. [See http://www.pabreastcancer.org/news_2005HB1606passed3.html]

The State of Connecticut sponsored a coalition of public health officials, researchers, and physicians to develop a comprehensive plan for the state to address cancer prevention and treatment. Among topics addressed: prevention; early detection; treatment; survivor resources; and end of life resources. [See http://www.dph.state.ct.us/communications/pwd/final%20plan%20sept%2014%202005.pdf]

Medical experts encourage regular screening recommend that all men who have a life expectancy of at least more 10 years should be offered the PSA test and DRE annually, beginning at age 50. They also recommend offering screening tests earlier to African American men, and men who have a father or brother with prostate cancer. [See http://www.cdc.gov/cancer/prostate/decisionguide/]

Recent research has shown that appropriate screening and treatment can alleviate much of the suffering associated with colorectal cancer, and reduce the number of deaths caused by this malignancy. [See American Academy of Family Physicians at http://www.aafp.org/afp/990600ap/3083.html]

The CDC has awarded $2.1 million to establish a new demonstration program to increase colorectal screening among Americans, aged 50 years or older (September 2005). The program sites will provide screening and diagnostic follow-up; conduct public education and outreach; establish standards, systems, policies, and procedures; develop partnerships; collect and track data; and evaluate the effectiveness of the demonstration program. [For further CDC guidance on such screening programs see http://www.cdc.gov/cancer/colorctl/#award]

To attract Internet users to an educational Web site on colorectal cancer, the CDC posted advertisements on Yahoo. Exposure to the advertisements was limited to health professionals and selected lay populations. The total cost of the campaign was $64,627, and resulted in over 26,000 visits to the Web site at a cost of $2.42 per visit. [See British Medical Journal Web site at http://bmj.bmjjournals.com/cgi/content/full/328/7449/1179]

Assuring Adequate Prenatal Care, Particularly for Minorities and New Immigrant Groups

Problem

According to the CDC, the United States ranked 28th in the world in infant mortality in 1998. (Infant mortality may be used as one proxy, though imperfect, of the effectiveness of prenatal care in the United States) This ranking is due in large part to disparities that continue to exist among various racial and ethnic groups in this country, particularly African Americans. [See http://www.cdc.gov/omh/AMH/factsheets/infant.htm]

Solutions

To reduce infant mortality, the CDC recommends a focus on modifying the behaviors, lifestyles, and conditions that affect birth outcomes, such as smoking, substance abuse, poor nutrition, lack of prenatal care, medical problems, and chronic illness.

Public health agencies including CDC/ATSDR, health care providers, and communities of all ethnic groups must partner to improve the infant mortality rate in the United States. [See http://www.cdc.gov/omh/AMH/factsheets/infant.htm]

> "The rates of low birth weight, very low birth weight, and preterm birth (less than 260 days' gestation) decreased with increasing levels of prenatal care for both blacks and whites. However, increasing levels of care were associated with a greater reduction among black infants than among white infants in low birth weight, very low birth weight, and low birth weight at term (greater than or equal to 260 days' gestation). When we compared mothers who received adequate care with those who received inadequate care, the relative risk of giving birth to a very-low-birth-weight infant was reduced 3.6-fold (95 percent confidence interval, 2.0 to 6.6) for black mothers and 2.1-fold (confidence interval, 1.3 to 3.4) for white mothers…" Murray, J.L. and Bernfield, M.

"The Differential Effect of Prenatal Care on the Incidence of Low Birth Weight Among Blacks and Whites in a Prepaid Health Care Plan." *New England Journal of Medicine.* Volume 319:1385-1391, November 24, 1988, Number 21 [See http://content.nejm.org/cgi/content/short/319/21/1385]

The New Jersey Supplementary Prenatal Care program provides prenatal services to immigrant pregnant women who are residing in New Jersey and are ineligible for Medicaid or NJ FamilyCare because of their alien status. [See the Access Project (a research affiliate of the Schneider Institute for Health Policy at Brandeis University) Web site at http://www.accessproject.org/adobe/healthcare_access_nj.pdf]

The New Jersey Presumptive Eligibility program provides prenatal services to all pregnant women who apply for Medicaid. This program covers the gap between when the application for Medicaid is made, and the Medicaid services become available. [See Children's Alliance at http://www.childrensalliance.org/4Download/prenatal_care2.pdf]

> "An Emory University School of Medicine program at Grady Memorial Hospital…is better able to improve birth outcomes by expanding its Centering Pregnancy program to include a bilingual and bicultural healthcare associate who will provide group prenatal care for 100 immigrant, Spanish-speaking Hispanic women. The Centering Pregnancy program at Grady focuses on prenatal care and combines assessment, education and support within a group setting. Emphasis is placed on self-care activities, education and social support to empower women within the health system." [See Emory Healthcare at http://www.emoryhealthcare.org/press_room/ehc_news/2005/Feb/Prenatal_Care.html}

Health Partners, the nonprofit health plan serving Medical Assistance recipients in Southeastern Pennsylvania, recently received the national 2004 Gold AHIP/Wyeth HERA Award for its Baby Partners prenatal outreach program. The program offers comprehensive prenatal support with intensive case management and one-on-one counseling for its Medicaid member population. During the 12-month study period, 1,951 members were enrolled in the Baby Partners program. As a result of Baby Partners strategies, the number of pre-term babies born in just one year decreased significantly, by 17 percent [See Apria Healthcare Web site news story at http://www.apria.com/resources/1,2725,494-189493,00.html; see Health Partners at http://www.healthpart.com/about_message.asp]

Assuring Medical, Dental and Mental Health Services for Low-Income Underinsured and Uninsured

Problem

The percentage of the nation's population without health insurance coverage was 15.7 percent in 2004.

The number without such coverage rose from 2003 by 800,000, to 45.8 million. The proportion and number of uninsured children did not change in 2004, remaining at 11.2 percent or 8.3 million. [See U.S. Census Bureau News Release of 08/30/2005 at http://www.census.gov/Press-Release/www/releases/archives/income_wealth/005647.html]

Solutions

Project Access was developed in 1995 by physicians in the Buncombe County Medical Society in Asheville, North Carolina, and is a system that provides healthcare to the low-income uninsured. It is a partnership between county government, county physicians, county service agencies, the hospital, and pharmacists. Ninety percent of practicing physicians in Buncombe County (over 600) now see 10–20 individuals referred into their program, with no expectation of payment. The county provides seed money, the Medical Society runs the program, and the hospital absorbs patient costs. Access to primary care services has been raised from 78 percent in 1995 to an astounding 93 percent in the year 2000. [See National Association of County and City Health Officials at http://archive.naccho.org/modelPractices/Result.asp?PracticeID=24]

The American Project Access Network (APAN) is a national nonprofit service organization that assists communities in establishing and sustaining coordinated systems of charity care based on the Project Access model. APAN uses lessons learned from other Project Access systems nationwide to assist other communities in the development of a Project Access program. [See http://www.apanonline.org/display.php?m=apanfaq.htm]

For an example of how this model can be adapted, see Sedgwick County, Kansas, where the Project Access is a community-based program that coordinates donated medical care and services provided by physicians, hospitals, pharmacies, and others for uninsured, low-income people living in Sedgwick County. The program is based on the Buncombe County Project Access model in Asheville, North Carolina. More than 65 percent of local physicians (members of the Medical Society of Sedgwick County) have agreed to provide donated care for 10–20 patients each year. All area hospitals are treating Project Access patients, and 65 pharmacies fill prescriptions at 15 percent below average wholesale price. The Wichita City Council and the Sedgwick County Commission have committed $500,000 for prescriptions annually. [See http://projectaccess.net/]

Temple University Children's Medical Center Project Access is an outreach program that helps parents enroll children in insurance programs. Staff members go into the North Philadelphia community, block by block, to help families obtain health insurance and health care for their children. Services performed include enrollment of uninsured children in the free or low-cost insurance program for which they qualify; educating families about the importance of primary and preventive health care and the appropriate utilization of community providers and resources; referring families with deeper individual, social and economic issues that create barriers to economic and personal self-sufficiency. [Contact Jennifer K. McGowan, public relations, 215-707-7787; see Association of American Medical Colleges (AAMC) at http://www.aamc.org/uninsured/northeast.htm]

At St. Joseph's Hospital in Atlanta, Georgia, Mercy Care Services provides healthcare to Atlanta's growing homeless population. Nurse and physician volunteers from Saint Joseph's Hospital provide basic health care services in the streets and shelters. Mercy Care includes an array of programs for medically underserved persons and is staffed by 119 employees including medical professionals, social services and mental health specialists. Services offered include primary care, social services and health education to the homeless, the uninsured and the growing immigrant population, particularly Spanish-speaking and Vietnamese immigrants. Care is provided through numerous mobile clinical sites in the metro Atlanta area. Also provided are health promotion and outreach programs to the homeless, persons with HIV and other individuals with chronic disease; prenatal and parenting education classes; domestic violence intervention; information and referral line. [See http://www.stjosephsatlanta.org/index.php?submenu=MercyCareServices&src=gendocs&link=MercyCareServices]

Better Todays is a project of Idaho State University's Institute of Rural Health and other partners. It educates gatekeepers and caregivers on the signs and symptoms of mental disorders in children and youth. The project has trained approximately 1,500 professionals, parents, and community members statewide. Better Todays offers training in the latest scientific information on the signs and symptoms of mental disorders in children and youth. A new component on suicide risk assessment and intervention has been added. Trainings feature expanded information on child trauma and its consequences for children at home, at school, and in the community. [See http://www.isu.edu/irh/bettertodays/]

Providing High-Quality Services to the Physically and Mentally Disabled

Problem

Physically and mentally disabled individuals face numerous life problems: employment or other means of providing for their subsistence; obtaining and maintaining a domicile; social interaction; transportation; and education and health services.

Solutions

St. John's Community Services in Virginia serves over 100 people with disabilities. Among the services provided are community-based residential living facilities, community participation programs, and an employment program that has placed numerous individuals in many area businesses.[See http://www.sjcs.org/va.html]

Guelph Services for Persons with Disabilities (GSPD), located in Ontario, Canada, provides residential and community services for physically disabled adults. This nonprofit organization is funded by both government and private funds (including the United Way of Guelph). GSPD provides 35 residential units. As well, it provides homemaking and personal support service to 25 people, located throughout the city, who require assistance with the activities of daily living. There are also programs for social and physical activities for the disabled. [See http://www.gspd.org/index.htm]

The Edinburgh Center, in Lexington Massachusetts, works with police departments in surrounding towns to prevent the arrest of persons suffering from mental illness, instead directing them to treatment. It is developing a jail diversion program in partnership with the Watertown and Waltham police departments. [See the Obsessive-Compulsive Foundation of Greater Boston at http://www.ocfboston.org/legis_archive.html]

The Birmingham [United Kingdom] Health Directorate has developed a prevention, rehabilitation, and maintenance program to prevent or delay the loss of independence in vulnerable [physically and mentally disabled] people, and to improve their quality of life. Utilizing teams of professional providers and community groups, this detailed report seeks to improve outcomes for the disabled while reducing costs for services providers and the community. [For this and other useful documents, see Birmingham, U.K. City Council Dept of Social Care and Health, Prevention Strategy 2003-2004 at http://www.birmingham.gov.uk/]