2013

COMMUNITY PREVENTIVE SERVICES Task Force

Annual Report To Congress

and to Agencies Related to the Work of the Task Force

2013

Community Preventive Services Task Force

The Guide to Community Preventive Services
THE COMMUNITY GUIDE
What Works to Promote Health

The 2013 Annual Report to Congress was prepared by the Community Preventive Services Task Force (Task Force) in response to the following requirement:

"…providing yearly reports to Congress and related agencies identifying gaps in research and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations."
(Affordable Care Act, § 4003(b)(1); Public Health Service Act § 399U(b)(6))

The Centers for Disease Control and Prevention provides "ongoing administrative, research, and technical support for the operations of the Task Force."
(Affordable Care Act, § 4003(b)(1); Public Health Service Act § 399U(c))

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Executive Summary

The Community Preventive Services Task Force (Task Force) is an independent, non-Federal, uncompensated panel of public health and prevention experts whose mandate is to identify community preventive programs, services, and policies that save American lives and dollars, increase longevity, and improve quality of life. To date, the Task Force has made 228 findings and recommendations about interventions to promote healthful lifestyles, encourage a healthy environment, and help ensure that all Americans have access to early, affordable, and appropriate treatment—all of which are vital to

- Promoting the public's health;
- Reducing disease, disability, and injury;
- Decreasing long-term healthcare costs; and
- Reducing employers' and government costs (e.g., employer-sponsored coverage, Medicare, Medicaid, and other social service programs) related to preventable diseases, disabilities, and injuries.

Task Force recommendations, and the systematic reviews of the evidence on which they are based, are compiled in The Community Guide (www.thecommunityguide.org). These evidence-based recommendations are not mandates for compliance or spending. Instead, they provide information for decision makers and stakeholders wanting to allocate resources effectively to protect and improve people's health; reduce future demand for healthcare spending that is driven by preventable disease and disability; and increase the productivity and competitiveness of the United States (U.S.) workforce.

The intent of this report and future reports to Congress is to feature the efforts of the Task Force related to a topic of high relevance to reducing the burden that preventable disease, injury, and disability places on individuals, families, businesses, communities, and the health system. For this report, cardiovascular disease (CVD)—commonly known as "heart disease and stroke"—is the focal point. CVD is the nation's number one killer of both men and women. The report describes how the Task Force arrives at proven, evidence-based recommendations for ways to strengthen public health efforts to prevent CVD, save lives, and make better use of our health resources. The report additionally highlights where research and program evaluation are needed to fill gaps in the evidence, to further prevent and reduce CVD. The report also summarizes the full list of prevention opportunities reviewed by the Task Force, lists key accomplishments since the last report to Congress, and lays out priorities and plans for coming years.

CVD accounts for one in every four deaths in the U.S. Medications and surgical procedures have been developed to improve the quality and help lengthen the lives of people living with CVD. However, quality of life is usually limited, and treating the disease is extremely expensive. Almost 16% of U.S. annual health expenditures go to treat the 83 million American adults who suffer from CVD. Annual overall costs from CVD are estimated at $444 billion, which includes the cost of healthcare services, medications, and lost productivity. The greatest promise for reducing CVD-related healthcare costs, pain, and suffering comes from preventing CVD from occurring in the first place, or from controlling it in its earliest stages.

This report discusses Task Force-identified programs, services, and policies that are effective in addressing almost all of the factors that put people at increased risk for CVD. For some CVD risk factors—physical inactivity, tobacco use, excessive alcohol consumption, and diabetes—the Task Force has already constructed extensive menus of effective programs, services, and policies. Clinical and public health service providers, communities, and businesses can choose from these menus the options best suited to their settings, populations, and resources. For each of the remaining modifiable CVD risk factors—high blood pressure; high cholesterol levels; diets high in fats, cholesterol, or salt; and obesity—

the Task Force has reviewed only a few programs, services, and policies to date. Over the coming years, the Task Force aims to develop comprehensive menus of options to address each of these as well.

A key component of the Task Force's mandate is to identify gaps in the evidence base related to all of its findings and recommendations. Evidence gaps for the CVD reviews are discussed in this report, and links are provided to evidence gaps for all other Task Force findings and recommendations. Filling these gaps has the potential to make a significant positive impact on public health, health disparities, and healthcare costs. Researchers and program evaluators can develop studies to help fill these gaps. The greatest impact can be seen when funding agencies highlight the evidence gaps as priority areas within their funding announcements, thereby encouraging targeted research and evaluation. The Task Force therefore encourages Congress to continue promoting research and evaluation to address these gaps.

Accomplishments in each area of the Task Force's mandate are featured in this report. Consistent with plans in the 2012 report, and with scientific and technical support from CDC, accomplishments include:

- Making 11 recommendations on preventing CVD, skin cancer, and motor vehicle-related injuries; reducing excessive alcohol consumption, tobacco use, and secondhand smoke exposure; and improving oral health.
- Increasing efficiencies by developing methods for determining when and how to incorporate existing high-quality systematic reviews completed by others into The Community Guide review process.
- Establishing routine announcement of new and updated Task Force recommendations in the *Morbidity and Mortality Weekly Report* (*MMWR*), sent to 177,938 electronic and 5,324 print subscribers.
- Expanding use of the Community Guide website through syndicating content. This places up-to-date Community Guide content on the websites of interested Task Force Liaisons and partners, thereby allowing Community Guide content to be seen by visitors to all the other websites as well.
- Enhancing use of Task Force recommendations through providing training and technical assistance to health organizations and agencies; Task Force Liaisons; and state and local health departments, boards of health, and community-based organizations in 24 states.
- Developing a comprehensive crosswalk tool that helps health departments identify the programs, services, and policies from The Community Guide whose use can help them secure national accreditation by the Public Health Accreditation Board (PHAB).
- Completing a comprehensive crosswalk between Healthy People 2020 objectives and all evidence-based interventions from The Community Guide that can help meet those objectives.

Using a process focused on preventing avoidable illness, disability, health care costs, and premature death, the Task Force prioritized the following topics for review during 2013-2015: preventing and managing CVD, cancer, diabetes, and obesity; increasing physical activity; preventing motor vehicle-related injury; reducing tobacco use and disparities in health status; and improving oral health. Task Force plans for 2013-2015 within its mandate are outlined in the report:

- Continuing to expand capacity and balance the production of new reviews with review updates.
- Documenting new stories showing how communities and businesses have used The Community Guide.
- Developing tools and technical assistance to help workplaces use Task Force recommendations.
- Developing technical support to help health departments use The Community Guide–PHAB crosswalk.
- Expanding a) the websites that syndicate Community Guide content, and b) web search capabilities.
- Preparing a curriculum for web-based technical assistance in using Task Force recommendations.
- Strengthening connections with the National Prevention Strategy and Healthy People 2020.
- Consulting with Federal programs about how they can help fill Task Force-identified gaps in evidence.
- Exploring joint dissemination with the US Preventive Services Task Force (USPSTF).

Community Preventive Services Task Force 2013 Annual Report To Congress

and to Agencies Related to the Work of the Task Force

Overview

The intent of the 2013 Annual Report to Congress and future reports is to feature the efforts of the Community Preventive Services Task Force (Task Force) related to a topic of high relevance to reducing the burden that preventable disease, injury, and disability places on individuals, families, businesses, communities, and the health system. For the 2013 report, cardiovascular disease—commonly known as "heart disease and stroke"—is the focal point.

Cardiovascular disease (CVD) is the nation's number one killer of both men and women. This report describes how the Task Force arrives at proven, evidence-based recommendations for ways to strengthen public health efforts to prevent CVD, save lives, and make better use of our health resources. The report additionally highlights where research and program evaluation are needed to fill gaps in the evidence, to further prevent and reduce CVD.

This 2013 report and future reports will also summarize the full list of prevention opportunities reviewed by the Task Force, list key accomplishments since the previous report, and lay out priorities and plans for coming years.

What is The Community Preventive Services Task Force? What is Its Congressional Mandate?

The Task Force is an independent, non-Federal, uncompensated panel of public health and prevention experts appointed by the Director of the Centers for Disease Control and Prevention (CDC). Its members represent a broad range of research, practice, and policy expertise in community preventive services, public health, health promotion, and disease prevention (Appendix A). The Task Force always includes members with experience in state and local health departments and members with experience in integrated health systems.

In all aspects of its work, the Task Force seeks input from partner organizations and agencies, and from individual policy makers, practitioners (e.g., health department staff, educators, city planners), scientists, and businesses. Many of the nation's leading public health practice and research agencies and organizations have official Liaison status with the Task Force (Appendix B). Liaisons participate in meetings of the Task Force and represent the views, concerns, and needs of their organizations and constituents as they:

- Help the Task Force identify the most pressing current public health priorities;

- Provide input while the Task Force examines the evidence to reach its recommendations;
- Disseminate Task Force recommendations and implementation guidance, and help their members and constituents translate evidence-based recommendations into actions; and
- Convey critical evidence gaps and needs to the nation's leading public health and private research funders, researchers, evaluators, and other stakeholders.

The United States (U.S.) Department of Health and Human Services established the Task Force in 1996 to enhance the efforts of a wide range of U.S. decision makers by identifying community preventive programs, services, and policies that help save American lives and dollars, increase longevity, and improve quality of life (Appendix C). Programs, services, and policies evaluated by the Task Force include informational and education programs, behavior change programs, organizational and public policies, and health systems interventions. The Task Force recommends use of programs, services, and policies for which it finds strong or sufficient evidence that they are effective, and it recommends against using programs, services, and policies for which it finds strong or sufficient evidence that they are ineffective or harmful. The Task Force also identifies programs, services, and policies that, currently, lack sufficient evidence to recommend for or against.

Task Force recommendations can be used broadly (e.g., statewide or nationwide). They can also be used in a wide range of community settings: schools, worksites, community centers, faith-based organizations, foundations, health plans, public health departments and clinics, public health and clinical training programs, and healthcare systems. These evidence-based recommendations are not mandates for compliance or spending. Instead, they provide information for decision makers and stakeholders wanting to allocate resources effectively to

- Protect and improve people's health.
- Reduce future demand for healthcare spending that is driven by preventable disease and disability.
- Increase the productivity and competitiveness of the U.S. workforce.

Task Force recommendations seek to reduce health and economic burdens from disease, injury, and disability; and to prevent wasteful use of resources on programs, services, and policies whose effectiveness has not been established. The Task Force coordinates with its sister panel, the U.S. Preventive Services Task Force (also independent and non-Federal), established in 1984 to provide evidence-based recommendations on effective clinical preventive services—such as the use of screening, counseling, and preventive medications (Appendix D). Recommendations of the two Task Forces are complementary and together identify evidence-based strategies to prevent disease and injury, and improve health, wellbeing, and productivity for people of all ages.

The Task Force has a Congressional mandate to undertake these actions:

- Develop additional topic areas for new recommendations;
- Update existing recommendations;

- Enhance dissemination of recommendations;
- Provide technical assistance to those health professionals, agencies, and organizations that request help in implementing recommendations;
- Integrate with Federal Government health objectives and targets for health improvement;
- Provide yearly reports to Congress and related agencies identifying research gaps and recommending priority areas deserving further examination; and
- Coordinate with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practice.

CDC is mandated to provide ongoing administrative, research, and technical support for all Task Force operations.

How Does The Task Force Develop Its Recommendations?

To reach its evidence-based recommendations, the Community Preventive Services Task Force uses a rigorous, replicable, and systematic review process. First, with input from its partners and stakeholders, the Task Force prioritizes topics for review, using a process focused on preventing avoidable illness, disability, healthcare costs, and premature death (see the section "How Does the Task Force Set Priorities for Future Reviews?"). Each systematic review then involves finding pre-existing, relevant, high-quality research and evaluation studies and subjecting them to a rigorous appraisal (Appendix E).

Investing in Worksite Wellness for The Dow Chemical Company Employees

Dow directly links the health of its employees to business goals. A four-pillar health strategy that includes prevention, quality and effectiveness, health system management, and advocacy creates an environment where employee health is a priority. Dow used Task Force recommendations in Worksite, Physical Activity, Obesity, and Tobacco topic areas. Between 2004 and 2010, Dow estimates that their comprehensive health strategy saved more than $100 million in U.S. healthcare costs. For the full story, go to http://www.thecommunityguide.org/CG-in-Action/Worksite-Dow.pdf

Each systematic review is conducted under the oversight of the Task Force by a coordination team consisting of Task Force members, official Liaisons, Federal and non-Federal scientists, practitioners (e.g., health department staff, educators, city planners), policy makers, and other stakeholders such as businesses, voluntary health organizations (e.g., American Heart Association, American Cancer Society), and professional organizations (e.g., American Dental Association, American Academy of Pediatrics). To provide users with information that will help them determine if the program, service, or policy being reviewed fits their needs and situations, the coordination team evaluates not only the overall effectiveness of the program, service, or policy, but also its applicability to different populations, settings, and contexts, as well as its costs and return on investment. The review coordination team then presents all of this information to the Task Force, which uses the information as the basis for its deliberations and recommendations. Needs and preferences vary greatly among different communities, businesses, and organizations. The amount and type of funding and other resources they have to address

health threats and problems also varies. Therefore, the Task Force reviews a number of approaches to achieve the same health improvement. For example, to address obesity, the Task Force looks at different ways to increase physical activity as well as ways to make it easier to choose healthy foods. The Task Force identifies the full range of preventive programs, services, and policies that can be used by communities and health systems to address a health issue (See Appendix F for examples). The Task Force approves a priority work order and then, in turn, evaluates all the programs, services, and policies on the list. The result is a "menu" of various evidence-based programs, services, and policies. From that menu, decision makers can select the option(s) best suited to their population, setting, preferences, and available resources. All Task Force recommendations, and the systematic reviews on which they are based, are compiled in The Guide to Community Preventive Services (Community Guide; see www.thecommunityguide.org).

How Do Communities, Organizations, and Businesses Use Task Force Recommendations?

The 228 Task Force recommendations currently available provide information for potential users—communities, workplaces, schools, public health agencies, healthcare systems, non-governmental organizations, and all levels of government—to choose approaches that address their needs and situations. New recommendations are added regularly. Some decision makers use the recommendations to communicate public health challenges and solutions to their communities. Others use them as planning tools—to help them determine how to combat a specific health problem, or to strengthen their overall approach to improving public health and getting the most from their resources. Specific examples of how communities, organizations, and businesses across the country have used Task Force recommendations to bring about healthful changes are featured in Appendix G.

Creating Walkable Communities in Rural North Carolina

In rural Granville County, North Carolina, the costs of obesity are evident in high mortality rates associated with heart disease, diabetes, stroke, and cancer. To help address obesity, Granville stakeholders created a plan to develop more walkable communities, using Task Force recommendations to increase physical activity. The plan—Granville Greenways Master Plan—outlines the future of a county that embraces changing the built environment to promote active lifestyles. For the full story, go to http://www.thecommunityguide.org/CG-in-Action/PhysicalActivity-NC.pdf and watch the video at http://www.youtube.com/watch?v=_BWVRg_49Eg&list=PLvrp9iOILTQYr25zksqMsfzwu86ZswvTz&index=2&feature=plpp_video

How Does The Task Force Help to Prevent and Limit the Burden of Cardiovascular Disease?

Cardiovascular disease (CVD, commonly known as "heart disease and stroke") is the leading cause of death for both men and women in the U.S., accounting for 1 in every 4 deaths—more than 700,000 deaths annually.[1] CVD is a label given to a number of diseases

of the heart and blood vessels. The most common type in the U.S. is coronary artery disease, which can cause heart attack, angina (chest pain), heart failure, and arrhythmia (irregular heartbeat).[2] CVD also leads to strokes.

Medications and surgical procedures have been developed to improve the quality and help lengthen the lives of people with CVD.[3] However, quality of life for those with CVD often remains compromised, and treating the disease is extremely expensive—for those with the disease, their families, and the healthcare system. Almost 16% of U.S. annual health expenditures go to treat 83 million American adults who suffer from CVD.[4] Annual overall costs from CVD are estimated at $444 billion, which includes the cost of healthcare services, medications, and lost productivity. Coronary artery disease alone costs the U.S. $108.9 billion each year.[5] The greatest promise for reducing CVD-related healthcare costs, pain, and suffering comes from preventing CVD from occurring in the first place, or from controlling it in its earliest stages.[6]

As with other preventable diseases and conditions, the Task Force approach to CVD is to review a wide range of intervention strategies. A number of factors put people at higher risk of getting CVD: high blood pressure; high cholesterol levels; tobacco use; diets high in fats, cholesterol, or salt; physical inactivity; obesity; diabetes; excessive alcohol use; and family history. (See http://www.cdc.gov/heartdisease/behavior.htm.) About half of Americans (49%) have at least one of the three most important modifiable risk factors: uncontrolled high blood pressure, uncontrolled high cholesterol, and tobacco use.

Identifying programs, services, and policies effective in reducing these risk factors is a fundamental Task Force priority. The Task Force has identified effective approaches to address most of the risk factors for CVD, singly and in combination (See Appendix F, Table F-1). These approaches include integrated community and health system practices, such as those shown in Table 1.

For some CVD risk factors—physical inactivity, tobacco use, excessive alcohol consumption, and diabetes—the Task Force has already constructed extensive menus of effective programs, services, and policies. Clinical and public health service providers, communities, and businesses can choose from these menus the options best suited to their settings, populations, and resources. For example, the Task Force has assessed the effectiveness of 14 approaches that can be used to increase physical activity, which leads to reductions in blood pressure and blood cholesterol, among other health benefits (Appendix F, Table F-1). The approaches reviewed include

- Behavioral approaches, such as enhanced school-based physical education;
- Informational approaches and campaigns, such as community-wide campaigns; and
- Environmental and policy approaches, such as street-scale urban design.

Table 1. Examples of Task Force Recommendations Addressing Risk Factors for Cardiovascular Disease		
Type of Intervention	**Description of Intervention**	**Task Force recommends it based on effectiveness in**
Team-Based Care—for CVD prevention	A health systems intervention that uses a team—including primary care providers, other health professionals (usually nurses and pharmacists), and patients—working together to improve blood pressure control among patients at risk for CVD	1) Reducing blood pressure in individuals 2) Improving blood pressure control in a larger proportion of patients
Reducing Patient Out-of-Pocket Costs—for medications to control high blood pressure and high cholesterol	Reducing patient out-of-pocket costs for medications to control high blood pressure and high cholesterol, when combined with additional policies or actions to improve patient–provider interaction and patient knowledge	1) Improving medication adherence 2) Lowering blood pressure and cholesterol
Clinical Decision-Support Systems—for CVD prevention	Computer-based information systems, specifically aimed at CVD prevention, designed to assist healthcare providers in implementing clinical guidelines at the point of care	1) Improving screening by healthcare providers for CVD risk factors 2) Improving practices for CVD-related preventive care, clinical tests, and treatments
Reducing Out-of-Pocket Costs—for evidence-based tobacco cessation treatments	Program and policy changes to make evidence-based tobacco cessation treatments—including medication, counseling, or both—more affordable	Increasing the number of tobacco users who quit, thereby reducing their risk of CVD and other tobacco-related diseases and conditions
Quitline interventions—to increase tobacco use cessation	Quitline interventions available at no cost to quitters—particularly proactive quitlines (i.e., those that offer follow-up counseling calls)—that provide evidence-based behavioral counseling and support, sometimes along with pharmacotherapy, to help tobacco users quit	Increasing tobacco use cessation among callers interested in quitting, thereby reducing their risk of CVD and other tobacco-related diseases and conditions

For each of the remaining modifiable CVD risk factors—high blood pressure; high cholesterol levels; diets high in fats, cholesterol, or salt; and obesity—the Task Force has reviewed only a few programs, services, and policies to date. Over the coming years, the

Task Force aims to develop comprehensive menus of options to address each of these as well.

The Millions Heart Initiative (www.millionhearts.hhs.gov) is one example of a national effort capitalizing on opportunities to prevent and control CVD. It has brought together communities, health systems, nonprofit organizations, Federal agencies, and private-sector partners from across the country to prevent one million heart attacks and strokes by 2017. Million Hearts features Task Force recommendations as important strategies for achieving its goal.

What are Major Evidence Gaps? Why are They Important? How are They Filled?

Each Community Guide review identifies critical evidence gaps—areas where information is lacking. Evidence gaps can exist whether or not a recommendation is made. For instance, when there is insufficient evidence for the Task Force to determine whether an intervention works at all, the Task Force suggests that researchers and program evaluators conduct more studies to determine if it works. Even when enough evidence exists for the Task Force to make a recommendation, some information may still be missing that could help users determine if the intervention will meet their particular needs. Evidence may be missing on whether the intervention will work everywhere for everyone, how much it will cost to implement the intervention, whether the intervention will provide adequate return on investment, or how users should structure or deliver the intervention to ensure it is as effective as possible.

Filling these evidence gaps has the potential to make a significant positive impact on public health, health disparities, and healthcare costs. Researchers and program evaluators can review Task Force-identified evidence gaps relevant to their research, develop studies to answer one or more of the outstanding questions, and then look for a way to get their studies funded. If the results of their research or evaluation are published, the publications become part of the evidence the Task Force reviews when it updates its recommendations. For example, when the Task Force updated its review of one-on-one education to increase colorectal cancer screening, three new studies of the effectiveness of this intervention were identified. When these three studies were combined with the two studies identified in their initial review, the Task Force had enough evidence to move from a finding of insufficient evidence to recommending one-on-one education based on strong evidence of effectiveness in increasing colorectal cancer screening.

Agencies and organizations that fund research and programs are crucial to filling evidence gaps. The greatest impact can be seen when these funders highlight Task Force-identified evidence gaps as priority areas within their funding announcements, thereby encouraging targeted research and evaluation. The resulting research or evaluation studies, when taken together, may by themselves contribute enough information to fill specific gaps. The Task Force therefore encourages Congress to continue promoting research and evaluation to address the evidence gaps.

What Evidence Gaps were Found within the Reviews in the Cardiovascular Disease Topic?

For reviews within the CVD topic (the first three reviews in Table 1), Task Force-identified evidence gaps are presented in Appendix H. Some of the most important of these gaps are discussed below. Evidence gaps for all of the reviews undertaken to address the risk factors for CVD are available on The Community Guide website (www.thecommunityguide.org).

Team-Based Care to Improve Blood Pressure Control

Evidence is lacking with respect to possible differences in the effectiveness of team-based care if teams include categories of health professionals—such as community health workers and dietitians—that were not adequately represented in the studies reviewed. Minimal information was available on how satisfied patients are with team-based care, and whether team-based care helps patients stick with healthy behaviors prescribed as part of their treatment plans. Evidence is also needed to assess whether team-based care works equally for patients of different racial or ethnic heritage or socioeconomic status. The Task Force also identifies the need for evidence on whether different amounts and types of communication between team members affect how well team-based care works, as well as how sustainable team-based care is over the long term. Also needed is evaluation of large-scale, real-world, team-based care initiatives.

In terms of economic analysis, the Task Force identifies the need for more estimates that include both intervention costs and healthcare costs beyond hypertension, as well as more comprehensive reporting of all the items that go into those estimates of intervention and healthcare costs. The Task Force also notes the lack of adequate estimates of the effects of team-based care on improved worker productivity, and the lack of long-term economic outcomes.

Reducing Out-of-Pocket Costs (ROPC) for Cardiovascular Disease Preventive Services

The Task Force identifies one evidence gap so important that it is included with the recommendation statement: inadequate evidence was available to assess the effectiveness of ROPC for behavioral counseling or behavioral support services, independent of ROPC for medications. Questions also remain about whether ROPC works equally well for older adults as for younger adults, and among people with different levels of education. There was not enough information for the Task Force to draw any conclusions about patient satisfaction with ROPC, nor about how ROPC affects adoption of healthful behaviors. Other evidence gaps relate to whether communication approaches to tell patients and providers about ROPC benefits are effective, as well as how many patients and providers receive this information.

In terms of economic analysis, the Task Force identifies that questions remain as to whether effectiveness varies by the overall expense of the medication. Additionally, the Task Force did not find enough complete economic evaluations to be able to assess the cost

effectiveness of ROPC. The Task Force was particularly interested in determining the cost effectiveness of value-based insurance design (VBID) plans. These insurance plans promote the use of services primarily when the clinical benefits exceed the cost and discourage the use of services when the benefits do not justify the cost. Cost effectiveness of VBID plans could not be determined because the available studies did not report the clinical outcomes that would be needed to measure effectiveness.

Clinical Decision-Support Systems (CDSS)

Again, the Task Force identifies one evidence gap that is so important, it is included with the recommendation statement: that most available evidence is from studies where CDSS were implemented by themselves rather than as part of a coordinated service delivery effort to address barriers at the patient, provider, organizational, and community levels. The Task Force indicated that more evidence is needed about implementation of CDSS as one part of a comprehensive service delivery system designed to improve outcomes for CVD risk factors and reduce CVD-related morbidity and mortality.

Since many CDSS have been implemented only relatively recently, the Task Force notes the lack of adequate information on long-term outcomes. They also highlight the need for more information on patient satisfaction, on how CDSS affect patient adherence to medication and treatment plans, and on other CVD risk factors. Other evidence gaps are whether CDSS is equally effective among different racial and ethnic groups and socioeconomic levels, and whether CDSS can help reduce health disparities. The Task Force notes gaps in evidence around how effective CDSS are when delivered by non-physician providers such as nurses and pharmacists. The Task Force also underscores the need for evaluation of large-scale, real-world CDSS. (The economic review of CDSS is still underway and any identified evidence gaps will be added to the website: www.thecommunityguide.org.)

How Has the Task Force Addressed Other Public Health Challenges? What is the Current Full Set of Task Force Recommendations?

High blood cholesterol levels and high blood pressure are risk factors that are specific to CVD, so reviews of approaches for reducing these risk factors are grouped under the CVD topic. The remaining risk factors for CVD are also related to other diseases and injuries, so each one of them (e.g., tobacco use, increasing physical activity) is a separate topic (see Table 2). The Task Force has also identified effective community preventive programs, services, and policies that address a wide range of other important public health topics (see Table 2). These approaches promote healthful lifestyles, encourage a healthy environment, and help ensure that all Americans have access to early, affordable, and appropriate treatment—all of which are vital to

- Promoting the public's health;
- Reducing disease, disability, and injury;
- Decreasing long term healthcare costs; and

- Reducing employers and government costs (e.g., employer-sponsored coverage, Medicare, Medicaid, and other social service programs) associated with preventable diseases, disabilities, and injuries.

Table 2. Topic Areas Addressed by Task Force Reviews June 1996-May 2013

Cardiovascular Disease and Related Risk Factor Topics	Other Topics
• Alcohol: Preventing Excessive Alcohol Consumption • Cardiovascular Disease Prevention & Control • Diabetes Prevention & Control • Nutrition: Promoting Good Nutrition • Obesity Prevention & Control • Physical Activity: Increasing Physical Activity • Tobacco: Reducing Tobacco Use & Secondhand Smoke Exposure • Worksite Health Promotion	• Adolescent Health: Improving Adolescent Health • Asthma Control • Birth Defects: Preventing Birth Defects • Cancer Prevention & Control • Emergency Preparedness & Response • Health Communication & Social Marketing • Health Disparities: Addressing Disparities in Health Status (Health Equity) • HIV/AIDS, Other STIs & Pregnancy: Preventing HIV/AIDS, Other STIs & Teen Pregnancy • Mental Health: Improving Mental Health • Motor Vehicle-Related Injury Prevention • Oral Health: Improving Oral Health • Vaccination: Increasing Appropriate Vaccinations • Violence Prevention

Appendix F contains all 228 current Task Force recommendations for programs, services, and policies, and indicates the strength of evidence:

- Strong (78) or sufficient (40) evidence of effectiveness.
- Strong (2) or sufficient (0) evidence of harm or lack of effectiveness.
- Insufficient evidence to determine effectiveness (108).

An insufficient evidence finding means there was not enough evidence to determine whether the intervention is, or is not, effective. It does *not* mean that the intervention does not work, but rather that additional research is needed to determine whether or not the intervention is effective. Reasons for insufficient evidence findings are described in Appendix F.

How Does the Task Force Set Priorities for Future Reviews?

The Task Force uses a multi-stage process to identify and prioritize future review topics. This process involves formally soliciting suggestions for high-priority topics from a wide range of stakeholders, including Task Force Liaison agencies and organizations, and the public. A Task Force committee oversees the process of compiling extensive background information on all proposed topics. A systematic evaluation of this information is followed by ranking proposed topics using predetermined prioritization criteria (Table 3). Next, the entire Task Force reviews and ranks topics as "highest," "high," "medium," and "lower" priority.

Table 3. Criteria for Defining Priority Areas for Future Task Force Reviews
• Potential magnitude of preventable morbidity, mortality, and healthcare burden for the U.S. population as a whole based on estimated reach (how many people are affected), impact, and feasibility.
• Potential to reduce health disparities across varied populations based on age, gender, race/ethnicity, income, education, disability, setting, context, and other factors.
• Degree and immediacy of interest expressed by major Community Guide audiences and constituencies, including public health and healthcare practitioners, community decision makers, the public, and policy makers.
• Alignment with other strategic community prevention initiatives, including, but not limited to, Healthy People 2020, The National Prevention Strategy, the County Health Rankings, and America's Health Rankings.
• Synergies with topically related recommendations from the U.S. Preventive Services Task Force and Advisory Committee on Immunization Practices.
• Availability of research to support informative systematic evidence reviews.
• The need to balance reviews and recommendations across health topics, risk factors, and types of services, settings, and populations.

The Task Force initially organizes and prioritizes topic areas, and then sequentially or concurrently reviews multiple programs, services, and policies within that area. This allows the Task Force to achieve significant economies of scale. It also provides decision makers with a menu of effective options for addressing each topic.

These are the highest priority topics for reviews in 2013-2015:

- Cardiovascular Disease and Related Risk Factor Priority Topics
  - Cardiovascular Disease Prevention and Control (new reviews)
  - Obesity Prevention and Control (new reviews)
  - Diabetes Prevention and Control (new reviews and updates to existing reviews)
  - Promoting Physical Activity (new reviews and updates to existing reviews)
  - Reducing Tobacco Use and Secondhand Smoke Exposure (new reviews and updates to existing reviews)

- Other High Priority Topics
  - Motor Vehicle-Related Injury Prevention (new reviews)
  - Addressing Disparities in Health Status (Health Equity) (new reviews)
  - Improving Oral Health (updates to existing reviews)
  - Cancer Prevention and Control – Preventing Skin Cancer; and Increasing Appropriate Breast, Cervical, and Colorectal Cancer Screening (new review and updates to existing reviews)

As with all Task Force reviews, these will evaluate the overall effectiveness of existing programs, services, and policies as well as their applicability to different populations, settings, and contexts; and their return on investment. This information helps Community

Guide users select approaches that best meet their needs, preferences, and constraints. As changes in science and resources permit, the Task Force balances the production of new reviews with updating existing reviews at regular intervals. Reviews are updated to ensure that recommendations are based on the current body of evidence. Also, updating reviews helps the Task Force assess whether researchers, program evaluators, and funders of research and programs are adequately addressing recognized evidence gaps.

What are the Key Accomplishments Over the Last Year?

Key accomplishments within each of the areas of the Task Force's mandate will be featured in this report and in future reports. In accordance with the planned actions identified in the 2012 report, the Task Force accomplished the following in the interval between the 2012 Report to Congress and this report. Note that while the Task Force received technical and research support from CDC to complete these actions, all recommendations are made solely by the non-federal, independent Task Force.

- **Developing additional topic areas for new recommendations and updating existing recommendations:**
  - Increased efficiency through developing methods for determining when and how existing high-quality systematic reviews completed by others can be incorporated into The Community Guide systematic review processes.
  - Conducted new systematic reviews and updates to existing reviews, resulting in 11 evidence-based recommendations (See Table 4).

- **Enhancing dissemination of recommendations:**
  - Established routine announcement of new and updated Task Force recommendations in the *Morbidity and Mortality Weekly Report (MMWR)* publication, which is distributed to 177,938 electronic and 5,324 print subscribers.
  - Expanded use of The Community Guide website (www.thecommunityguide.org) through syndicating content. This places Community Guide content on the websites of interested Task Force Liaisons and partners, and automatically updates it, so Community Guide content can be seen by visitors to all the other websites as well.

- **Providing technical assistance to those health professionals, agencies, and organizations that request help in implementing recommendations:**
  - Enhanced use of Task Force recommendations through providing training and technical assistance to health organizations and agencies; Task Force Liaisons; staff who oversee Federally funded programs at CDC; and state and local health departments, boards of health, and community-based organizations in 24 states.
  - Developed a comprehensive crosswalk tool that helps health departments identify the many evidence-based programs, services, and policies from The Community Guide whose use can help them secure national accreditation by the Public Health Accreditation Board.

Table 4. Task Force Reviews Completed Since 2012 Report To Congress		
Topic Area	**New Reviews**	**Recommendations**
Alcohol: Preventing Excessive Alcohol Consumption	1. Electronic Screening and Brief Interventions (e-SBI)	Recommended (Strong Evidence)
Cardiovascular Disease Prevention and Control	2. Reduced Out-of-Pocket Cost for Cardiovascular Disease Preventive Services Among Patients with High Blood Pressure and High Cholesterol	Recommended (Strong Evidence)
	3. Clinical Decision-Support Systems (CDSS) for Cardiovascular Disease Prevention	Recommended (Sufficient Evidence)
	Updates to Existing Reviews	
Cancer Prevention & Control—Preventing Skin Cancer	4. Primary and Middle School Interventions to Increase UV Protective Behaviors	Recommended (Strong Evidence)
Motor Vehicle-Related Injury Prevention	5. Publicized Sobriety Checkpoint Programs	Recommended (Strong Evidence)
Improving Oral Health	6. Statewide or Community-wide Sealant Promotion	Insufficient Evidence
	7. Community Water Fluoridation	Recommended (Strong Evidence)
	8. School-based or –Linked Sealant Delivery Programs	Recommended (Strong Evidence)
Tobacco: Reducing Tobacco Use & Secondhand Smoke Exposure	9. Smoke-Free Policies to Reduce Tobacco Use	Recommended (Strong Evidence)
	10. Mass Reach Campaigns When Combined with Other Interventions	Recommended (Strong Evidence)
	11. Increasing the Unit Price of Tobacco Products	Recommended (Strong Evidence)

- **Integrating with Federal government health objectives and targets for health improvement:**
  - Worked with Healthy People staff to complete a comprehensive crosswalk between Healthy People 2020 objectives and evidence-based interventions from The Community Guide that can help meet those objectives. All linkages are highlighted in the new Evidence-Based Resources database at www.HealthyPeople.gov.
  - Collaborated with Healthy People staff to align search terms between www.HealthyPeople.gov and www.thecommunityguide.org.

- **Identifying and communicating important evidence gaps, to help policy makers, funders, scientists, and evaluators optimize resources for research and evaluation:**
  - Refined table formats for presenting evidence gaps so they are more usable by funders, researchers, and program evaluators.
  - Provided consultation to staff within the National Institutes of Health and CDC regarding how they might create opportunities for their grantees to conduct research and evaluation studies to fill Task Force-identified evidence gaps.

- **Coordinating with the U.S. Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP):**
  - Worked with support staff for the USPSTF to identify audiences and topics that would be candidates for joint distribution of information about USPSTF and Community Preventive Services Task Force recommendations.
  - Reviewed conflict of interest and nominations procedures of the USPSTF and ACIP as part of updating comparable Task Force processes.

What's Ahead?

Demand for Task Force evidence-based recommendations continues to grow—from funders, those involved in performance improvement, and others.[7] Policy makers, the health sector, employers, third-party payers, and the public recognize the imperatives to keep people healthy and productive, and to reduce the burden of healthcare costs on governments and the private sector. It has become clear that factors affected by community preventive services can have even more influence on Americans' health than access to quality medical care.[8]

To meet the increasing demand, and with technical and research support from CDC, the Task Force plans to undertake the following actions within the components of its mandate:

- **Developing additional topic areas for new recommendations and updating existing recommendations:**
  - Continue to balance the production of new reviews and review updates.
  - Continue to identify updates for expedited review.
  - Continue to explore options for expanding review capacity.

- **Enhancing dissemination of recommendations:**
  - Increase the number of websites that syndicate content from The Community Guide website.
  - Further refine how The Community Guide website can be searched through custom search functions.
  - Document new "The Community Guide in Action" stories showing how communities and businesses have used The Community Guide.

- **Providing technical assistance to those health professionals, agencies, and organizations that request help in implementing recommendations:**
  - Prepare a core curriculum for interactive, web-based technical assistance to help people use Task Force recommendations.
  - Develop technical assistance strategies to help state and local health departments use the tool that crosswalks Community Guide evidence-based programs, services, and policies with Public Health Accreditation Board standards and measures.
  - Develop tools and technical assistance processes to assist small- and medium-sized workplaces in using Task Force recommendations.

- **Integrating with Federal government health objectives and targets for health improvement:**
  - Strengthen connections between The Community Guide and the National Prevention Strategy.
  - Continue work with Healthy People 2020 staff to increase web links between www.HealthyPeople.gov and www.thecommunityguide.org that will assist users in efficiently connecting Task Force recommendations and national public health goals.

- **Identifying and communicating important evidence gaps, to help policy makers, funders, scientists, and evaluators optimize resources for research and evaluation:**
  - Using newly finalized templates, prepare tables of evidence gaps for all recent and current Community Guide reviews and post them on The Community Guide website for ready access by researchers, program evaluators, and funders.
  - Continue to consult with researchers and funders (e.g., National Institutes of Health, Robert Wood Johnson Foundation, Agency for Healthcare Research and Quality, CDC, and private sector funders) on ways they might help to fill gaps in evidence.
  - Help programs within CDC use The Community Guide in planning their evaluations.

- **Coordinating with the U.S. Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP):**
  - Evaluate health system supports for both USPSTF and ACIP recommendations.
  - Explore joint dissemination of USPSTF and Community Preventive Services Task Force recommendations on related topics (e.g., reducing excessive alcohol consumption) to capitalize on potential synergy in clinical and community settings.

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Appendix A. List of Current Task Force Members

Jonathan E. Fielding, MD, MPH, MBA (Chair)
Director of Public Health and Health Officer, County of Los Angeles Department of Public Health;
Professor of Health Services and Pediatrics, Schools of Public Health and Medicine, University of California, Los Angeles

Barbara K. Rimer, DrPH, MPH (Vice-Chair)
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Marshall H. Chin, MD, MPH, FACP
Richard Parrillo Family Professor of Healthcare Ethics in the Department of Medicine, University of Chicago;
Director, Chicago Center for Diabetes Translation Research;
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Gilbert Ramirez, DrPH
Senior Associate Dean for Academic Affairs and Educational Effectiveness, School of Public Health, West Virginia University

Patrick L. Remington, MD, MPH
Professor and Associate Dean for Public Health, Gordon T. Ridley, Consultant to Dean, University of Wisconsin School of Medicine and Public Health

Appendix B. Official Task Force Liaison Agencies and Organizations

Liaisons participate in meetings of the Task Force and represent the views, concerns, and needs of their organizations and constituents by contributing as follows:

- Helping the Task Force identify the most pressing current public health priorities.
- Serving on and recommending other participants for systematic review teams.
- Providing input while the Task Force examines the systematic review findings to reach its recommendations.
- Disseminating the Task Force recommendations and implementation guidance, and helping their members and constituents translate evidence-based recommendations into action.
- Conveying the critical evidence gaps and needs identified by Task Force review teams to the nation's leading public and private research and programmatic funders, researchers, evaluators, and other stakeholders.

The following agencies and organizations have official Liaison status with the Task Force:

Federal Agency Liaisons	Organization Liaisons
• Agency for Healthcare Research and Quality (as staff support to United States Preventive Services Task Force) • Department of Health and Human Services, Office of Disease Prevention and Health Promotion • Department of Veterans Affairs, Veterans Health Administration, Office of Patient Care Services, National Center for Health Promotion and Disease Prevention • Health Resources and Services Administration • Indian Health Service • National Institutes of Health • Prevention Research Centers, Centers for Disease Control and Prevention • Substance Abuse and Mental Health Services Administration • United States Air Force • United States Army Public Health Command • United States Navy Medicine	• American Academy of Family Physicians • American Academy of Nurse Practitioners • American Academy of Pediatrics • American Academy of Physician Assistants • American College of Preventive Medicine • American Medical Association • American Public Health Association • America's Health Insurance Plans • Association for Prevention Teaching and Research • Association of Schools of Public Health • Association of State and Territorial Health Officials • Center for Advancing Health • Directors of Health Promotion and Education • Institute of Medicine • National Association of County and City Health Officials • National Association of Local Boards of Health • Public Health Foundation • Quad Council of Public Health Nursing Organizations • Society for Public Health Education

Appendix C. The Utility of Community Preventive Services

The U.S. spends a higher portion of its gross domestic product on health than any other country, but our overall health system performance ranks 37th, well below many countries that spend less.[1] Preventing disease and injury is the most effective, common-sense way to improve and protect health. Although approximately 91% of U.S. health spending goes to healthcare services, administration, and health insurance,[2] the factors that influence health have been estimated as follows: behavioral factors (40%), genetics (30%), social circumstances (15%), medical care (10%), and environmental conditions (5%).[3] Community preventive efforts can affect these factors:

- ***Increase healthy longevity***—Today's youth could be the first generation to live shorter and less healthy lives than their parents.[4]
- ***Reduce illness burden***—Many Americans suffer from preventable, costly chronic conditions, such as diabetes, for a long period prior to death.[5]
- ***Reduce the likelihood of becoming ill***—Protecting Americans' health by preventing diseases makes sense and can save money.[6]
- ***Reduce healthcare spending***—Community-based disease prevention efforts can help restrain the growth in healthcare spending by reducing both the need and the demand for clinical services.[7]
- ***Make healthy choices easy choices***—Making healthy choices is easier with access to options such as healthy food, safe physical activity and recreation, and smoke-free environments.[8]
- ***Maintain or improve economic vitality***—A healthy, vibrant community is a productive community with a resilient workforce and economic vitality. Healthy, safe communities may help attract new employers and industries, create jobs, increase housing values, enhance community prosperity, and support global competitiveness.[9]
- ***Reduce waste***—Implementing Task Force-recommended programs and services can increase delivery of recommended clinical preventive services in multiple settings (e.g., clinics, worksites, schools), reducing both the healthcare services otherwise needed for preventable conditions and related productivity losses.[10]
- ***Enhance national security***—According to the 2010 Mission: Readiness report, "*Too Fat to Fight,"* obesity is the leading medical reason young men and women fail to qualify for military service.[11]
- ***Prepare communities for emergencies***—First responders and public health workers are fortified with evidence-based guidelines for responding to tornadoes, hurricanes, floods, other natural disasters, infectious disease outbreaks, and other threats.[12]
- ***Empower individuals, families, employers, schools, and communities***—Putting Task Force-recommended community preventive services into practice provides information, resources, skills, and environments in which people, communities, and organizations can thrive.[13]

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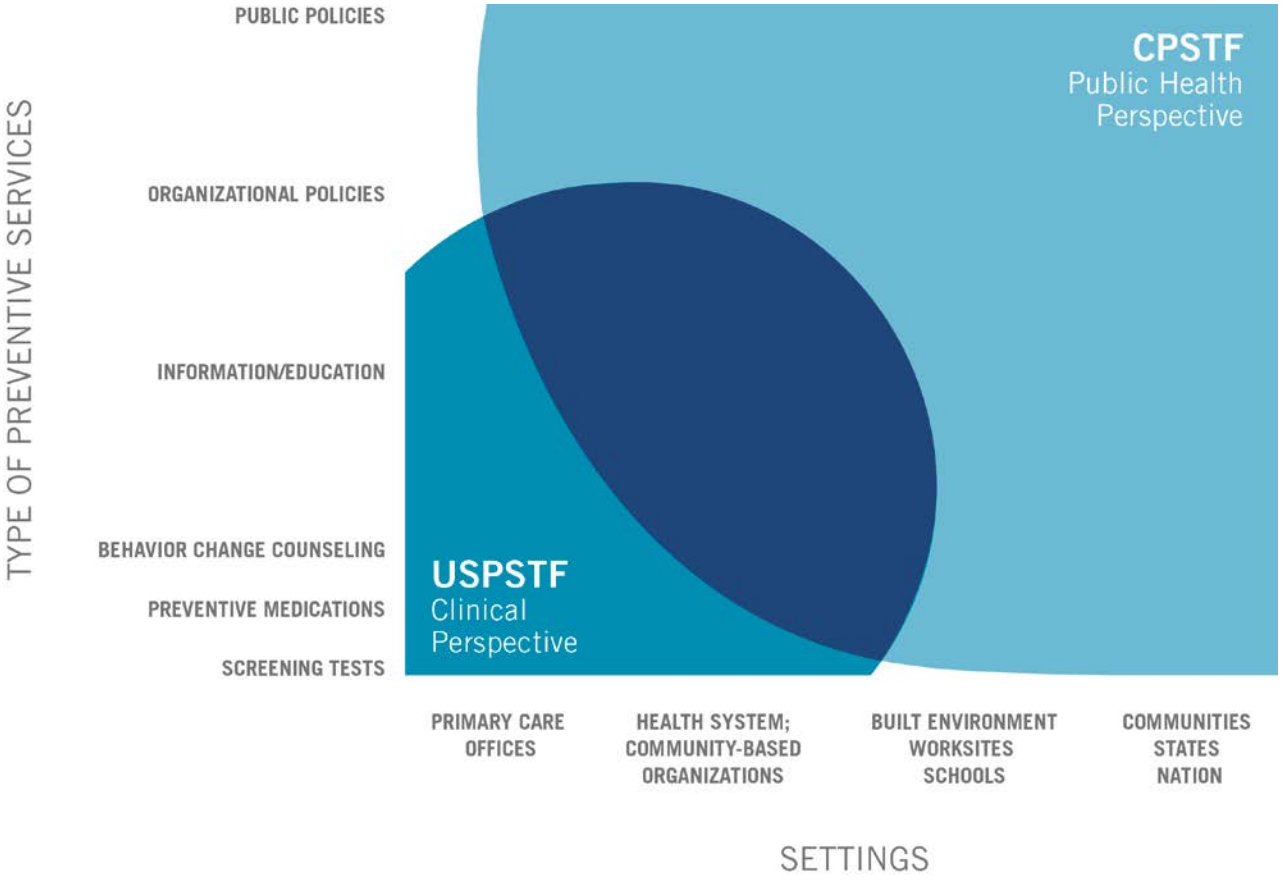
Appendix D. How the Community Preventive Services Task Force Relates to its Sister Task Force—the U.S. Preventive Services Task Force

The Task Force was created as a complement to the independent U.S. Preventive Services Task Force (USPSTF), which was established in 1984 to provide evidence-based recommendations for primary care clinicians, other healthcare professionals, and decision makers on effective *clinical preventive services*—such as screening, counseling, and preventive medications for asymptomatic people without established disease. The Agency for Healthcare Research and Quality (AHRQ) is mandated to provide ongoing administrative, research, and technical support to the USPSTF to support its operations. A diagram outlining the domains of the Task Force and USPSTF is shown below. The Task Force also complements the work of the Advisory Committee on Immunization Practices (ACIP), which develops recommendations for the routine administration of vaccines to children and adults.



Complementary Work of the Community Preventive Services Task Force (CPSTF) and the U.S. Preventive Services Task Force (USPSTF)

Appendix E. The Work of the Community Preventive Services Task Force

How the Community Preventive Services Task Force Conducts its Work and Makes its Recommendations

The Task Force meets three times annually in person and additional times by conference call, and communicates throughout the year by phone and through email to carry out these activities:

- Set priorities for selecting topics for systematic review.
- Participate in developing and refining systematic review methods.
- Assign members to serve on systematic review teams.
- Assess the findings of each review and make recommendations for policy, practice, and research.
- Identify key research and evidence gaps and recommend new research to be conducted in critical areas.
- Help to disseminate findings and recommendations to public health and healthcare practitioners and policy makers, and provide tools and technical assistance to help implement those findings and recommendations.

The Task Force bases its recommendations on a rigorous, replicable, and systematic review process that includes these steps:

- Conduct an extensive search to identify and gather all existing evidence on community-based health promotion and disease prevention programs, services, and policies in high-priority topic areas.
- Evaluate the strength and limitations of the evidence gathered. Assess whether the programs, services, and policies are effective in promoting health and preventing disease, injury, and disability.
- Examine the applicability of these programs, services, and policies to varied populations and settings (e.g., based on age, gender, race/ethnicity, income, inner city/suburban/rural location).
- Conduct appropriate economic and financial analyses of cost and return on investment, to provide a full complement of information to inform decision making.

These systematic reviews are conducted, with oversight from the Task Force, by scientists and other subject matter experts from CDC in collaboration with a wide range of government (Federal, state, and local), academic, policy, and practice-based partners and stakeholders. The Task Force examines the evidence, produces findings and recommendations about effective and ineffective programs, services, and policies, and identifies evidence gaps that need to be filled. Task Force recommendations provide evidence-based options from which decision makers and stakeholders can choose what best meets their needs: the recommendations are not mandates for compliance or spending.

The compilation of all Task Force reviews, findings, and recommendations is known as the Guide to Community Preventive Services (Community Guide). The Community Guide helps decision makers, practitioners, and scientists select the prevention strategies best suited to

their settings and populations—based on the strength of evidence for or against the effectiveness of specific policies, programs, and services, and their applicability to varied populations and circumstances. The evidence gaps that are identified help researchers, program evaluators, and funders of research and program focus their future efforts.

Appendix F. List of Task Force Recommendations and Other Findings

Information on all recommendations and other findings is available at www.thecommunityguide.org.

Recent Task Force findings and recommendations are accompanied by a rationale statement that explains Task Force conclusions and provides other relevant information.

Categories of Task Force Recommendations and Other Findings

- *Recommendations*—The Task Force uses the following terms to describe its recommendations:
    - **Recommended:** The systematic review of available studies provides evidence that the intervention is effective. The Task Force can recommend an intervention on the basis of
        - **Strong evidence** of its effectiveness, or
        - **Sufficient evidence** of its effectiveness.
            - The categories of 'strong' and 'sufficient' evidence reflect the Task Force's degree of confidence that an intervention has beneficial effects. They do not relate directly to the expected magnitude of benefits. The categorization is based on several factors, such as study design, number of studies, and consistency of the effect across studies.
    - **Recommended Against:** The systematic review of available studies provides evidence that the intervention is harmful or not effective. The Task Force can recommend against an intervention on the basis of
        - **Strong evidence** that it is harmful or not effective, or
        - **Sufficient evidence** that it is harmful or not effective.
- *Other Findings*—When the available studies do not provide enough evidence to determine if the intervention is, or is not, effective, the Task Force arrives at a finding of **Insufficient Evidence**. This does not mean that the intervention does not work. It means that additional research is needed to determine whether or not the intervention is effective. There are several reasons why the Task Force would find insufficient evidence to determine effectiveness of an intervention:
    a) There are not enough studies to draw firm conclusions.
    b) The available studies have inconsistent findings.
    c) The interventions were too varied to make an overall conclusion.
    d) The quality of the included studies was poor.
    e) Concerns exist about applicability or potential harms of the intervention.

† Denotes that review is an update to an existing review.

Appendix Table F-1: Cardiovascular Disease and Related Risk Factor Topics and Findings

Topic	Recommendations and Other Findings	Review Completion Date
Cardiovascular Disease Prevention and Control		
Team-Based Care in Improving Blood Pressure Control	Recommended (Strong Evidence)	April 2012
Reduced Out-of-Pocket Cost for Cardiovascular Disease Preventive Services Among Patients with High Blood Pressure and High Cholesterol	Recommended (Strong Evidence)	November 2012
Clinical Decision-Support Systems (CDSS) for Cardiovascular Disease Prevention	Recommended (Sufficient Evidence)	April 2013
Alcohol: Preventing Excessive Alcohol Consumption		
Interventions Directed to the General Population		
Dram Shop Liability	Recommended (Strong Evidence)	March 2010
Increasing Alcohol Taxes	Recommended (Strong Evidence)	June 2007
Maintaining Limits on Days of Sale	Recommended (Strong Evidence)	June 2008
Maintaining Limits on Hours of Sale	Recommended (Strong Evidence)	February 2009
Regulation of Alcohol Outlet Density	Recommended (Sufficient Evidence)	February 2007
Electronic Screening and Brief Interventions (e-SBI)	Recommended (Strong Evidence)	August 2012
Privatization of Retail Alcohol Sales	Recommended Against (Strong Evidence)	April 2011
Overservice Law Enhancement Initiatives	Insufficient Evidence	March 2010
Responsible Beverage Service	Insufficient Evidence	October 2010
Interventions Directed to Underage Drinkers		
Enhanced Enforcement of Laws Prohibiting Sales to Minors	Recommended (Sufficient Evidence)	February 2006
Diabetes Prevention and Control		
Healthcare System Level Interventions		
Case Management Interventions to Improve Glycemic Control	Recommended (Strong Evidence)	January 2001
Disease Management Programs	Recommended (Strong Evidence)	December 2000
Self-Management Education		

Topic	Recommendations and Other Findings	Review Completion Date
Diabetes Self-Management Education in Community Gathering Places – Adults with Type 2 Diabetes	Recommended (Sufficient Evidence)	March 2001
Diabetes Self-Management Education in the Home – Children and Adolescents with Type 1 Diabetes	Recommended (Sufficient Evidence)	March 2001
Diabetes Self-Management Education in the Worksite	Insufficient Evidence	March 2001
Diabetes Self-Management Education in Recreational Camps	Insufficient Evidence	March 2001
Diabetes Self-Management Education in School Settings	Insufficient Evidence	September 2000
Diabetes Self-Management Education in the Home – Adults with Type 2 Diabetes	Insufficient Evidence	March 2001
Nutrition: Promoting Good Nutrition		
School-Based Programs Promoting Nutrition and Physical Activity	Insufficient Evidence	June 2003
Obesity Prevention and Control		
Interventions in Community Settings		
Worksite Programs†	Recommended (Strong Evidence)	February 2007
Behavioral Interventions to Reduce Screen Time	Recommended (Sufficient Evidence)	January 2008
Technology-Supported Interventions: Multicomponent Coaching or Counseling Interventions to Maintain Weight Loss	Recommended (Sufficient Evidence)	June 2009
Technology-Supported Interventions: Multicomponent Coaching or Counseling Interventions to Reduce Weight	Recommended (Sufficient Evidence)	June 2009
Mass Media Interventions to Reduce Screen Time	Insufficient Evidence	January 2008
School-Based Programs	Insufficient Evidence	October 2003
Provider-Oriented Interventions		
Multicomponent Interventions with Client Interventions	Insufficient Evidence	February 2008
Multicomponent Provider Interventions	Insufficient Evidence	February 2008
Provider Education When Used Alone	Insufficient Evidence	October 2007
Provider Education with a Client Intervention When Used Alone	Insufficient Evidence	February 2008
Provider Feedback	Insufficient Evidence	October 2007
Provider Reminders	Insufficient Evidence	October 2007
Physical Activity: Promoting Physical Activity		
Behavioral and Social Approaches		
Enhanced School-Based Physical Education	Recommended (Strong Evidence)	October 2000

Topic	Recommendations and Other Findings	Review Completion Date
Individually-Adapted Health Behavior Change Programs	Recommended (Strong Evidence)	February 2001
Social Support Interventions in Community Settings	Recommended (Strong Evidence)	February 2001
Classroom-Based Health Education to Reduce TV Viewing and Video Game Playing	Insufficient Evidence	October 2000
College-Based Physical Education and Health Education	Insufficient Evidence	February 2001
Family-Based Social Support	Insufficient Evidence	February 2001
Campaigns and Informational Approaches		
Community-Wide Campaigns	Recommended (Strong Evidence)	February 2001
Classroom-Based Health Education Focused on Providing Information	Insufficient Evidence	October 2000
Campaigns and Informational Approaches to Increase Physical Activity: Mass Media Campaigns†	Insufficient Evidence	March 2010
Environmental and Policy Approaches		
Creation of or Enhanced Access to Places for Physical Activity Combined with Informational Outreach Activities	Recommended (Strong Evidence)	May 2001
Point-of-Decision Prompts to Encourage Use of Stairs	Recommended (Strong Evidence)	June 2005
Community-Scale Urban Design and Land Use Policies and Practices	Recommended (Sufficient Evidence)	June 2004
Street-Scale Urban Design and Land Use Policies and Practices	Recommended (Sufficient Evidence)	June 2004
Transportation and Travel Policies and Practices	Insufficient Evidence	February 2004
Tobacco: Reducing Tobacco Use and Secondhand Smoke Exposure		
Decreasing Tobacco Use Among Workers		
Incentives and Competitions to Increase Smoking Cessation Combined with Additional Interventions	Recommended (Strong Evidence)	June 2005
Smoke-Free Policies to Reduce Tobacco Use†	Recommended (Strong Evidence)	November 2012
Incentives and Competitions to Increase Smoking Cessation	Insufficient Evidence	June 2005
Increasing Tobacco Use Cessation		
Increasing the Unit Price of Tobacco Products	Recommended (Strong Evidence)	November 2012
Mass Media Campaigns When Combined with Other Interventions†	Recommended (Strong Evidence)	April 2013

Topic	Recommendations and Other Findings	Review Completion Date
Provider Reminders with Provider Education	Recommended (Strong Evidence)	February 2000
Quitline Interventions†	Recommended (Strong Evidence)	August 2012
Reducing Out-of-Pocket Costs for Evidence Based Tobacco Cessation Treatments†	Recommended (Strong Evidence)	April 2012
Mobile Phone-Based Interventions	Recommended (Sufficient Evidence)	December 2011
Provider Reminders When Used Alone	Recommended (Sufficient Evidence)	February 2000
Internet-Based Interventions	Insufficient Evidence	December 2011
Mass Media - Cessation Contests	Insufficient Evidence	May 2000
Mass Media - Cessation Series	Insufficient Evidence	May 2000
Provider Assessment and Feedback	Insufficient Evidence	February 2000
Provider Education When Used Alone	Insufficient Evidence	February 2000
Reducing Secondhand Smoke Exposure		
Smoking Bans and Restrictions	Recommended (Strong Evidence)	February 2000
Community Education to Reduce Exposure in the Home	Insufficient Evidence	February 2000
Reducing Tobacco Use Initiation		
Increasing the Unit Price of Tobacco Products†	Recommended (Strong Evidence)	November 2012
Mass Media Campaigns When Combined with Other Interventions	Recommended (Strong Evidence)	April 2013
Restricting Minors' Access to Tobacco Products		
Community Mobilization with Additional Interventions	Recommended (Sufficient Evidence)	June 2001
Sales Laws Directed at Retailers When Used Alone	Insufficient Evidence	June 2001
Active Enforcement of Sales Laws Directed at Retailers When Used Alone	Insufficient Evidence	June 2001
Community Education about Youth's Access to Tobacco Products When Used Alone	Insufficient Evidence	June 2001
Laws Directed at Minors' Purchase, Possession, or Use of Tobacco Products When Used Alone	Insufficient Evidence	June 2001
Retailer Education with Reinforcement and Information on Health Consequences When Used Alone	Insufficient Evidence	June 2001
Retailer Education without Reinforcement When Used Alone	Insufficient Evidence	June 2001

Appendix Table F-2: Other Topics and Task Force Findings and Recommendations

Topic	Recommendations and Other Findings	Review Completion Date
Adolescent Health: Improving Adolescent Health		
Person-to-Person Interventions to Improve Caregivers' Parenting Skills	Recommended (Sufficient Evidence)	October 2007
Asthma Control		
Home-Based Multi-Trigger, Multicomponent Environmental Interventions		
Home-Based Multi-Trigger, Multicomponent Interventions for Children and Adolescents	Recommended (Strong Evidence)	June 2008
Home-Based Multi-Trigger, Multicomponent Interventions for Adults	Insufficient Evidence	June 2008
Birth Defects: Preventing Birth Defects		
Maternal and Infant Health Outcomes		
Community-Wide Campaigns to Promote the Use of Folic Acid Supplements	Recommended (Sufficient Evidence)	June 2004
Interventions to Fortify Food Products with Folic Acid†	Recommended (Sufficient Evidence)	June 2008
Cancer Prevention and Control		
Increasing Appropriate Breast, Cervical and Colorectal Cancer Screening		
Client-Oriented		
Reducing Structural Barriers - Breast Cancer§	Recommended (Strong Evidence)	March 2010
Reducing Structural Barriers - Colorectal Cancer§	Recommended (Strong Evidence)	March 2010
One-on-One Education - Breast Cancer§	Recommended (Strong Evidence)	March 2010
One-on-One Education - Cervical Cancer§	Recommended (Strong Evidence)	March 2010
One-on-One Education - Colorectal Cancer§	Recommended (Sufficient Evidence)	March 2010
Client Reminders - Breast Cancer§	Recommended (Strong Evidence)	July 2010
Client Reminders - Cervical Cancer§	Recommended (Strong Evidence)	July 2010
Client Reminders - Colorectal Cancer§	Recommended (Strong Evidence)	July 2010

§ Updated Review; Screening for breast, cervical, and colorectal cancers are reported individually within each strategy, but are part of the same review

Topic	Recommendations and Other Findings	Review Completion Date
Small Media - Breast Cancer	Recommended (Strong Evidence)	December 2005
Small Media - Cervical Cancer	Recommended (Strong Evidence)	December 2005
Small Media - Colorectal Cancer	Recommended (Strong Evidence)	December 2005
Group Education - Breast Cancer§	Recommended (Sufficient Evidence)	October 2009
Reducing Client Out-of-Pocket Costs - Breast Cancer§	Recommended (Sufficient Evidence)	October 2009
Reducing Client Out-of-Pocket Costs - Colorectal Cancer§	Insufficient Evidence	October 2009
Reducing Client Out-of-Pocket Costs - Cervical Cancer§	Insufficient Evidence	October 2009
Mass Media - Breast Cancer§	Insufficient Evidence	October 2009
Mass Media - Cervical Cancer§	Insufficient Evidence	October 2009
Mass Media - Colorectal Cancer§	Insufficient Evidence	October 2009
Group Education - Cervical Cancer§	Insufficient Evidence	October 2009
Group Education - Colorectal Cancer§	Insufficient Evidence	October 2009
Client Incentives - Breast Cancer§	Insufficient Evidence	July 2010
Client Incentives - Cervical Cancer§	Insufficient Evidence	July 2010
Client Incentives - Colorectal Cancer§	Insufficient Evidence	July 2010
Reducing Structural Barriers - Cervical Cancer§	Insufficient Evidence	March 2010
Provider-Oriented		
Provider Reminder and Recall Systems	Recommended (Strong Evidence)	February 2006
Provider Assessment and Feedback§	Recommended (Sufficient Evidence)	October 2009
Provider Incentives§	Insufficient Evidence	October 2009
Informed Decision Making		
Promoting Informed Decision Making for Cancer Screening	Insufficient Evidence	February 2002

§ Updated Review; Screening for breast, cervical, and colorectal cancers are reported individually within each strategy, but are part of the same review

Topic	Recommendations and Other Findings	Review Completion Date
Emergency Preparedness and Response		
School Dismissals to Reduce Transmission of Pandemic Influenza: Severe Pandemic	Recommended (Sufficient Evidence)	August 2012
School Dismissals to Reduce Transmission of Pandemic Influenza: Moderate to Low Severity Pandemic	Insufficient Evidence	August 2012
Health Disparities: Addressing Disparities in Health Status (Health Equity)		
Education Programs and Policies		
Full-Day Kindergarten	Recommended (Strong Evidence)	December 2011
Health Communication & Social Marketing		
Health Communication Campaigns That Include Mass Media and Health-Related Product Distribution	Recommended (Strong Evidence)	December 2010
Culturally Competent Healthcare		
Cultural Competency Training for Healthcare Providers	Insufficient Evidence	October 2001
Culturally Specific Healthcare Settings	Insufficient Evidence	October 2001
Programs to Recruit and Retain Staff who Reflect the Community's Cultural Diversity	Insufficient Evidence	October 2001
Use of Interpreter Services or Bilingual Providers	Insufficient Evidence	October 2001
Use of Linguistically and Culturally Appropriate Health Education Materials	Insufficient Evidence	October 2001
Early Childhood Development Programs		
Comprehensive, Center-Based Programs for Children of Low-Income Families	Recommended (Strong Evidence)	June 2000
Housing		
Tenant-Based Rental Assistance Programs	Recommended (Sufficient Evidence)	February 2001
Mixed-Income Housing Developments	Insufficient Evidence	October 2000
HIV/AIDS, Other STIs & Pregnancy: Preventing HIV/AIDS, Other Sexually Transmitted Infections, and Pregnancy		
Interventions for Adolescents		
Group-Based Comprehensive Risk Reduction Interventions for Adolescents	Recommended (Sufficient Evidence)	June 2009

Topic	Recommendations and Other Findings	Review Completion Date
Youth Development Behavioral Interventions Coordinated with Community Service to Reduce Sexual Risk Behaviors in Adolescents	Recommended (Sufficient Evidence)	October 2007
Group-Based Abstinence Education Interventions for Adolescents	Insufficient Evidence	June 2009
Youth Development Behavioral Interventions Coordinated with Sports or Club Participation to Reduce Sexual Risk Behaviors in Adolescents	Insufficient Evidence	April 2008
Youth Development Behavioral Interventions Coordinated with Work or Vocational Training to Reduce Sexual Risk Behaviors in Adolescents	Insufficient Evidence	April 2008
Interventions for Men Who Have Sex with Men		
Group-Level Behavioral Interventions for Men Who Have Sex With Men	Recommended (Strong Evidence)	June 2005
Individual-Level Behavioral Interventions for Men Who Have Sex With Men	Recommended (Strong Evidence)	June 2005
Community-Level Behavioral Interventions for Men Who Have Sex With Men	Recommended (Sufficient Evidence)	June 2005
Partner Counseling and Referral Services		
Partner Notification by Provider Referral to Identify HIV-Positive People	Recommended (Sufficient Evidence)	February 2005
Partner Notification by Contact Referral to Identify HIV-Positive People	Insufficient Evidence	February 2005
Partner Notification by Patient Referral to Identify HIV-Positive People	Insufficient Evidence	February 2005
Mental Health: Improving Mental Health		
Collaborative Care for the Management of Depressive Disorders†	Recommended (Strong Evidence)	June 2010
Home-Based Depression Care Management Among Older Adults	Recommended (Strong Evidence)	February 2008
Clinic-Based Depression Care Management Among Older Adults	Recommended (Sufficient Evidence)	February 2008
Mental Health Benefits Legislation	Recommended (Sufficient Evidence)	August 2012

Topic	Recommendations and Other Findings	Review Completion Date
Community-Based Exercise Interventions Among Older Adults	Insufficient Evidence	February 2008
Motor Vehicle-Related Injury Prevention		
Alcohol-Impaired Driving		
Publicized Sobriety Checkpoint Programs†	Recommended (Strong Evidence)	August 2012
Multicomponent Interventions with Community Mobilization	Recommended (Strong Evidence)	June 2005
Ignition Interlocks	Recommended (Strong Evidence)	April 2006
0.08% Blood Alcohol Concentration (BAC) Laws	Recommended (Strong Evidence)	August 2000
Maintaining Current Minimum Legal Drinking Age (MLDA) Laws	Recommended (Strong Evidence)	August 2000
Intervention Training Programs for Servers of Alcoholic Beverages	Recommended (Sufficient Evidence)	June 2005
Lower BAC Laws for Young or Inexperienced Drivers	Recommended (Sufficient Evidence)	June 2000
Mass Media Campaigns	Recommended (Sufficient Evidence)	June 2002
School-Based Programs: Instructional Programs	Recommended (Sufficient Evidence)	October 2003
School-Based Programs: Peer Organization	Insufficient Evidence	October 2003
School-Based Programs: Social Norming Campaigns	Insufficient Evidence	October 2003
Designated Driver Promotion Programs: Incentive Programs	Insufficient Evidence	October 2003
Designated Driver Promotion Programs: Population-Based Campaigns	Insufficient Evidence	October 2003
Child Safety Seats		
Laws Mandating Use	Recommended (Strong Evidence)	June 1998
Distribution and Education Programs	Recommended (Strong Evidence)	June 1998
Incentive and Education Programs	Recommended (Sufficient Evidence)	June 1998
Community-Wide Information and Enhanced Enforcement Campaigns	Recommended (Sufficient Evidence)	June 1998
Education Programs When Used Alone	Insufficient Evidence	June 1998
Safety Belts		
Enhanced Enforcement Programs	Recommended (Strong Evidence)	October 2000
Laws Mandating Use	Recommended (Strong Evidence)	October 2000
Primary (vs. Secondary) Enforcement Laws	Recommended (Strong Evidence)	October 2000

Topic	Recommendations and Other Findings	Review Completion Date
Oral Health: Improving Oral Health		
Dental Caries (Cavities)		
Community Water Fluoridation†	Recommended (Strong Evidence)	April 2013
School-Based or -Linked Sealant Delivery Programs†	Recommended (Strong Evidence)	April 2013
Statewide or Community-Wide Sealant Promotion†	Insufficient Evidence	April 2013
Oral and Facial Injuries		
Population-Based Interventions to Encourage Use of Helmets, Facemasks, and Mouthguards in Contact Sports	Insufficient Evidence	November 2001
Oral and Pharyngeal Cancers		
Population-Based Interventions for Early Detection	Insufficient Evidence	June 2000
Skin Cancer: Preventing Skin Cancer		
Community-Wide Interventions		
Multicomponent Community-Wide Interventions†	Recommended (Sufficient Evidence)	April 2012
Mass Media†	Insufficient Evidence	June 2011
Education and Policy Approaches		
Education and Policy Approaches in Outdoor Recreation Settings	Recommended (Sufficient Evidence)	July 2002
Education and Policy Approaches in Primary School Settings	Recommended (Sufficient Evidence)	August 2012
Primary and Middle School Interventions to Increase UV Protective Behaviors†	Recommended (Strong Evidence)	August 2012
Education and Policy Approaches in Secondary Schools and Colleges	Insufficient Evidence	February 2002
Education and Policy Approaches for Healthcare Settings and Providers	Insufficient Evidence	July 2002
Education and Policy Approaches in Child Care Centers	Insufficient Evidence	February 2001
Education and Policy Approaches in Outdoor Occupation Settings	Insufficient Evidence	July 2002
Interventions Targeting Parents and Caregivers		
Interventions Targeting Children's Parents and Caregivers	Insufficient Evidence	July 2002

Topic	Recommendations and Other Findings	Review Completion Date
Vaccination: Increasing Appropriate Vaccinations		
Targeted Vaccinations		
Enhancing Access to Vaccination Services		
Expanded Access in Healthcare Settings When Used Alone	Insufficient Evidence	February 2002
Reducing Client Out-of-Pocket Costs When Used Alone	Insufficient Evidence	June 2002
Increasing Community Demand for Vaccinations		
Client or Family Incentives When Used Alone	Insufficient Evidence	June 2002
Client Reminder and Recall Systems When Used Alone	Insufficient Evidence	June 2002
Clinic-Based Client Education When Used Alone	Insufficient Evidence	June 2002
Community-Wide Education When Used Alone	Insufficient Evidence	June 2002
Vaccination Requirements When Used Alone	Insufficient Evidence	June 2002
Interventions Implemented in Combination		
Multiple Interventions Implemented in Combination	Recommended (Strong Evidence)	October 2002
Provider- or System-Based Interventions		
Provider Reminders When Used Alone	Recommended (Strong Evidence)	October 2001
Provider Assessment and Feedback When Used Alone	Insufficient Evidence	June 2002
Provider Education When Used Alone	Insufficient Evidence	June 2002
Standing Orders When Used Alone	Insufficient Evidence	October 2001
Universally Recommended Vaccines		
Community-Based Interventions Implemented in Combination†	Recommended (Strong Evidence)	June 2010
Enhancing Access to Vaccination Services		
Home Visits to Increase Vaccination Rates†	Recommended (Strong Evidence)	March 2009
Reducing Client Out-of-Pocket Costs†	Recommended (Strong Evidence)	October 2008
Vaccination Programs in Schools and Organized Child Care Centers†	Recommended (Strong Evidence)	June 2009
Vaccination Programs in WIC Settings†	Recommended (Strong Evidence)	March 2009
Expanded Access in Healthcare Settings When Used Alone	Insufficient Evidence	December 1997

Topic	Recommendations and Other Findings	Review Completion Date
Increasing Community Demand for Vaccinations		
Vaccination Requirements for Child Care, School and College Attendance†	Recommended (Strong Evidence)	June 2009
Client Reminder and Recall Systems†	Recommended (Strong Evidence)	February 2008
Client or Family Incentive Rewards†	Recommended (Sufficient Evidence)	April 2011
Client-Held Paper Immunization Records†	Insufficient Evidence	March 2010
Clinic-Based Education When Used Alone†	Insufficient Evidence	February 2011
Community-Wide Education When Used Alone†	Insufficient Evidence	March 2010
Monetary Sanctions†	Insufficient Evidence	April 2011
Provider- or System-Based Interventions		
Immunization Information Systems	Recommended (Strong Evidence)	July 2010
Provider Assessment and Feedback†	Recommended (Strong Evidence)	February 2008
Provider Reminders†	Recommended (Strong Evidence)	June 2008
Standing Orders When Used Alone†	Recommended (Strong Evidence)	June 2008
Healthcare System-Based Interventions Implemented in Combination†	Recommended (Strong Evidence)	December 2010
Provider Education When Used Alone†	Insufficient Evidence	March 2010
Violence Prevention		
Early Childhood Home Visitation		
Early Childhood Home Visitation	Recommended (Strong Evidence)	February 2002
Firearms Laws		
"Shall Issue" Concealed Weapons Carry Laws	Insufficient Evidence	April 2002
Bans on Specified Firearms or Ammunition	Insufficient Evidence	October 2001
Child Access Prevention (CAP) Laws	Insufficient Evidence	April 2002
Combinations of Firearms Laws	Insufficient Evidence	April 2002
Firearm Registration and Licensing of Firearm Owners	Insufficient Evidence	October 2001
Restrictions on Firearm Acquisitions	Insufficient Evidence	October 2001
Waiting Periods for Firearm Acquisition	Insufficient Evidence	October 2001
Zero Tolerance of Firearms in Schools	Insufficient Evidence	October 2001

Topic	Recommendations and Other Findings	Review Completion Date
Reducing Psychological Harm Among Children and Adolescents From Traumatic Events		
Cognitive Behavioral Therapy		
Group Cognitive-Behavioral Therapy	Recommended (Strong Evidence)	June 2006
Individual Cognitive-Behavioral Therapy	Recommended (Strong Evidence)	June 2006
Other Therapies		
Art Therapy	Insufficient Evidence	June 2006
Pharmacological Therapy	Insufficient Evidence	June 2006
Play Therapy	Insufficient Evidence	June 2006
Psychodynamic Therapy	Insufficient Evidence	June 2006
Psychological Debriefing	Insufficient Evidence	June 2006
School-Based Programs		
School-Based Programs to Prevent Violence	Recommended (Strong evidence)	June 2005
Therapeutic Foster Care		
Therapeutic Foster Care for the Reduction of Violence by Chronically Delinquent Adolescents	Recommended (Sufficient Evidence)	June 2002
Therapeutic Foster Care for the Reduction of Violence by Children with Severe Emotional Disturbance	Insufficient Evidence	June 2002
Youth Transfer to Adult Criminal System		
Policies Facilitating the Transfer of Juveniles to Adult Justice Systems	Recommended Against (Strong Evidence)	April 2003

Appendix G. The Community Guide in Action: Examples of Communities Using Task Force Findings and Recommendations

The following table lists a number of specific examples, by location and topic area, of how Task Force findings and recommendations have helped communities across the country to bring about healthful changes. It is not an exhaustive compilation, but rather an illustrative overview. To read the full stories, click on the links provided in the table. You can also access them from the home page of the Community Guide website at www.thecommunityguide.org.

State-Location*	Title	Finding / Recommendation Topic Area(s)	Link to Full Story
Alaska – Hoonah community and Alaska Department of Health and Social Services	Rural Community Works Together to Stay "Fun and Fit"	Nutrition Obesity Physical Activity Schools	http://www.thecommunityguide.org/CG-in-Action/FunandFit-AK.pdf
California – Los Angeles County Department of Public Health	Planning a Strategy: Changing the Way a County Health Department Addresses Health Conditions	Cardiovascular Disease (CVD) Obesity Tobacco	http://www.thecommunityguide.org/CG-in-Action/LACounty.pdf
Florida – Duval County Health Department, Jacksonville	A Good Shot: Reaching Immunization Targets in Duval County	Vaccines	http://www.thecommunityguide.org/CG-in-Action/Vaccinations-FL.pdf
Florida – Jefferson & Madison County Health Departments	Community-Wide Effort to Make Florida Tobacco Free	Tobacco	http://www.thecommunityguide.org/CG-in-Action/TobaccoFree-FL.pdf
Maryland – Department of Health and Mental Hygiene	Maryland Businesses Support Worksite Wellness Effort to Combat Chronic Disease	Diabetes Obesity Worksite	http://www.thecommunityguide.org/CG-in-Action/Worksite-MD.pdf
Maryland – Western Maryland Health System	Mobilizing Funding Support to Battle Overweight and Obesity	Obesity	http://www.thecommunityguide.org/CG-in-Action/Obesity-MD.pdf
Michigan – Dow Chemical Company	Investing in Worksite Wellness for Employees	Obesity Physical Activity Tobacco Worksite	http://www.thecommunityguide.org/CG-in-Action/Worksite-Dow.pdf

State-Location*	Title	Finding / Recommendation Topic Area(s)	Link to Full Story
Minnesota – Blue Cross and Blue Shield	Evidence-Based Recommendations Get Minnesotans in the Groove	Obesity Physical Activity Schools Worksite	http://www.thecommunityguide.org/CG-in-Action/PhysicalActivity-MN.pdf
Montana – Department of Public Health and Human Services	An Evidence-Based Approach to Montana's Health Landscape	Asthma Tobacco Vaccines	http://www.thecommunityguide.org/CG-in-Action/PublicHealth-MT.pdf
National	Lowering Legal Blood Alcohol Limits Saves Lives	Alcohol Motor Vehicle Injury	http://www.thecommunityguide.org/CG-in-Action/BAC.pdf
Nebraska – City of Lincoln and Lancaster County	Blueprint for Success in Reducing Tobacco Use	Tobacco	http://www.thecommunityguide.org/CG-in-Action/Tobacco-NE.pdf
New York - New York State Department of Health Cancer Services Program	Screening New Yorkers to Save Lives	Cancer Screening	http://www.thecommunityguide.org/CG-in-Action/CancerScreening-NY.pdf
North Carolina – Granville County	Creating Walkable Communities in Rural North Carolina	Obesity Physical Activity	http://www.thecommunityguide.org/CG-in-Action/PhysicalActivity-NC.pdf
South Carolina – St. James-Santee Family Health Center	Black Corals: A Gem of a Cancer Screening Program in South Carolina	Cancer Screening	http://www.thecommunityguide.org/CG-in-Action/CancerScreening-SC.pdf
*All examples can also be accessed from The Community Guide website at www.thecommunityguide.org or by clicking on the "In Action" image on the right side of the homepage.			

Appendix H. Evidence Gaps Identified in Reviews within the Cardiovascular Disease Topic

Evidence gaps for all other topic areas can be found at www.thecommunityguide.org.

Appendix Table G-1.Type of Evidence Gap

Other outcomes in addition to the outcomes on which the Task Force recommendation is based	Whether the intervention works in different populations	Whether the intervention works in different settings	Whether variations in the intervention affect how well it works	The cost and cost effectiveness of the intervention	How to implement the intervention
Cardiovascular Disease Prevention and Control: Team-Based Care (TBC) to Improve Blood Pressure Control **To fill evidence gaps related to this intervention, we need information in these areas:**					
• Patient-centered outcomes o Patient satisfaction with care o Patient adherence to healthy behaviors as part of their treatment plan	• Race/Ethnicity • Socioeconomic status o Income o Education o Insurance status	---	• Composition of the team o Inclusion of team members other than just physician, nurse, and pharmacists (e.g., community health workers and dietitians)	• Estimates that include both healthcare and intervention costs • Complete reporting of all that goes into estimates for intervention and healthcare costs • Estimates of the impact of TBC on improved work productivity due to reduced absences • Long-term economic outcomes (measured as quality adjusted life years [QALYs])	• Large-scale, real-world application of TBC • Communication within the team o Frequency (e.g., weekly, monthly) o Channel (e.g., face-to-face, telephone, e-mail, text message) • Sustainability of TBC over time

Type of Evidence Gap: We need more information on					
Other outcomes in addition to the outcomes on which the Task Force recommendation is based	**Whether the intervention works in different populations**	**Whether the intervention works in different settings**	**Whether variations in the intervention affect how well it works**	**The cost and cost effectiveness of the intervention**	**How to implement the intervention**
Cardiovascular Disease Prevention and Control: Reduced Out-of-Pocket Cost (ROPC) **To fill evidence gaps related to this intervention, we need information in these areas:**					
• Patient satisfaction • Healthy behaviors o Nutrition o Physical activity • Morbidity • Mortality • Consistency in evaluating both clinical and behavioral outcomes across all types of studies o Policy and practice-based studies that assess clinical outcomes as shown below, not just changes in medication adherence ▪ Changes in blood pressure ▪ Changes in cholesterol o Evaluations of multi-component interventions that report changes in medication adherence, not just clinical outcomes	• Older adults • Education	---	• Effectiveness of ROPC for behavioral counseling (e.g., nutrition counseling) or behavioral support services (e.g., community-based weight management programs) independent of ROPC for medications • Effectiveness by total medication cost	• Relationships between amount of cost reduction and outcomes or patient use • Complete economic evaluations • Cost-effectiveness for studies evaluating value-based insurance design (VBID) plans because they did not report the clinical outcomes needed to measure effectiveness • Cost of communicating ROPC to providers and patients • Patient out-of-pocket cost saved in dollar amount More economic studies with timely estimates and with comparison groups	• Effectiveness and reach of communication strategies to raise awareness of covered ROPC benefits among patients and providers

Type of Evidence Gap: We need more information on					
Other outcomes in addition to the outcomes on which the Task Force recommendation is based	**Whether the intervention works in different populations**	**Whether the intervention works in different settings**	**Whether variations in the intervention affect how well it works**	**The cost and cost effectiveness of the intervention**	**How to implement the intervention**
Cardiovascular Disease Prevention and Control: Clinical Decision-Support Systems (CDSS) To fill evidence gaps related to this intervention, we need information in these areas:					
• Long-term outcomes: o > 12-month follow-up • Patient-centered outcomes o Patient satisfaction with care o Adherence to medication and treatment plans • Related CVD risk factors o Blood pressure o Cholesterol o Diabetes • Mortality • Morbidity	• Race/Ethnicity • Socioeconomic status o Income o Education o Insurance status • Impact on health disparities	---	• Effectiveness of CDSS with non-physician providers o Nurses o Pharmacists	*[Economic review is still underway; evidence gaps will be identified when it is completed]*	• Large-scale, real-world application of CDSS • CDSS integrated with public health recommen-dations • CDSS in combination with other interventions such as team-based care to overcome barriers at the patient, provider, organizational, and community levels

www.thecommunityguide.org

The Centers for Disease Control and Prevention provides administrative, research, and technical support for the Community Preventive Services Task Force.