7

Educational and Community-Based Programs

Co-Lead Agencies: Centers for Disease Control and Prevention
Health Resources and Services Administration

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Goal

Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life.

Overview

Educational and community-based programs have played an integral role in the attainment of Healthy People 2000 objectives and will continue to contribute to the improvement of health outcomes in the United States by the year 2010. These programs, developed to reach people outside traditional health care settings, are fundamental for health promotion and quality of life.

Issues and Trends

People working together can improve individual health and create healthier communities. Although more research is needed in community health improvement, clearly, the health of communities not only depends on the health of individuals but also on whether the physical and social aspects of communities enable people to live healthy lives.[1] Health and quality of life rely on many community systems and factors, not simply on a well-functioning health and medical care system. Making changes within existing systems, such as the school system, can effectively and efficiently improve the health of a large segment of the community. Also, environmental and policy approaches, such as better street lighting and policies to fortify foods, tend to have a greater impact on the whole community than do individual-oriented approaches.[2] An increasing number of communities are using community health planning processes, such as Assessment Protocol for Excellence in Public Health (APEX/PH); Healthy Cities, Healthy Communities; and Planned Approach to Community Health (PATCH), to take ownership of their health and quality-of-life improvement process.[3]

Communities experiencing the most success in addressing health and quality-of-life issues have involved many components of their community: public health, health care, business, local governments, schools, civic organizations, voluntary health organizations, faith organizations, park and recreation departments, and other interested groups and private citizens. Communities that are eager to improve the health of specific at-risk groups have found that they are more likely to be successful if they work collaboratively within their communities and if the social and physical environments also are conducive to supporting healthy changes.

Because many health problems relate to more than one behavioral risk factor as well as to social and environmental factors, communities with effective programs also work to improve health by addressing the multiple determinants of a health

problem. Among the more effective community health promotion programs are those that implement comprehensive intervention plans with multiple intervention strategies, such as educational, policy, and environmental, within various settings, such as the community, health care facilities, schools (including colleges and universities), and worksites.[1, 4, 5, 6]

Educational strategies may include efforts to increase health awareness, communication, and skill building. Policy strategies are those laws, regulations, formal and informal rules, and understandings adopted on a collective basis to guide individual and collective behavior.[2, 7, 8, 9] These include health-friendly policies designed to encourage healthful actions (for example, flex-time at worksites that enables employees to engage in physical activity, clinic hours that meet the needs of working people), and policies to discourage or limit unhealthy actions (for example, restrictions on the sale of tobacco products to minors as a way to discourage youth tobacco use). Environmental strategies are measures that alter or control the legal, social, economic, and physical environment.[10] They make the environment more supportive of health and well-being (for example, increasing the accessibility of low-fat foods in grocery stores to encourage a low-fat diet). Environmental measures also are used to discourage actions that are not supportive of health (for example, the removal of cigarette vending machines from public buildings to discourage smoking).

These educational, policy, and environmental strategies are effective when used in as many settings as appropriate.[5] Settings—schools, worksites, health care facilities, and the community—serve as channels to reach desired audiences as well as apply strategies in as broad a population as possible. These settings also provide major social structures for intervening at the policy level to facilitate healthful choices.[10]

The school setting. The importance of including health instruction in education curricula has been recognized since the early 1900s.[11] In 1997, the Institute of Medicine advised that students should receive the health-related education and services necessary for them to derive maximum benefit from their education and enable them to become healthy, productive adults.[12]

The school setting, ranging from preschool to university, is an important avenue to reach the entire population and specifically to educate children and youth. Schools have more influence on the lives of young people than any other social institution except the family and provide a setting in which friendship networks develop, socialization occurs, and norms that govern behavior are developed and reinforced. Each school day about 48 million youth in the United States attend almost 110,000 elementary and secondary schools for about 6 hours of classroom time. More than 95 percent of all youth aged 5 to 17 years are enrolled in school. Schools are second only to homes among the primary places that children spend their time and thus are one of the significant places where children may be exposed to potentially harmful environmental conditions. (See Focus Area 8. Environmental Health.) During high school, national dropout rates average 12

percent. Prior to high school, dropout is almost nonexistent.[13, 14, 15] Because healthy children learn better than children with health problems, schools also have an interest in addressing the health needs of students. Although schools alone cannot be expected to address the health and related social problems of youth, they can provide, through their climate and curriculum, a focal point for efforts to reduce health-risk behaviors and improve the health status of youth.[16]

In 1990, the key elements of school health education were identified: a documented, planned, and sequential program of health education for students in kindergarten through grade 12; a curriculum that addresses and integrates education about a range of categorical health problems and issues at developmentally appropriate ages; activities to help young persons develop the skills they will need to avoid risky behaviors; instruction provided for a prescribed amount of time at each grade level; management and coordination in each school by an education professional trained to implement the program; instruction from teachers who have been trained to teach the subject; involvement of parents, health professionals, and other concerned community members; and periodic evaluation, updating, and improvement.[17]

More than 12 million students currently are enrolled in the Nation's 3,600 colleges and universities.[18] Thus, colleges and universities are important settings for reducing health-risk behaviors among many young adults. Health clinics at the postsecondary level can help empower students to take responsibility for their own health through education, prevention, early detection, and treatment. In addition, colleges and universities can play an important role in eliminating racial and ethnic disparities and other inequalities in health outcomes by influencing how people think about these issues and providing a place where opinions and behaviors contributing to these factors can be addressed.

The worksite setting. The growing cost of health care combined with the increase of preventable acute and chronic illnesses drive the continuing need for comprehensive worksite health promotion programs. (See Focus Area 20. Occupational Safety and Health.) The worksite setting provides an opportunity to implement educational programs and policy and environmental actions that support health, which benefit managers, employees, and, ultimately, the community as a whole. These programs have become an integral part of corporate plans to reduce health care costs, improve worker morale, decrease absenteeism, and improve behaviors associated with increased worker productivity.[19] Although reductions in health risks have been achieved through many worksite health promotion programs, risk reduction for hourly and part-time workers and companies with fewer than 50 employees has lagged.[20]

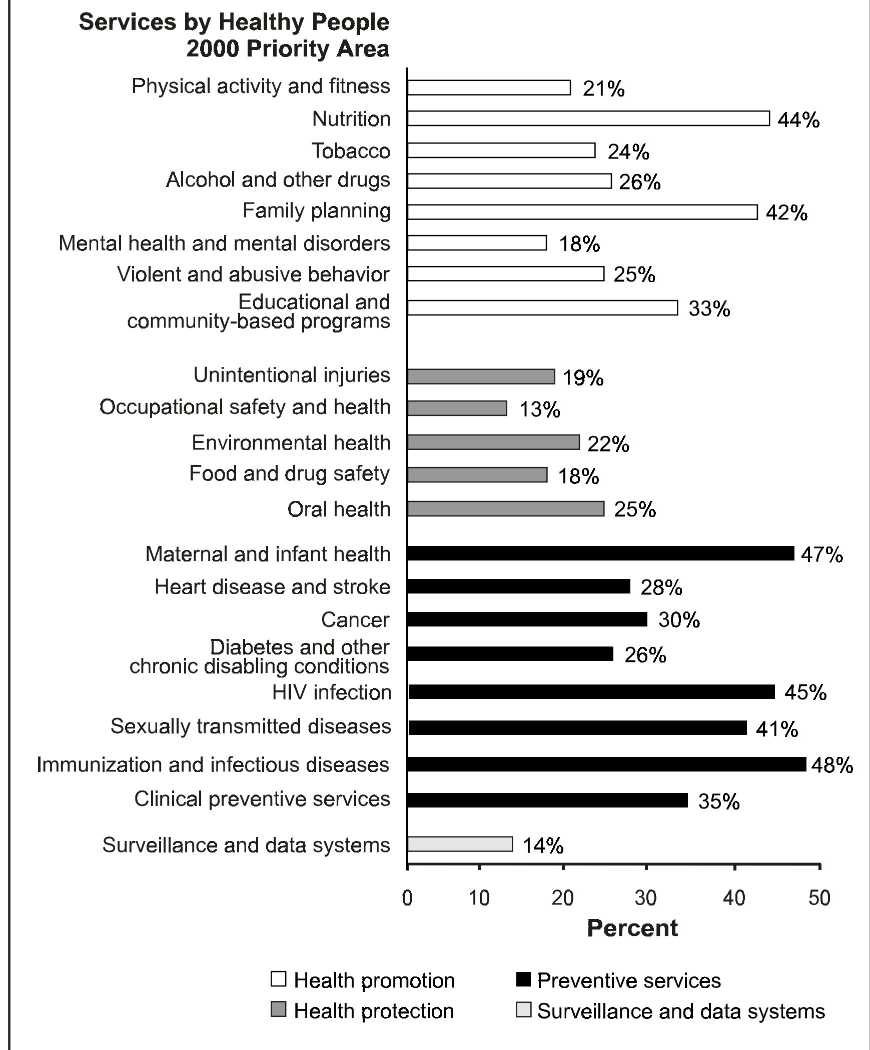
The health care setting. In health care facilities, including hospitals, medical and dental clinics, and offices, health care providers often see their patients at a teachable moment. Individualized education and counseling by health care providers at such moments in these settings have been shown to have positive and clinically significant effects on behavior in persons with chronic and acute conditions.[10]

(See Focus Area 1. Access to Quality Health Services.) Providers must be cognizant of these opportunities and prepared to provide appropriate patient education. Institutions that employ providers also must be cognizant and allow sufficient time and training for patient education and counseling to occur.

The health care setting is critical to the delivery of health education and health promotion because of the dramatic change it has undergone in the past 10 years. In 1989, 18 percent[21] of the population reported they were covered by some form of managed care; in 1996 that number had risen to 29 percent, an increase of 57 percent. As of June 1999, the number had jumped to 70 percent. As of January 1, 1997, more than 4.9 million Medicare beneficiaries were enrolled in managed care plans, accounting for 13 percent of the total Medicare program and representing a 108 percent increase in managed care enrollment since 1993. As of June 30, 1998, over 16 million, or 54 percent, of Medicaid beneficiaries were enrolled in managed care programs.

Growth in enrollment in managed care plans has been accompanied by the development of the Health Plan Employer Data and Information Set (HEDIS) and a set of common data indicators to examine performance by managed care organizations (MCOs) by the National Committee on Quality Assurance (NCQA). The latest version of HEDIS requires MCOs to report on more than 50 prevention-oriented indicators.[22] With the increasing marketing importance of HEDIS to MCOs, there will be greater demands for MCO health promotion programs to address HEDIS-related issues.[23] As a result, increased attention must be devoted to examining patient satisfaction with health promotion programs in health care organizations.

The community setting. While health promotion in schools, health care centers, and worksites provides targeted interventions for specific population groups, community-based programs can reach the entire population. Broad public concern and support are vital to the functioning of a healthy community and to ensure the conditions in which people can be healthy.[24] Included in the community setting are public facilities; local government and agencies; and social service, faith, and civic organizations that provide channels to reach people where they live, work, and play. They can be strong advocates for educational, policy, and environmental changes throughout the community. Places of worship may be a particularly important setting for health promotion initiatives, and they may effectively reach some underserved populations. Approaches to prevention must account for the character of the community and ensure community participation in the process.[3] Valuable and effective health benefits of community-based approaches have been demonstrated by community interventions that have served a variety of ethnic, racial, and socioeconomic population groups.[3, 7, 25] Community-based approaches in conjunction with targeted approaches in schools, health care, and worksites increase the likelihood for success to improve personal and community health.



Source: National Association of County and City Health Officials, National Profile of Local Health Departments, 1996–97.

A community health promotion program should include:

- Community participation with representation from at least three of the following community sectors: government, education, business, faith organizations, health care, media, voluntary agencies, and the public.
- Community assessment to determine community health problems, resources, and perceptions and priorities for action.
- Measurable objectives that address at least one of the following: health outcomes, risk factors, public awareness, or services and protection.
- Monitoring and evaluation processes to determine whether the objectives are reached.

- Comprehensive, multifaceted, culturally relevant interventions that have multiple targets for change—individuals (for example, racial and ethnic, age, and socioeconomic groups), organizations (for example, worksites, schools, and faith communities), and environments (for example, local policies and regulations)—and multiple approaches to change, including education, community organization, and regulatory and environmental reforms.

Schools are natural settings for reaching children and youth whereas worksites can reach the majority of adults. Efforts to reach older adults necessarily must involve the community at large. Senior centers have been established in most communities and provide a range of services, including health promotion programs for adults aged 60 years and older. Several types of housing arrangements designed specifically for older adults also can be found in many communities, including congregate housing, life care facilities, and retirement villages. These usually offer some mix of health care, recreational programs, and other types of activities and services. Health promotion strategies, policies, and educational approaches have been developed for aging populations.[26]

Disparities

The U.S. population is composed of many diverse groups. Evidence indicates a persistent disparity in the health status of racially and culturally diverse populations as compared with the overall health status of the U.S. population. Over the next decade, the composition of the Nation will become more racially and ethnically diverse, thereby increasing the need for effective prevention programs tailored to specific community needs. Poverty, lack of adequate access to quality health services, lack of culturally and linguistically competent health services, and lack of preventive health care also are underlying factors that must be addressed. (See Focus Area 1. Access to Quality Health Services.) Given these disparities, the need for appropriate interventions is clear.

Effective prevention programs in diverse communities must be tailored to community needs and take into consideration factors concerning individuals, such as disability status, sexual orientation, and gender appropriateness, which also play a significant role in determining health outcomes, behaviors, use patterns, and attitudes across age, racial, and ethnic groups. For example, women often are the health care decisionmakers and caregivers in their families and in their communities. When provided with enabling services and health promotion and prevention information, they can make better health choices and better navigate the health care system to get the information and services they and their families need.

Opportunities

Health promotion programs need to be sensitive to the diverse cultural norms and beliefs of the people for whom the programs are intended. Achieving such sensitivity is a continuing challenge as the Nation's population becomes increasingly

diverse. To ensure that interventions are culturally appropriate, linguistically competent, and appropriate for the needs of racial, ethnic, gender, sexual orientation, disability status, and age groups within the community, members of the populations served and their gatekeepers must be involved in the community assessment and planning process.

Community assessment helps to identify the cultural traditions and beliefs of the community and the education, literacy level, and language preferences necessary for the development of appropriate materials and programs. In addition, a community assessment can help identify levels of social capital and community capacity. Such assessments help identify the skills, resources, and abilities needed to manage health improvement programs in communities.[5, 27]

Educational and community-based programs must be supported by accurate, appropriate, and accessible information derived from a science base. Increasing evidence supports the efficacy and effectiveness of health education and health promotion in schools, worksites, health care facilities, and community-based programming.[8] Gaps in research include the dissemination and diffusion of effective programs, new technologies, policies, relationships between settings, and approaches to disadvantaged and special populations.[10]

Communities need to be involved as partners in conducting research ensuring that the content of the prevention efforts developed is tailored to meet the needs of the communities and populations being served. Communities also need to be involved as equal partners in research—to enhance the appropriateness and sustainability of science-based interventions and prevention programs and ensure that the lessons of research are transferred back to the community. Sustainability is necessary for successful research to be translated into programs of lasting benefit to communities.

The importance of social ecology on behavior and the successes of environmental and policy approaches to health promotion and disease prevention need further documentation. Techniques to evaluate community processes and community health improvement methods and models need to be refined and disseminated so that other communities can learn from and duplicate successful strategies. Issues of partnering and the role of collaborative efforts to increase the capacity of individuals and communities to achieve long-term outcomes and improvements in health status are not fully understood[27] and should be evaluated. Mechanisms need to be developed to share what is learned in an appropriate and timely manner with communities.

Interim Progress Toward Year 2000 Objectives

Progress toward the 14 educational and community-based program objectives in Healthy People 2000 has been mixed. Improvements have been made in the number of worksites that offer health promotion activities and in the proportion of

hospitals that offer patient education programs. New information from the National College Health Risk Behavior Survey shows that college students are receiving information on health topics such as human immunodeficiency virus (HIV) and sexually transmitted disease prevention. High school completion rates have not changed from their baseline. Participation in health promotion activities by hourly workers over age 18 years exceeds the target. Baseline data are available for older adults participating in health promotion activities and on counties with programs for certain racial and ethnic populations.

Note: Unless otherwise noted, data are from the Centers for Disease Control and Prevention, National Center for Health Statistics, *Healthy People 2000 Review, 1998–99.*

Educational and Community-Based Programs

Goal: Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life.

Number	Objective Short Title
School Setting	
7-1	High school completion
7-2	School health education
7-3	Health-risk behavior information for college and university students
7-4	School nurse-to-student ratio
Worksite Setting	
7-5	Worksite health promotion programs
7-6	Participation in employer-sponsored health promotion activities
Health Care Setting	
7-7	Patient and family education
7-8	Satisfaction with patient education
7-9	Health care organization sponsorship of community health promotion activities
Community Setting and Select Populations	
7-10	Community health promotion programs
7-11	Culturally appropriate and linguistically competent community health promotion programs
7-12	Older adult participation in community health promotion activities

School Setting

7-1. Increase high school completion.

Target: 90 percent.

Baseline: 85 percent of persons aged 18 to 24 years had completed high school in 1998.

Target setting method: Consistent with National Education Goals Panel—Goals 2000.

Data source: Current Population Survey, U.S. Department of Commerce, Bureau of the Census.

NOTE: THE TABLE BELOW MAY CONTINUE TO THE FOLLOWING PAGE.

Persons Aged 18 to 24 Years, 1998 (unless noted)	Completed High School
	Percent
TOTAL	85
Race and ethnicity	
American Indian or Alaska Native	85
Asian or Pacific Islander	94
Asian	94
Native Hawaiian and other Pacific Islander	DSU
Black or African American	81
White	85
Hispanic or Latino	63
Not Hispanic or Latino	DNA
Black or African American	81
White	90
Gender	
Female	87
Male	83
Family income level	
Poor	DNA
Near poor	DNA
Middle/high income	DNA

Persons Aged 18 to 24 Years, 1998 (unless noted)	Completed High School
	Percent
Disability status	
Persons with disabilities	79 (1995)
Persons without disabilities	86 (1995)

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

NOTE: THE TABLE ABOVE MAY HAVE CONTINUED FROM THE PREVIOUS PAGE.

Dropping out of school is associated with delayed employment opportunities, poverty, and poor health. During adolescence, dropping out of school is associated with multiple social and health problems, including substance abuse, delinquency, intentional and unintentional injury, and unintended pregnancy. Some researchers suggest that the antecedents of drug and alcohol problems, school dropout, delinquency, and a host of other problems can be identified in the early elementary grades, long before the actual problems manifest themselves. These antecedents include low academic achievement and low attachment to school, adverse peer influence, inadequate family management and parental supervision, parental substance abuse, sensation-seeking behavior, and diminished personal capabilities. Children who perform poorly in school, are more than a year behind their modal grade, and are chronically truant are more likely to exhibit risk behaviors and experience serious problems in adolescence. Finally, risk of these outcomes is increased if children fail to form meaningful social bonds to positive adult and peer role models with whom they interact at school or in the community. If high school dropout rates are addressed as part of the Nation's health promotion and disease prevention agenda, unwarranted risks of problem behavior may be reduced and the health of young people improved.

The target of 90 percent set for this objective is consistent with the National Education Goal to increase the high school graduation rate to at least 90 percent. A National Education Objective under that goal is to eliminate the gap in high school graduation rates between racial and ethnic minority and nonminority students. In 1998, only 63 percent of Hispanic or Latino and 81 percent of African American youth aged 18 to 24 years had completed high school, compared to a completion rate of 90 percent for white, non-Hispanic youth.

7-2. Increase the proportion of middle, junior high, and senior high schools that provide school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health.

Target and baseline:

Objective	Schools Providing School Health Education in Priority Areas	1994 Baseline	2010 Target
		Percent	
7-2a.	**All components**	28	70
	Individual components to prevent health problems in the following areas		
7-2b.	Unintentional injury	66	90
7-2c.	Violence	58	80
7-2d.	Suicide	58	80
7-2e.	Tobacco use and addiction	86	95
7-2f.	Alcohol and other drug use	90	95
7-2g.	Unintended pregnancy, HIV/AIDS, and STD infection	65	90
7-2h.	Unhealthy dietary patterns	84	95
7-2i.	Inadequate physical activity	78	90
7-2j.	Environmental health	60	80

Target setting method: 150 percent improvement for 7-2a; percentage improvement varies for individual components 7-2b through 7-2j.

Data source: School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

7-3. Increase the proportion of college and university students who receive information from their institution on each of the six priority health-risk behavior areas.

Target: 25 percent.

Baseline: 6 percent of undergraduate students received information from their college or university on all six topics in 1995: injuries (intentional and unintentional), tobacco use, alcohol and illicit drug use, sexual behaviors that cause unintended pregnancies and sexually transmitted diseases, dietary patterns that cause disease, and inadequate physical activity.

Target setting method: Better than the best.

Data source: National College Health Risk Behavior Survey, CDC, NCCDPHP.

Undergraduates, 1995	Received Information on Six Priority Health-Risk Behavior Areas
	Percent
TOTAL	6
Race and ethnicity	
American Indian or Alaska Native	DSU
Asian or Pacific Islander	DSU
Asian	DSU
Native Hawaiian and other Pacific Islander	DSU
Black or African American	8
White	6
Hispanic or Latino	5
Not Hispanic or Latino	DNA
Black or African American	8
White	6
Gender	
Female	6
Male	6
Family income level	
Poor	DNC
Near poor	DNC
Middle/high income	DNC
Disability status	
Persons with disabilities	DNC
Persons without disabilities	DNC
Sexual orientation	DNC

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

The School Health Education Study[28] conducted during the 1960s identified 10 conceptual areas that have traditionally served as the basis of health education curricula. Subsequently, six categories of behaviors have been identified as responsible for more than 70 percent of illness, disability, and death among adolescents and young adults. These categories, which should be the primary focus of school

health education, are injuries (unintentional and intentional), tobacco use, alcohol and illicit drug use, sexual behaviors that cause unintended pregnancies and sexually transmitted diseases, dietary patterns that cause disease, and inadequate physical activity.[29] While unintentional and intentional injuries are grouped together, the prevention program and policy implications for each are distinct given the differences in the risk behaviors and related health outcomes. In addition to the 6 behavior categories, environmental health (recognized influence on personal and community health), mental and emotional health, personal health, and consumer health are among the 10 conceptual areas being added to track the influence of these factors between 2000 and 2010. Text about the contributions school health education can make in achieving objectives can be found in the appropriate Healthy People 2010 focus areas.

The overall goal of the National Health Education Standards for youth is to achieve health literacy.[30] It is important that youth are able to find, understand, and use information and services to enhance health. Research has shown that for health education curricula to affect priority health-risk behaviors among adolescents, effective strategies, considerable instructional time, and well-prepared teachers are required. To attain this objective, States and school districts need to support effective health education with appropriate policies, teacher training, effective curricula, and regular progress assessment. In addition, the support of families, peers, and the community at large is critical to long-term behavior change among adolescents. Health education and health promotion activities also can be conducted in postsecondary settings and reach the Nation's future leaders, teachers, corporate executives, health professionals, and public health personnel. Personal involvement in a health promotion program can educate future leaders about the importance of health and engender a commitment to prevention.

In 1995, 23 percent of undergraduate students reported receiving information on unintentional injuries, 38 percent on intentional injuries, 49 percent on alcohol and other drug use, 55 percent on unintended pregnancy, HIV/AIDS, and STD infection; 30 percent on unhealthy dietary patterns; and 36 percent on inadequate physical activity.[31]

7-4. Increase the proportion of the Nation's elementary, middle, junior high, and senior high schools that have a nurse-to-student ratio of at least 1:750.

Target and baseline:

Objective	Increase in Schools With Nurse-to-Student Ratio of at Least 1:750	1994 Baseline	2010 Target
		Percent	
7-4a.	All middle, junior high, and senior high schools	28	50
7-4b.	Senior high schools	26	50
7-4c.	Middle and junior high schools	32	50
7-4d.	Elementary schools	Developmental	

Target setting method: 79 percent improvement for 7-4a (all schools combined); percentage improvement varies for individual components 7-4b and 7-4c.

Data source: School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP. Data for elementary schools are developmental.

The importance of providing health services to students in schools is widely accepted.[12] Such services began over 100 years ago to control communicable disease and reduce absenteeism. Over the years, school health services have evolved to keep pace with changes in the health care, social, and educational systems in the United States.[32] Current models of school health services reflect an understanding that children's physical and mental health are linked to their abilities to succeed academically and socially in the school environment.[15]

School nurses serve 48 million youth in the Nation's schools. School nurses assess student health and development, help families determine when medical services are needed, and serve as a professional link with physicians and community resources. Nurses manage care and provide services to support and sustain school attendance and academic achievement. A licensed practical nurse or registered nurse is an essential component of a healthy school. The ratio of 1 school nurse per 750 students should be improved if many students with special needs are enrolled.[33] For children with disabilities, the nurse is an essential resource. These children are dependent on daily medication, nursing procedures, or special diets for normal function.

Worksite Setting

7-5. Increase the proportion of worksites that offer a comprehensive employee health promotion program to their employees.

Target and baseline:

Objective	Increase in Worksites Offering a Comprehensive Employer-Sponsored Health Promotion Program	1999 Baseline	2010 Target
		Percent	
7-5a.	Worksites with fewer than 50 employees	Developmental	
7-5b.	Worksites with 50 or more employees	34	75
7-5c.	Worksites with 50 to 99 employees	33	75
7-5d.	Worksites with 100 to 249 employees	33	75
7-5e.	Worksites with 250 to 749 employees	38	75
7-5f.	Worksites with 750 or more employees	50	75

Target setting method: Better than the best.

Data source: National Worksite Health Promotion Survey, Association for Worksite Health Promotion (AWHP).

7-6. Increase the proportion of employees who participate in employer-sponsored health promotion activities.

Target: 75 percent.

Baseline: 61 percent of employees aged 18 years and older participated in employer-sponsored health promotion activities in 1994.

Target setting method: Better than the best.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

NOTE: THE TABLE BELOW MAY CONTINUE TO THE FOLLOWING PAGE.

Employees Aged 18 Years and Older, 1994	Participated in Employer-Sponsored Health Promotion Activities
	Percent
TOTAL	61
Race and ethnicity	
American Indian or Alaska Native	DSU
Asian or Pacific Islander	50

Employees Aged 18 Years and Older, 1994	Participated in Employer-Sponsored Health Promotion Activities
	Percent
Asian	DNC
Native Hawaiian and other Pacific Islander	DNC
Black or African American	57
White	61
Hispanic or Latino	60
Not Hispanic or Latino	62
Black or African American	57
White	62
Gender	
Female	60
Male	63
Family income level	
Poor	57
Near poor	63
Middle/high income	61
Education level (aged 25 years and older)	
Less than high school	62
High school graduate	65
At least some college	60
Geographic location	
Urban	61
Rural	64
Insurance status	
Persons with insurance	DNA
Persons without insurance	DNA
Disability status	
Persons with activity limitations	56
Persons without activity limitations	62

Employees Aged 18 Years and Older, 1994	Participated in Employer-Sponsored Health Promotion Activities
	Percent
Select populations	
Employees at worksites with 50 or more employees	65
Employees at worksites with fewer than 50 employees	DSU

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

NOTE: THE TABLE ABOVE MAY HAVE CONTINUED FROM THE PREVIOUS PAGE.

By 1999, 95 percent of employers with more than 50 employees reported that they offered at least one health promotion activity.[20] While the growth in worksite health promotion programming since 1985 has been remarkable, many programs lack comprehensive design or sufficient duration and therefore are potentially limited in their impact on employee health and well-being.[34] Participation rates in worksite health promotion programs generally are low. Most worksite statistics indicate that enrollees in worksite health promotion programs tend to be salaried employees whose general health is better than average. Employees working in administrative support, service, crafts, and trades often have greater health risks and higher rates of illness and injury than professional and administrative workers do. Contributing factors include differences in socioeconomic status, in the nature of the work, and in access to and extent of health insurance coverage as well as exclusion of those workers from worksite health promotion programs. This exclusion may be an unintentional result of failing to market the program effectively to the workers.[35] Optimally, worksite health promotion efforts should be part of a comprehensive occupational health and safety program.

More than 80 percent of private-sector employees work in organizations of fewer than 50 people.[36] Over the next decade, strategies need to be developed to provide workers in these settings access to health promotion programs.[37, 38] Limited purchasing power can make the provision of health promotion services difficult for worksites with only a few employees. Employers can take advantage of community agency programs and services through outsourcing and by collaborating with other small worksites to purchase services, such as employee assistance programs and health insurance for preventive health services, to increase their purchasing power and benefits offered to their employees.[38]

Collaboration between trade and professional organizations is needed to identify new opportunities for worksite health promotion. Employee involvement to define and manage worksite health promotion activities can be especially valuable to ad-

dress resource constraints among smaller employers while simultaneously enhancing program success.[38]

Health Care Setting

7-7. (Developmental) Increase the proportion of health care organizations that provide patient and family education.

Potential data source: Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Survey.

7-8. (Developmental) Increase the proportion of patients who report that they are satisfied with the patient education they receive from their health care organization.

Potential data source: Press Ganey.

7-9. (Developmental) Increase the proportion of hospitals and managed care organizations that provide community disease prevention and health promotion activities that address the priority health needs identified by their community.

Potential data source: Annual Survey, American Hospital Association.

The concept of increased consumer protection in the health care industry, particularly in the form of a Consumers' Bill of Rights and Responsibilities, is gaining support. These protections include consumers' rights to accurate, easily understood information related to choice of a health plan—its benefits, availability of specialty care, and confidentiality of medical records. However, the right to comprehensive patient and family education is missing from this list. Two distinctive characteristics of health care settings underscore their importance to promote patient and family education: improved health is a primary objective; and health care providers generally are considered credible sources of information.[10] The interaction between these two factors helps create an environment conducive to effective patient and family education programs and activities. The positive and clinically significant effects of patient education and counseling of persons with chronic and acute conditions are well documented; however, the amount and types of health promotion and disease prevention activities offered by managed care organizations to their participating employers vary widely.[23]

On the national level, about 70 percent of employees are covered by some form of managed care. The growth of MCOs is expected to increase. For example, as of January 1, 1997, more than 4.9 million Medicare beneficiaries were enrolled in managed care plans, accounting for 13 percent of the total Medicare program and representing a 108 percent increase in managed care enrollment since 1993.[39] An-

other important factor is the emerging role of the National Committee on Quality Assurance and its development of the Health Plan Employer Data and Information Set (HEDIS) and set of common data indicators for examining performance of MCOs. The latest version of HEDIS requires MCOs to report on more than 50 prevention-oriented indicators, largely secondary and tertiary prevention-related issues.[22] With the increasing marketing importance of HEDIS to MCOs, there will be greater demands for health promotion to address HEDIS-related issues, potentially leaving critical programming gaps.[23] As a result, increased public attention must be devoted to examining patient satisfaction in health care organizations.

Community health promotion services provided by hospitals and MCOs are growing, as illustrated by the expansion of Federal and State managed care reform legislation directed at the creation of a core set of prevention activities across MCOs.[23] Despite the different motivations and strategic objectives of public health and managed care organizations, they share a mutual interest to improve the health of communities and specific populations within communities. Collaboration between managed care plans and public health agencies is a logical consequence of the health promotion objectives shared by these organizations.[40] Additionally, a number of Federal public health agencies are developing collaborative relationships with the managed care community on issues of clinical preventive services and prevention surveillance and research.[41]

Community Setting and Select Populations

7-10. (Developmental) Increase the proportion of Tribal and local health service areas or jurisdictions that have established a community health promotion program that addresses multiple Healthy People 2010 focus areas.

Potential data source: Special Survey, Association of State and Territorial Directors of Health Promotion and Public Health Education (ASTDHPPHE).

This objective reflects the need for comprehensive and multifaceted health promotion and community health improvement activities at the State and local levels. A 1996 review of the literature on 135 urban health promotion programs conducted between 1980 and 1995 found that a specific model for program planning and implementation was identified in only 41 percent of programs.[42] In addition, community members constituted the smallest percentage of those involved in the local effort, and very little tailoring to the population and population groups served was noted. These efforts also had a strong focus on the individual rather than the population.[42]

This objective includes activities conducted through local health departments as well as those conducted by other community-based organizations, particularly in those communities not served by a local health department. Activities such as Assessment Protocol for Excellence in Public Health (APEX/PH); Healthy Cities, Healthy Communities; and Planned Approach to Community Health (PATCH)

recognize the need for community involvement and mobilization as basic methods for planning, implementing, and evaluating educational and community-based programs. Public health departments, community health centers, faith communities, civic organizations, voluntary health organizations, businesses, worksites, schools, universities, Area Health Education Centers (AHECs), and healthy city or community groups are a few of the organizations that plan and deliver such programs in the United States.

Identifying the use of established health promotion planning and identification models provides information on strategically planned and implemented programs. Single-method or noncomprehensive approaches are considered less productive.

7-11. Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs.

Target and baseline:

Objective	Increase in Local Health Department Community Health Promotion and Disease Prevention Programs That Are Culturally Appropriate and Linguistically Competent	1996–97 Baseline	2010 Target
		Percent	
7-11a.	Access to quality health services	Developmental	
	Clinical preventive services	35	*
7-11b.	Arthritis, osteoporosis, and chronic back conditions	Developmental	
7-11c.	Cancer	30	50
	Diabetes and chronic disabling conditions	26	*
7-11d.	Chronic kidney disease	Developmental	
7-11e.	Diabetes	Developmental	
7-11f.	Disability and secondary conditions	Developmental	
7-11g.	Educational and community-based programs	33	50
7-11h.	Environmental health	22	50
7-11i.	Family planning	42	50
	Food and drug safety	18	*
7-11j.	Food safety	Developmental	
7-11k.	Medical product safety	Developmental	
7-11l.	Health communication	Developmental	
7-11m.	Heart disease and stroke	28	50
7-11n.	HIV	45	50
7-11o.	Immunization and infectious diseases	48	50

Objective	Increase in Local Health Department Community Health Promotion and Disease Prevention Programs That Are Culturally Appropriate and Linguistically Competent	1996–97 Baseline	2010 Target
		Percent	
7-11p.	Injury and violence prevention	Developmental	
	Unintentional injuries	19	*
	Violent and abusive behavior	25	*
7-11q.	Maternal, infant (and child) health	47	50
7-11r.	Mental health (and mental disorders)	18	50
7-11s.	Nutrition and overweight	44	50
7-11t.	Occupational safety and health	13	50
7-11u.	Oral health	25	50
7-11v.	Physical activity and fitness	21	50
7-11w.	Public health infrastructure	Developmental	
	Surveillance and data systems	14	*
7-11x.	Respiratory diseases	Developmental	
7-11y.	Sexually transmitted diseases	41	50
7-11z.	Substance abuse (alcohol and other drugs)	26	50
7-11aa.	Tobacco use	24	50
7-11bb.	Vision and hearing	Developmental	

*These are Healthy People 2000 priority areas that are not applicable to Healthy People 2010.

Target setting method: Percentage improvement varies by program.

Data source: National Profile of Local Health Departments, National Association of County and City Health Officials (NACCHO).

Over the next decade, the Nation’s population will become even more diverse. Mainstream health education activities often fail to reach select populations.[43] This may contribute to select and disadvantaged communities lagging behind the overall U.S. population on virtually all health status indicators. In 1991, an estimated 78,643 excess deaths occurred among African Americans and an additional 4,485 among Hispanics or Latinos.[44] Approximately 75 percent of these excess deaths occurred in seven categories, all of which had contributing factors that can be controlled or prevented: cancer, cardiovascular disease, cirrhosis, diabetes, HIV or AIDS, homicide, and unintentional injuries. Special efforts are needed to develop and disseminate culturally and linguistically appropriate health information to overcome the cultural differences and meet the special language needs of these population groups.

7-12. Increase the proportion of older adults who have participated during the preceding year in at least one organized health promotion activity.

Target: 90 percent.

Baseline: 12 percent of adults aged 65 years and older participated during the preceding year in at least one organized health promotion activity in 1998 (age adjusted to the year 2000 standard population).

Target setting method: Better than the best.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

NOTE: THE TABLE BELOW MAY CONTINUE TO THE FOLLOWING PAGE.

Adults Aged 65 Years and Older, 1998 (unless noted)	Participated in at Least One Health Promotion Activity in Preceding Year
	Percent
TOTAL	12
Race and ethnicity	
American Indian or Alaska Native	DSU
Asian or Pacific Islander	22
Asian	22
Native Hawaiian and other Pacific Islander	DSU
Black or African American	8
White	12
Hispanic or Latino	8
Not Hispanic or Latino	12
Black or African American	8
White	12
Gender	
Female	13
Male	10
Family income level	
Poor	8
Near poor	9
Middle/high income	16

Adults Aged 65 Years and Older, 1998 (unless noted)	Participated in at Least One Health Promotion Activity in Preceding Year
	Percent
Education level	
Less than high school	6
High school	10
At least some college	20
Disability status	
Persons with activity limitations	10 (1995)
Persons without activity limitations	12 (1995)
Sexual orientation	DNC

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.
Note: Age adjusted to the year 2000 standard population.

NOTE: THE TABLE ABOVE MAY HAVE CONTINUED FROM THE PREVIOUS PAGE.

Adults aged 65 years or older numbered 33.9 million in 1996. They represented 12.8 percent of the U.S. population, about one in every eight persons. More than any other age group, older adults are seeking health information and are willing to make changes to maintain their health and independence. Prevention efforts should focus on modifiable risk behaviors and early diagnosis and match the leading problems by age (for example, aged 60 or 65 to 74 years, 75 to 84 years, and 85 years and older) and functional status. Programs should address these health issues through multiple strategies, including education, counseling, screening/chemoprophylaxis, environmental enhancements, and protective services. As with any successful program, those for older adults need to be tailored to the audience.

Related Objectives From Other Focus Areas

1. Access to Quality Health Services
- 1-3. Counseling about health behaviors

2. Arthritis, Osteoporosis, and Chronic Back Conditions
- 2-8. Arthritis education

3. Cancer
- 3-10. Provider counseling about cancer prevention

5. Diabetes
- 5-1. Diabetes education

6. Disability and Secondary Conditions

- 6-9. Inclusion of children and youth with disabilities in regular education programs
- 6-13. Surveillance and health promotion programs

9. Family Planning

- 9-11. Pregnancy prevention education

11. Health Communication

- 11-6. Satisfaction with health care providers' communication skills

16. Maternal, Infant, and Child Health

- 16-7. Childbirth classes

17. Medical Product Safety

- 17-3. Provider review of medications taken by patients
- 17-5. Receipt of oral counseling about medications from prescribers and dispensers

18. Mental Health and Mental Disorders

- 18-12. State tracking of consumer satisfaction

19. Nutrition and Overweight

- 19-16. Worksite promotion of nutrition education and weight management
- 19-17. Nutrition counseling for medical conditions

20. Occupational Safety and Health

- 20-9. Worksite stress reduction programs

22. Physical Activity and Fitness

- 22-8. Physical education requirement in schools
- 22-9. Daily physical education in schools
- 22-10. Physical activity in physical education class
- 22-12. School physical activity facilities
- 22-13. Worksite physical activity and fitness

24. Respiratory Diseases

- 24-6. Patient education

26. Substance Abuse

- 26-23. Community partnerships and coalitions

27. Tobacco Use

- 27-11. Smoke-free and tobacco-free schools
- 27-12. Worksite smoking policies

Terminology

(A listing of abbreviations and acronyms used in this publication appears in Appendix H.)

Community: A specific group of people, often living in a defined geographical area, who share a common culture, values, and norms and who are arranged in a social structure according to relationships the community has developed over a period of time.[45]

Community-based program: A planned, coordinated, ongoing effort operated by a community that characteristically includes multiple interventions intended to improve the health status of members of the community.

Community capacity: The characteristics of communities that affect their ability to identify, mobilize, and address social and public health problems.[46, 47]

Community health planning or community health improvement process: Helps a community mobilize to collect and use local data; set health priorities; and design, implement, and evaluate comprehensive programs that address community health and quality of life issues.[1]

Community health promotion program: Includes all of the following: (1) community participation with representation from at least three of the following community sectors: government, education, business, faith organizations, health care, media, voluntary agencies, and the public, (2) community assessment, guided by a community assessment and planning model, to determine community health problems, resources, perceptions, and priorities for action, (3) targeted and measurable objectives to address at least one of the following: health outcomes, risk factors, public awareness, services, and protection, (4) comprehensive, multifaceted, culturally relevant interventions that have multiple targets for change, and (5) monitoring and evaluation processes to determine whether the objectives are reached.

Comprehensive worksite health promotion programs: Refers to programs that contain the following elements: (1) health education that focuses on skill development and lifestyle behavior change in addition to information dissemination and awareness building, preferably tailored to employees' interests and needs, (2) supportive social and physical work environments, including established norms for healthy behavior and policies that promote health and reduce the risk of disease, such as worksite smoking policies, healthy nutrition alternatives in the cafeteria and vending services, and opportunities for obtaining regular physical activity, (3) integration of the worksite program into the organization's administrative structure, (4) related programs, such as employee assistance programs, and (5) screening programs, preferably linked to medical care service delivery to ensure followup and appropriate treatment as necessary and to encourage adherence. Optimally, these efforts should be part of a comprehensive occupational health and safety program.[37, 48]

Culturally appropriate: Refers to an unbiased attitude and organizational policy that values cultural diversity in the population served. Reflects an understanding of diverse attitudes, beliefs, behaviors, practices, and communication patterns that could be attributed to race, ethnicity, religion, socioeconomic status, historical and social context, physical or mental ability, age, gender, sexual orientation, or generational and acculturation status. Includes an awareness that cultural differences may affect health and the effectiveness of health care delivery. Knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, disability, or habits.

Excess deaths: The statistically significant difference between the number of deaths expected and the number that actually occurred.

Health: A state of physical, mental, and social well-being and not merely the absence of disease and infirmity.

Health care organizations: Included are hospitals, managed care organizations, home health organizations, long-term care facilities, and community-based health care providers.

Health education: Any planned combination of learning experiences designed to predispose, enable, and reinforce voluntary behavior conducive to health in individuals, groups, or communities.[49]

Health literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[50]

Health promotion: Any planned combination of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities.[49]

Health promotion activity: Broadly defined to include any activity that is part of a planned health promotion program, such as implementing a policy to create a smoke-free workplace, developing walking trails in communities, or teaching the skills needed to prepare healthy meals and snacks.

Healthy community: A community that is continuously creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.[51]

Healthy public policy: Characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives by making healthy choices possible and easier for citizens. It makes social and physical environments health enhancing.[45]

High school completion rate: Refers to the percentage of persons aged 18 to 24 years who are not currently enrolled in high school and who report that they have received a high school diploma or the equivalent, such as a General Education Development certificate.

Linguistically competent: Refers to skills for communicating effectively in the native language or dialect of the targeted population, taking into account general educational levels, literacy, and language preferences.

Local health service areas: Refers to local health jurisdictions and local health unit catchment areas.

Managed care organizations (MCOs): Refers to systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish health care services to members. Managed care includes health maintenance organizations, preferred provider organizations, and point-of-service plans.

Patient and family education: Refers to a planned learning experience using a combination of methods, such as teaching, counseling, skill building, and behavior modification, to promote patient self-management and patient and family empowerment regarding their health.

Postsecondary institutions: Includes 2- and 4-year community colleges, private colleges, and universities.

Quality of life: An expression that, in general, connotes an overall sense of well-being when applied to an individual and a pleasant and supportive environment when applied to a community. On the individual level, health-related quality of life (HRQOL) has a strong relationship to a person's health perceptions and ability to function. On the community level, HRQOL can be viewed as including all aspects of community life that have a direct and quantifiable influence on the physical and mental health of its members.[52]

School health education: Any combination of learning experiences organized in the school setting to predispose, enable, and reinforce behavior conducive to health or to prepare school-aged children to be able to cope with the challenges to their health in the years ahead.[49]

Settings (worksites, schools, health care sites, and the community): Major social structures that provide channels and mechanisms of influence for reaching defined populations and for intervening at the policy level to facilitate healthful choices and address quality-of-life issues. Conceptually, the overall community, worksites, schools, and health care sites are contained under the broad umbrella of "community." Health promotion and health education may occur within these individual settings or across settings in a comprehensive, communitywide approach.[10]

Social capital: The process and conditions among people and organizations that lead to accomplishing a goal of mutual social benefit, usually characterized by four interrelated constructs: trust, cooperation, civic engagement, and reciprocity.[49]

Social ecology: Refers to the complex interactions among people and their physical and social environments and the effects of these interactions on the emotional, physical, and social well-being of individuals and groups.[53]

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