

4. EDUCATIONAL AND COMMUNITY-BASED PROGRAMS

Number	Objective
1	High school completion
2	School health education
3	Undergraduate health risk behavior information
4	School nurse-to-student ratio
5	Worksite health promotion programs
6	Participation in employer-sponsored health promotion activities
7	Patient satisfaction with health care provider communication
8	Patient and family education
9	Community disease prevention and health promotion activities
10	Community health promotion initiatives
11	Culturally appropriate community health promotion programs
12	Elderly participation in community health promotion

Educational and Community-Based Programs

Goal

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

Terminology

(A listing of all acronyms used in this publication appears on page 28 of the Introduction.)

The following definitions are important in the discussion of educational and community-based programs:

Community: A specific group of people, often living in a defined geographical area, who share a common culture, values, and norms and are arranged in a social structure according to relationships the community has developed over a period of time.¹

Community-based program: A planned, coordinated, ongoing effort that characteristically includes multiple interventions.

Community capacity: The characteristics of communities that affect their ability to identify, mobilize, and address social and public health problems.^{2,3}

Community health planning or community health improvement process: Helps a community mobilize; collect and use local data; set health priorities; and design, implement, and evaluate comprehensive programs that address community health and quality of life issues.⁴

Excess deaths: Deaths that would not occur if mortality rates for minorities were the same as for nonminorities.

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

Health education: Promotes healthy behaviors by informing and educating individuals through the use of materials and structured activities.

Health literacy: The capacity to obtain, interpret, and understand basic health information and services and the competence to use such information and services to enhance health.⁵

Health promotion: Any planned combination of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities.⁶

Healthy community: A community that is continuously creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.⁷

Healthy public policy: Characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. The main aim of healthy public policy is to create a

1 supportive environment to enable people to lead healthy lives by making healthy choices possible and
2 easier for citizens. It makes social and physical environments health enhancing.⁸
3

4 **Quality of life:** An expression that, in general, connotes an overall sense of well-being when applied to
5 an individual and a pleasant and supportive environment when applied to a community. On the individual
6 level, health-related quality of life (HRQOL) has a strong relationship to a person's health perceptions
7 and ability to function. On the community level, HRQOL can be viewed as including all aspects of
8 community life that have a direct and quantifiable influence on the physical and mental health of its
9 members.⁹
10

11 **Settings—worksites, schools, health care sites, and the community:** Major social structures that
12 provide channels and mechanisms of influence for reaching defined populations and for intervening at the
13 policy level to facilitate healthful choices and address quality of life issues. Conceptually, the overall
14 community, worksites, schools, and health care sites are contained under the broad umbrella of
15 "community." Health promotion and health education may occur within these individual settings or across
16 settings in a comprehensive community approach.¹⁰
17

18 **Social capital:** The degree of social cohesion that exists in communities; the stronger these bonds, the
19 more likely that members of a community will cooperate for mutual benefit.¹¹
20

21 **Social ecology:** Refers to the complex interactions among people and their physical and social
22 environments and the effects of these interactions on the emotional, physical, and social well-being of
23 individuals and groups.¹²
24

25 **Overview**

26
27 Attainment of the Healthy People 2010 objectives and improvement in health outcomes in the United
28 States by the year 2010 will depend substantially on educational and community-based efforts. These
29 objectives should stimulate and encourage collaborative action and efficient use of resources from
30 multiple sectors and community systems to improve individual health and create healthier communities.
31 Although more research is needed in community health improvement, much has been learned in the past
32 few decades. We know that the health of our communities does not depend just on the health of
33 individuals, but also on whether the physical and social aspects of the communities make it possible for
34 people to live healthy lives.¹³ People's health and quality of life depend on many community systems and
35 factors and not simply on a well-functioning health and medical care system. Making changes within
36 existing systems, such as the school system or the health care system, can effectively and efficiently
37 improve the health of a large segment of the community. Also, environmental and policy approaches tend
38 to have a greater impact on the whole community than individual-oriented approaches.¹⁴ Today, a
39 growing number of communities strive to achieve a healthier community by using community health
40 planning processes such as APEX/PH (Assessment Protocol for Excellence in Public Health), Healthy
41 Cities, Healthy Communities, and PATCH (Planned Approach to Community Health). These
42 communities take ownership of their health and quality of life improvement process and work to sustain
43 initiatives that result in healthy people in healthy communities.¹⁵
44

45 In their efforts to address difficult health and quality of life issues, the most successful communities have
46 involved multiple sectors of the community: public health, health care, businesses, local government,
47 schools, civic organizations, voluntary health organizations, faith organizations, park and recreation
48 departments, and many other groups and private citizens who are interested in improving the health of
49 their community. Eager to improve the health of a specific at-risk group, communities have realized that
50 they also must address the wider community, since members of a specific group are more likely to change

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1 and maintain the change when there is support from the rest of their community and from their social and
2 physical environment.

3
4 Because many health problems relate to more than one behavioral risk factor and to social and
5 environmental factors, effective communities also work to improve health by addressing the multiple
6 determinants of a health problem. The most effective community health promotion programs are those
7 that implement a comprehensive intervention plan that uses multiple intervention strategies, such as
8 educational, policy, and environmental strategies, within various settings, such as the community,
9 schools, health care facilities, and worksites.¹⁶⁻¹⁹

10
11 Three important strategies—educational, policy, and environmental—can be helpful in changing
12 knowledge, attitudes, skills, behaviors, policies, environmental measures, and social supports needed to
13 improve the health and well-being of the community. Educational strategies include awareness,
14 communication, and skill building. Policy strategies are those laws, regulations, formal and informal
15 rules, and understandings that are adopted on a collective basis to guide individual and collective
16 behavior.²⁰⁻²³ They include health-friendly policies designed to encourage healthful actions (e.g., flex-
17 time at worksites that enable employees to engage in physical activity; clinic hours that meet the needs of
18 working parents) and policies to discourage or limit unhealthy actions (e.g., restrictions on sale of tobacco
19 products to minors to discourage youth tobacco use). Environmental strategies are measures that alter or
20 control the legal, social, economic, and physical environment.²⁴ They alter the environment to make it
21 more supportive of health and well-being—for example, increasing the number of streetlights to
22 discourage crime and encourage physical activity and increasing the accessibility of low-fat foods in
23 grocery stores to encourage a low-fat diet. Environmental measures also are used to discourage actions
24 that are not supportive of health—for example, the removal of cigarette vending machines from public
25 buildings to discourage smoking.

26
27 These educational, policy, and environmental strategies are effective when used in as many settings as
28 appropriate.²⁵ These settings—schools, worksites, health care facilities, and the community—serve as
29 channels for reaching the desired people as well as sites for applying strategies. These settings also
30 generate the possibility of intervening at the policy level to facilitate healthful choices.²⁶

31
32 The school, ranging from preschool to university level, provides an important setting for ultimately
33 reaching the entire population and more immediately for educating children and youth. Schools have
34 more influence on the lives of youth than any other social institution except the family, providing a setting
35 through which friendship networks are developed, socialization occurs, and norms that govern behavior
36 are developed and reinforced. Each schoolday about 48 million youth in the United States attend almost
37 110,000 elementary and secondary schools for about 6 hours of classroom time. More than 95 percent of
38 all youth aged 5 to 17 are enrolled in school. During high school, national dropout rates average 12
39 percent; however, prior to high school, dropout is almost nonexistent.^{27,28, 28a} The goals of schools are
40 consistent with the goals of health promotion. Because healthy children learn better than children with
41 health problems, to achieve their educational mission, schools must help address the health needs of
42 students. Furthermore, the underlying responsibility of schools to prepare youth to lead productive lives
43 makes health promotion a central facet of the educational mission. Although schools alone cannot be
44 expected to address the health and related social problems of youth, they can provide, through their
45 climate and curriculum, a focal point for efforts to reduce health risk behaviors and improve the health
46 status of youth.²⁹

47
48 More than 12 million students currently are enrolled in the Nation's 3,600 colleges and universities. Of
49 these students, approximately 7.1 million are aged 18 to 24 years, or 57 percent of the college population.
50 Of all persons aged 18 to 24 years in the United States, one-fourth currently are either full- or part-time
51 college students. Of all persons aged 20 to 24 years, more than half have attended college.³⁰⁻³² Thus,

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1 colleges and universities are important settings for reducing health-risk behaviors among many young
2 adults.

3
4 The growing cost of health care and the increasing problem of preventable acute and chronic illnesses
5 have brought health education to the forefront of worksite concerns. Health promotion programs in the
6 worksite are critical to the long-term maintenance of our Nation's health. This setting provides an
7 opportunity for implementing educational programs and policy and environmental actions that support
8 health, which are beneficial to both managers and employees. Increasing awareness, promoting
9 individual lifestyle and health-related behavior changes, and creating supportive work environments and
10 policies are the core of worksite health promotion. Worksite health promotion programs are essential to
11 keeping our workforce healthy, strong, and productive. These programs have become an integral part of
12 the corporate plan to reduce health care costs, improve worker morale, decrease absenteeism, and
13 improve behaviors that are associated with increased worker productivity.³³

14
15 Comprehensive worksite health promotion programs contain the following elements: (1) health education
16 that focuses on skill development and lifestyle behavior change in addition to information dissemination
17 and awareness building, preferably tailored to employee interests and needs; (2) supportive social and
18 physical work environments, including established norms for healthy behavior and policies that promote
19 health and reduce the risk of disease such as worksite smoking policies, healthy nutrition alternatives in
20 the cafeteria and vending services, and opportunities for obtaining regular physical activity; (3)
21 integration of the worksite program into the organization's administrative structure; (4) related programs
22 such as employee assistance programs (EAPs); and (5) screening programs, preferably linked to medical
23 care service delivery to ensure followup and appropriate treatment as necessary and encourage
24 adherence.^{34,35}

25
26 Companies should take into consideration the scope of the community in which they interact and provide
27 support. The span of health care needs and the diversity of employees at the worksites require effective
28 educational health promotion programs that target modifiable health behaviors and issues of the
29 employee. High program participation rates are necessary to achieve the organizational benefits of
30 worksite health promotion efforts. Employee involvement in planning and managing the program is
31 essential to program success. Although reductions in health risks have been achieved in many worksites'
32 health promotion programs, risk reduction for hourly and part-time workers and companies with fewer
33 than 50 employees has lagged.

34
35 In health care facilities, including hospitals, medical and dental clinics, and offices, health care providers
36 see their patients an average of four times a year and often at a teachable moment. Health care providers
37 can lend expertise and credibility to community intervention efforts as well as provide prevention
38 education and advocate for healthy public policy and environmental change. Patient and family education
39 refers to a planned learning experience using a combination of methods such as teaching, counseling, skill
40 building, and behavior modification to promote patient self-management and patient and family
41 empowerment regarding their health. Health care organizations include a broad range of entities that
42 conduct or provide patient and family education. Included are hospitals, managed care organizations,
43 home health organizations, long-term care facilities, and community-based health care providers.

44
45 Numerous reviews have examined the effects of education and counseling in health care settings for
46 persons with chronic and acute illnesses and for primary prevention. These reviews generally conclude
47 that the effect of education and counseling on behavior in persons with chronic and acute conditions is
48 positive and clinically significant.³⁶ From these reviews, several principles of educational programs that
49 produce larger effects have been identified, including the individualization of education, relevance of
50 content, explicit feedback on progress made by the learner, and reinforcement.³⁷ It also is known that

1 behavioral and skills training are more effective in achieving learning outcomes than informational
2 approaches used alone.

3
4 While schools are natural settings for reaching children and youth and worksites reach the majority of
5 adults, efforts to reach older adults must necessarily involve the community at large. Senior centers have
6 been established in most communities and provide a range of services, including health promotion
7 programs, for roughly 20 to 25 percent of older adults. Several types of housing arrangements designed
8 specifically for older adults also can be found in many communities, including congregate housing, life
9 care facilities, and retirement villages. These usually offer some mix of health care, recreational
10 programs, and other types of activities and services. Health promotion strategies, policies, and
11 educational approaches have been developed in recent years for public health and aging populations.³⁸
12

13 The community as a setting includes public facilities; local government and agencies; and social service,
14 faith, and civic organizations that provide channels for reaching people where they live, work, and play.
15 Places of worship may be a particularly important setting for health promotion initiatives among some
16 underserved populations. Area Health Education Centers (AHECs), for example, link the academic
17 resources of university health science centers with local planning, educational, and clinical resources.
18 These groups and organizations also can be strong advocates for educational, policy, and environmental
19 changes throughout the community. In our approach to prevention, we must take into account the
20 character of the community and ensure community participation in the process.³⁹ It is essential for
21 individuals to get involved in their community to ensure that needs are being addressed and resources are
22 being properly allocated.
23

24 Broad public concern and support are vital to the functioning of a healthy community and ensuring the
25 conditions in which people can be healthy. Because improvements in health status are not likely to yield
26 to medical interventions alone, communities need to be engaged more than ever in the development of
27 solutions to their health problems.⁴⁰ The community itself is a source of effective action.⁴¹ Considerable
28 research exists that demonstrates that organized community efforts to prevent disease and promote health
29 are both valuable and effective. The health benefits of community-based approaches have been
30 demonstrated by community interventions serving a variety of ethnic and socioeconomic population
31 groups.^{42,43,43a}
32

33 In summary, a community health promotion program should include the following:
34

- 35 • Involved community participation with representation from at least three of the following community
36 sectors: government, education, business, faith organizations, health care, media, voluntary agencies,
37 and the public;
- 38 • A community assessment to determine community health problems, resources, and perceptions and
39 priorities for action;
- 40 • Measurable objectives that address at least one of the following: health outcomes, risk factors, public
41 awareness, or services and protection;
- 42 • A monitoring and evaluation process to determine whether the objectives are reached; and
- 43 • Comprehensive, multifaceted, culturally relevant interventions that have multiple targets for
44 change—individuals (e.g., minority, age, and socioeconomic groups), organizations (e.g., worksites,
45 schools, faith), and environments (e.g., local policies/regulations)—and multiple approaches to
46 change, including education, community organization, regulatory, and environmental.
47
48
49
50

1 ***Effective Community Health Promotion for the 21st Century***
2

3 The U.S. population is composed of many diverse groups. Over the next decade, the composition of the
4 Nation will become more racially and ethnically diverse than ever before. Declining mortality and falling
5 birth rates, both in part the result of successful public health policies and programs, have influenced the
6 rapid aging of the U.S. population. The elderly population, which is 10 times larger in 1990 than in 1900,
7 will more than double from 1990 to 2030.⁴⁴ The challenge for public health in an aging population is to
8 minimize the impact of disease and disability among older persons through prevention, health promotion,
9 and assistive services in a range of settings. Gender appropriateness also plays a significant role in
10 determining health outcomes, behaviors, use patterns, and attitudes within all age groups. Women often
11 are the health care decisionmakers and caregivers in their families and in their communities. When
12 provided with enabling services and health promotion and prevention information, they can make better
13 health choices and better navigate the health care system to get the care they and their families need.
14

15 As the diversity of the Nation's population changes, so must the types of health programs and
16 interventions provided. Ensuring the adoption of healthy lifestyle choices requires health promotion
17 programs not only to objectively assess the needs of the community and properly distribute resources, but
18 also to function in ways that are sensitive to the cultural norms and beliefs of the people involved. To
19 ensure that interventions are culturally appropriate, linguistically competent, and appropriate for the needs
20 of racial, ethnic, gender, and age groups within the community, it is vital to involve members of the
21 populations served and their gatekeepers in the community assessment and planning process. Currently,
22 inability to effectively communicate the services available and lack of identification of the needs of the
23 community are two barriers that deter some people from accessing appropriate health services and health
24 promotion programs.
25

26 Community assessment will help to identify the cultural traditions and beliefs of the community and the
27 education, literacy level, and language preferences necessary for the development of appropriate materials
28 and programs. Many health programs are not designed with sensitivity to the diverse health beliefs,
29 practices, use patterns, and attitudes of the many ethnic, cultural, gender, and age groups living in
30 America today. In order to reduce health disparities and increase access to care for ethnic and cultural
31 minorities and for the elderly in the United States, health programs must be culturally competent, age
32 appropriate, and gender specific. In addition, we need to determine ways to help increase the social
33 capital and community capacity so that communities have resources, skills, and abilities for managing
34 health improvement programs.^{45,46}
35

36 We must explore and evaluate mechanisms for taking into account the character of the community and
37 ensuring community participation in the process. For us to continue to make progress, educational and
38 community-based programs must be supported by accurate, appropriate, and accessible information
39 derived from a prevention science base. Strides have been made toward building an evidentiary base for
40 the efficacy and effectiveness of health education and health promotion in the four settings described
41 previously (schools, worksites, health care facilities and for community-based programming in general).
42 Gaps in research are especially prominent for dissemination and diffusion of effective programs, new
43 technologies, influence of policy, relations between settings, and approaches to marginal and special
44 subgroups.⁴⁷
45

46 Communities, researchers, and funding agencies can ensure a strong and effective science base for
47 prevention by working in partnership to develop priorities and identify research questions linked to
48 comprehensive programs for improving health. Communities need to be involved as partners in research
49 to ensure that results are appropriate and that the content and the prevention efforts developed are tailored
50 to meet the needs of the communities and populations being served. Communities also need to be
51 involved as equal partners in research to enhance the appropriateness and sustainability of science-based

1 interventions and prevention programs. Sustainability is necessary for successful research to be translated
2 into programs of lasting benefit to communities.

3
4 Efforts are needed to document the importance of social ecology on behavior and the successes of
5 environmental and policy approaches to health promotion and disease prevention. Efforts also are needed
6 to refine techniques for evaluating community processes and community health improvement methods
7 and models. We need to examine issues of partnering and linkages and the role of collaborative efforts,
8 including coalition building within communities, and their role in increasing the capacity of individuals
9 and communities to achieve long-term outcomes and improvements in health status.⁴⁸ Mechanisms need
10 to be expanded to share what is learned in an appropriate and timely manner with communities.

11 **Progress Toward Year 2000 Objectives**

12 Progress has been made in identifying, using, and developing national data sources for objectives in this
13 priority area. The following is a progress summary of the 14 Educational and Community-Based
14 Programs objectives.
15

- 16
17
18 • Objective 8.12, hospital-based patient education and community health promotion, is one that has
19 almost reached its target for the year 2000. The baseline was 66 percent; it increased to 68 percent in
20 1987 and to 86 percent in 1990.
- 21
22 • Three objectives have baseline data that exceed the year 2000 goal. The 1994 data sets revealed
23 family discussion of health issues (objective 8.9) has a baseline of 83 percent, surpassing the target of
24 75 percent; television partnerships with community organizations for health promotion (objective
25 8.13) has baseline data of 100 percent, surpassing the target of 75 percent; and health promotion
26 activities for hourly workers (objective 8.7) has a baseline of 21 percent, which slightly exceeds the
27 target of 20 percent. Attainment of these goals has resulted in dropping objectives 8.9 and 8.13 for
28 the year 2010. Objective 8.7 has been expanded for Healthy People 2010 to include worksites with
29 fewer than 50 employees.
- 30
31 • Two objectives are advancing to their respective targets. Worksite health promotion activities
32 (objective 8.6) has a target of 85 percent, and effective public health systems (objective 8.14) has a
33 target of 90 percent. Worksite health promotion programs have expanded significantly from 65
34 percent in the early 1980s to 81 percent in 1992. The 1992-93 National Association of County and
35 City Health Officials (NACCHO) survey revealed for objective 8.14 that of the local health
36 departments reporting, 84 percent provided health education, 96 percent provided immunization, 64
37 percent provided prenatal care, and 30 percent provided primary care. Objective 8.14 has been
38 referred to the focus area on Public Health Infrastructure for the year 2010.
- 39
40 • Objective 8.3 aims to achieve access to high quality and developmentally appropriate preschool
41 programs for all disadvantaged children and children with disabilities. In 1995, 54 percent of low-
42 income children had received at least 1 year of Head Start services, and 63 percent of disabled 3- to-
43 5-year-olds were enrolled in preschool.
- 44
45 • Two objectives have moved away from their identified baselines of 64 percent (years of healthy life
46 [objective 8.1]) and 86 percent (completion of high school [objective 8.2]). The targets for these
47 objectives are 65 percent and 90 percent, respectively.
- 48

- 1 • Three objectives have recently gathered baseline data for the first time:
 - 2
 - 3 ▪ Schools with comprehensive school health education (objective 8.4). This objective was
 - 4 modified during the 1995 midcourse revisions to “comprehensive school health
 - 5 education.” Baseline data revealed 11 percent of middle schools and high schools met
 - 6 five essential criteria for comprehensive school health education and 2.3 percent met all
 - 7 eight criteria. The target set for objective 8.4 is 75 percent.
 - 8
 - 9 ▪ Health promotion programs for older adults (objective 8.8). The 1995 National Health Interview
 - 10 Survey (NHIS) notes that 12 percent of adults 65 years and over participated in a health
 - 11 promotion program (exercise or health class).
 - 12
 - 13 ▪ States with community health programs addressing at least three Healthy People 2000 priority
 - 14 areas (objective 8.10). A 1992-93 survey by NACCHO revealed that 81 percent of local health
 - 15 departments in 35 States offered such programs. However, the survey does not offer data
 - 16 regarding the proportion of the population served by these programs.
 - 17
- 18 • Programs for racial and ethnic minority groups (objective 8.11) will have baseline data before the end
- 19 of the decade.
- 20
- 21 • Health promotion in postsecondary institutions (objective 8.5) continues to lack a data source.
- 22

Draft 2010 Objectives

Objectives for the School Setting

High School Completion

- 29 **1. (Former 8.2) Increase the high school completion rate to at least 90 percent.** (Baseline: 86
- 30 percent of people aged 18 through 24 had completed high school in 1996^{49,50})
- 31

Select Populations	1996
African American	83%
American Indian/Alaska Native	Not available
Asian/Pacific Islander	Not available
Hispanic	62%
White	92%
Male	Not available
Female	Not available

32
33 **Note:** High school completion rates include those who received high school diplomas, as well as
34 those who received alternative credentials such as a General Education Development (GED)
35 certificate.

36
37 **Target Setting Method:** Better than the best.

38
39 **Data Source:** Dropout Rates in the United States, 1996, U.S. Department of Education, National
40 Center for Education Statistics.

1 Dropping out of school is associated with employment later than usual, poverty, and poor health. During
2 adolescence, dropping out of school is associated with multiple social and health problems, including
3 substance abuse, delinquency, intentional and unintentional injury, and unintended pregnancy. The
4 antecedents of these problems appear to be highly interrelated and may form a constellation of common
5 precursors. Some researchers suggest that the antecedents of drug and alcohol problems, school dropout,
6 delinquency, and, a host of other problems can be identified in the early elementary grades, long before
7 the actual problems manifest. These include low academic achievement and low attachment to school,
8 adverse peer influence, inadequate family management and parental supervision, parental substance
9 abuse, sensation-seeking behavior, and diminished self-efficacy. For example, children who perform
10 poorly in school: are more than a year behind their modal grade, are chronically truant, and are more
11 likely to exhibit risk behaviors and experience serious problems in adolescence. Children also are placed
12 at increased risk when their attitudes toward education are negative and their adjustment to school has
13 been difficult. Finally, risk is increased if children fail to form meaningful social bonds to positive adult
14 and peer role models with whom they interact at school or in the community. By addressing high school
15 dropout rates as part of the Nation's health promotion and disease prevention agenda, it may be possible
16 to reduce unwarranted risks of problem behavior and improve the health of our young people.
17

18 The target of 90 percent set for this objective is consistent with the National Education Goal to increase
19 the high school graduation rate to at least 90 percent. A National Education Objective under that goal is
20 to eliminate the gap in high school graduation rates between minority and nonminority students. In 1996,
21 only 62 percent of Hispanic/Latino and 83 percent of African-American youth aged 18 through 24 had
22 completed high school, compared to a completion rate of 92 percent for white, non-Hispanic youth.
23

24 *School Health Education*

- 25
- 26 **2. (Former 8.4) Increase to at least 30 percent the proportion of the Nation's middle/junior high**
27 **and senior high schools that require 1 school year of health education.** (Baseline: 20 percent of
28 middle/junior and senior high schools required 1 school year of health education, 1994 School Health
29 Policies and Programs Study⁵¹)

30 **Note the following operational definition:** For this objective health education refers to instruction
31 on health education topics required in one or more courses.
32

33

34 **Target Setting Method:** 50 percent improvement.
35

36 **Data Source:** School Health Policies and Programs Study (SHPPS) 2000, CDC.
37

- 38 **3. (Former 8.5) Increase to at least 12 percent the proportion of undergraduate students**
39 **attending postsecondary institutions who receive information from their college or university**
40 **on all six priority health risk behavior areas (behaviors that cause unintentional and intentional**
41 **injuries, tobacco use, alcohol and other drug use, sexual behaviors, dietary patterns that cause**
42 **disease, and inadequate physical activity).** (Baseline data: In 1995 the National College Health
43 Risk Behavior Survey reported that 6 percent of undergraduate students received information from
44 their college or university on all six topics⁵²)
45

46 **Note the following operational definition:** Postsecondary institutions include 2- and 4-year
47 community colleges, private colleges, and universities.
48

49 **Target Setting Method:** 100 percent improvement.
50

51 **Data Source:** National College Health Risk Behavior Survey, CDC.

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1 Health promotion has been included as one of the desired outcomes of formal education in the United
2 States at least since 1918, when the Commission on the Reorganization of Secondary Education named
3 health as the first of seven Cardinal Principles of Education.⁵³ In 1997, the Institute of Medicine stated in
4 its report *Schools and Health: Our Nation's Investment* that students should receive the health-related
5 education and services necessary for them to derive maximum benefit from their education and to enable
6 them to become healthy, productive adults.

7
8 The School Health Education Study⁵⁴ conducted during the 1960s identified 10 conceptual areas that have
9 traditionally served as the basis of health education curricula. More recently, CDC identified six
10 categories of behaviors that are responsible for more than 70 percent of mortality and morbidity among
11 adolescents and young adults and thus should be the primary focus of school health education: (1)
12 behaviors that cause unintentional and intentional injuries, (2) tobacco use, (3) alcohol and other drug use,
13 (4) sexual behaviors that cause unintended pregnancies and sexually transmitted diseases, (5) dietary
14 patterns that cause disease, and (6) inadequate physical activity.⁵⁵ These behaviors usually are established
15 during youth, persist into adulthood, are interrelated, and contribute simultaneously to poor health,
16 education, and social outcomes.

17
18 The recently released National Health Education Standards⁵⁶ set the overarching goal of health education
19 as the development of health literacy—the capacity to obtain, interpret, and understand basic health
20 information and services and the competence to use such information and services to enhance health.
21 Because these standards are so new, few curricula have been redesigned or developed based on them,
22 although this is one of the intended outcomes of the standards development process. Research has shown
23 that for health education curricula to be successful in reducing priority health risk behaviors among
24 adolescents, effective strategies, considerable instructional time, and well-prepared teachers are required.
25 To attain this objective, States and school districts should support implementation of effective health
26 education with appropriate policies, teacher training programs, provision of effective curricula, and
27 regular assessment of progress. In addition, the role of the family, peers, and community at large is
28 critical to long-term behavior change among adolescents.

29
30 Health education and health promotion activities can be conducted in these settings and reach the
31 Nation's future leaders, teachers, corporate executives, health professionals, and public health personnel.
32 Personal involvement in a health promotion program can educate future leaders about the importance of
33 health and engender a commitment to prevention that will benefit the future patients, students, and
34 employees of today's students. Health promotion programs in postsecondary institutions should focus on
35 the same six behaviors described above.

36
37 The School Health Policies and Programs Study 2000 will measure health education policies and
38 programs in elementary, middle/junior, and senior high schools at the State, district, school, and
39 classroom levels nationwide. This study was first conducted in 1994. It will be repeated in 2000 and at
40 least one more time before 2010. The National College Health Risk Behavior Survey provides
41 information on the receipt of information on each of the six priority health risk behavior topics among
42 nationally representative samples of undergraduate students attending postsecondary institutions. This
43 survey was conducted in 1995 and will be repeated in the next decade.

1 **School Nurses**

- 2
- 3 **4. Increase to at least 42 percent the proportion of the Nation’s elementary, middle/junior, and**
4 **senior high schools that have a nurse-to-student ratio of at least 1:750.** (Baseline: In the 1994
5 School Health Policies and Programs Study, 28 percent of middle/junior and senior high schools had
6 a nurse-to-student ratio of at least 1:750⁵⁷)

7

8 **Target Setting Method:** 50 percent improvement.

9

10 **Data Source:** School Health Policies and Programs Study (SHPPS) 2000, CDC.

11

12 The importance of providing health services to students in schools is widely accepted.⁵⁸ The provision of
13 such services began over 100 years ago, with the purpose of controlling communicable disease and
14 reducing absenteeism. Over the years, school health services have evolved to keep pace with changes in
15 the health care, social, and educational systems in the United States.⁵⁹ Current models of school health
16 services reflect an understanding that children’s physical and mental health are linked to their abilities to
17 succeed academically and socially in the school environment.⁶⁰

18

19 Existing models of school health services span a wide range. In some schools, only basic needs such as
20 emergency care are met.⁶¹ At the other end of the spectrum are “full-service schools” that provide
21 comprehensive primary health care, mental health counseling, social services, and educational
22 counseling.⁶² While the number of full-service schools is growing, only a fraction of schools provide
23 primary health care.^{63,64} Most commonly, school health services consist of basic care provided by
24 registered nurses, sometimes with the assistance of health aides.^{65,66} School nurses are the traditional
25 “backbone” of school health services and often are the only health care providers at the school site on a
26 regular basis. The National Association of School Nurses recommends a ratio of 1 school nurse per 750
27 students.

28

29 **Objectives for the Worksite**

30

31 *Worksite Health Promotion*

- 32
- 33 **5. (Developmental/Former 8.6) Increase to at least __ percent the proportion of worksites that**
34 **offer a comprehensive employee health promotion program to their employees.** Baseline:

35

Comprehensive Employer-Sponsored Health Promotion Programs	1992
Among organizations with 500+ employees	Not available
Among organizations with 100-499 employees	Not available
Among organizations with 50-99 employees	Not available
Among organizations with less than 50 employees	Not available

36

37 **Note:** Reanalysis of the 1992 National Survey of Worksite Health Promotion Activities⁶⁷ can provide
38 a baseline estimate for worksites employing 50 or more people that offer “comprehensive” programs.
39 The developmental component of this objective is the need for baseline estimates for worksites
40 employing fewer than 50 people.

41

42 **Potential Data Source:** National Survey of Worksite Health Promotion Activities, ODPHP.

6. (Former 8.7) Increase to at least 50 percent the proportion of all employees who participate in employer-sponsored health promotion activities. Baseline:

Participation in Employer-Sponsored Health Promotion Programs		1994
Overall		37%
Employees at worksites with 50+ employees		48%
Employees at worksites with <50 employees		Not available
Select Populations		1994
African American		39%
American Indian/Alaska Native		35%
Asian/Pacific Islander		36%
Hispanic		33%
White		36%
Male		37%
Female		37%

Note: Data will be available for the job categories recognized by the Department of Labor. Health promotion activities are broadly defined to include such things as participation in a walking group, a back care class, stress reduction education, injury prevention talks, or a tobacco cessation program.

Target Setting Method: Better than the best.

Data Source: National Health Interview Survey (NHIS), CDC, NCHS, 1994 Healthy People 2000 Supplement.

By 1992, over 80 percent of employers with more than 50 employees reported offering at least one health promotion activity.⁶⁸ However, while the growth in worksite health promotion programming since 1985 has been remarkable, many programs are not comprehensive in design or of sufficient duration and therefore are potentially limited in their impact on employee health and well-being.^{69,70} Optimally, worksite health promotion efforts should be part of a comprehensive occupational health and safety program.

Over the next decade, attention needs to be given to developing strategies to provide workers in small work settings access to health promotion programs.^{71,72} More than 80 percent of private sector employees work in organizations of fewer than 50 people.⁷³ Smaller worksites can be at a disadvantage in providing health promotion services by their more limited purchasing power. By taking advantage of community agency programs and services through outsourcing and by collaborating with other smaller worksites to purchase services such as EAPs and health insurance for preventive health services, they may be able to take advantage of the economies larger purchasers have.⁷⁴

Collaboration with trade and professional organizations associated with small settings is needed to identify new opportunities for worksite health promotion. Employee involvement in defining and managing worksite health promotion activities can be especially valuable in addressing resource constraints among smaller employers while simultaneously enhancing program success.⁷⁵ Participation rates in worksite health promotion programs are generally low.^{76,77} Most worksite statistics indicate that enrollees in worksite health promotion programs tend to be salaried employees whose general health is better than average.

1 Because of changes that are transforming American worksites, it is becoming even more difficult to get
2 employees to participate in traditionally structured worksite health promotion programs. Employees
3 working in administrative support, service, crafts, and trades often have greater health risks and higher
4 rates of illness and injury than professional and administrative workers. Contributing factors include
5 socioeconomic differences, differences in the nature of the work performed, differences in access to and
6 extent of health insurance coverage, and exclusion of those workers from worksite health promotion
7 programs. This exclusion may not occur by intent but can occur through failure to market the program
8 effectively to them.⁷⁸

9
10 ***Objectives for the Health Care Setting***

11
12 *Health Education and Community Health Promotion*

13
14 **7. (Developmental) Increase to __ the percent of patients who report they are satisfied with the**
15 **communication they receive from their health care providers about how decisions are made**
16 **about their health care.**

17
18 **Potential Data Source:** Consumer Assessment of Health Plans Survey (CAHPS), AHCPR.

19
20 **8. (Developmental/Former 8.12) Increase to __ the percent of health care organizations that**
21 **provide patient and family education.**

22
23 **Note the following operational definition:** Health care organizations refers to organizations that
24 provide health care services.

25
26 **Potential Data Source:** Joint Commission on Accreditation of Healthcare Organizations.

27
28 **9. (Developmental/Former 8.12) Increase to __ percent the proportion of managed care**
29 **organizations and hospitals that provide community disease prevention and health promotion**
30 **activities that address the priority health needs identified by their communities.**

31
32 **Select Populations**

African American	Not available
American Indian/Alaska Native	Not available
Asian/Pacific Islander	Not available
Hispanic	Not available
White	Not available
Male	Not available
Female	Not available

33
34 **Note the following operational definition:** Managed care organizations refers to systems that
35 integrate the financing and delivery of health care services to covered individuals by means of
36 arrangements with selected providers to furnish health care services to members. Managed care
37 includes health maintenance organizations (HMOs), preferred provider organizations (PPOs), and
38 point-of-service (POS) plans.

39
40 **Potential Data Source:** American Hospital Association Survey.

41 On the national level, about 70 percent of employees are covered by some form of managed care. The
42 growth of managed care organizations (MCOs) is expected to increase. For example, as of January 1,

1 1997, more than 4.9 million Medicare beneficiaries were enrolled in managed care plans, accounting for
2 13 percent of the total Medicare program and representing a 108 percent increase in managed care
3 enrollment since 1993.⁷⁹ Another important factor is the emerging role of the National Committee on
4 Quality Assurance (NCQA) and its development of the Health Plan Employer Data and Information Set
5 (HEDIS) and a set of common data indicators for examining performance of MCOs. The latest version
6 requires MCOs to report on more than 50 prevention-oriented indicators, largely secondary and tertiary
7 prevention-related issues.⁸⁰ With the increasing marketing importance of HEDIS to MCOs, there will be
8 greater demands for health promotion to address HEDIS-related issues, potentially leaving critical
9 programming gaps.⁸¹ As a result, increased public attention must be devoted to examining patient
10 satisfaction with care in health care organizations.

11
12 There is a growing movement to support increased consumer protections in the health care industry,
13 particularly as a consumer's Bill of Rights and Responsibilities. Among these principles are consumers'
14 rights to accurate, easily understood information related to choice of a health plan, its benefits, availability
15 of specialty care, and confidentiality of medical records. What is being largely ignored is the right to
16 comprehensive patient and family education. Two distinctive characteristics of health care settings
17 underscore their importance in promoting patient and family education: (1) improved health is a primary
18 objective of activities in this setting, and (2) health care providers are generally considered credible
19 sources of information.⁸² The interaction of these two factors helps to create an environment conducive to
20 effective patient and family education programs and activities. It is well documented that patient
21 education and counseling of persons with chronic and acute conditions have resulted in positive and
22 clinically significant effects. However, published data suggest that there is wide variability in the amount
23 and types of health promotion and disease prevention activities offered by MCOs to their participating
24 employers.⁸³

25
26 Finally, community health promotion services provided by hospitals and MCOs are experiencing a great
27 deal of growth. This is illustrated by the expansion of Federal and State-level managed care reform
28 legislation directed at the creation of a core set of prevention activities across MCOs.⁸⁴ Despite the
29 differing motivations and strategic objectives of public health and managed care, they share a mutual
30 interest in improving the health of communities and specific populations within communities.
31 Collaboration between managed care plans and public health agencies is a logical consequence of the
32 health promotion objectives shared by these organizations.⁸⁵ Additionally, a number of Federal public
33 health agencies are developing collaborative relationships with the managed care community on issues of
34 clinical preventive services and prevention surveillance and research.⁸⁶

1 ***Objectives for the Community Setting and Special Populations***

2
3 *Community-Based Health Promotion*

4
5 **10. (Developmental/Former) Increase to at least __ percent the proportion of local health service**
6 **areas/jurisdictions that have established a community health promotion initiative that**
7 **addresses multiple Healthy People 2010 focus areas.**

8
9 **Note the following operational definition:** Local health service areas refers to local health
10 jurisdictions and local health serving unit catchment areas.

11
12 Community health promotion initiative includes all of the following:

- 13
14 1. Community assessment process involving community entities (guided by a community
15 assessment and planning model such as APEX/PH; Healthy Cities, Healthy Communities;
16 PATCH; or other comprehensive models).
17
18 2. Targeted objectives.
19
20 3. Multiple intervention strategies, including education, policy, and environmental/social
21 supports.
22
23 4. Evaluation.

24
25 **Potential Data Source:** To be developed and administered by Association of State and
26 Territorial Directors of Health Promotion and Public Health Education (ASTDHPPE), a survey
27 of local health departments and other health serving entities, identified by ASTDHPPE
28 representatives in each State, concerning characteristics of health promotion initiatives existing in
29 local health service areas/jurisdictions of these identified entities.
30

31 Many of the behavioral and environmental factors associated with unnecessary loss of health or life are
32 modifiable. Recent research and demonstration projects addressing chronic disease indicate that the
33 prevention approaches that hold the greatest promise are community based and communitywide and focus
34 on both individual behavior and environmental and societal influences. Effective strategies will be those
35 that are designed to influence not only the individual but also the social norms that operate in the broader
36 environment where people live and work. Social norms are shaped by a variety of institutions, including
37 educational institutions, religious institutions, courts and legislatures, and the media. To encourage and
38 sustain health- promoting practices, the community should be actively engaged in creating an
39 environment that supports individual action. The active involvement of many sectors in a community—
40 the committed participation of schools, libraries, faith organizations, worksites, government, businesses,
41 health care organizations, and voluntary agencies—increases the potential for sustained behavior change
42 and positive health benefits.
43

44 Community health promotion involves a new and complex technology. A growing number of States and
45 community-based organizations are assisting communities in establishing health promotion programs, but
46 more resources and technical assistance are needed. Public health departments, community health
47 centers, faith communities, civic organizations, voluntary health organizations, businesses, AHECs, and
48 healthy cities/communities groups are just a few of the organizations planning and delivering such
49 programs in the United States. The focus and design of community health promotion programs should
50 reflect needs identified through a recognizable and valid community assessment and planning process.

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1 Utilization of such a process provides some assurance that systematic and appropriate planning has
2 occurred and that priority needs of the community will be addressed.

3
4 This objective reflects the need for current program theory and practice related to noncategorical health
5 promotion and community health improvement activities being conducted at the State and local levels
6 throughout the country. Activities such as APEX/PH; Healthy Cities, Healthy Communities; and PATCH
7 recognize the need for community involvement and mobilization as basic methods for planning,
8 implementing, and evaluating educational and community-based programs. By identifying the use of
9 established health promotion planning and identification models, this objective provides more
10 information on strategically planned and implemented programs vs. single method or noncomprehensive
11 approaches that are considered to be not as productive.

12
13 *Culturally and Linguistically Appropriate Approaches*

14
15 **11. (Developmental/Former 8.11) Increase to at least __ percent the proportion of local health**
16 **departments that have established culturally appropriate and linguistically competent**
17 **community health promotion and disease prevention programs for racial and ethnic minority**
18 **populations.**

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Select Populations

African American	Not available
American Indian/Alaska Native	Not available
Asian/Pacific Islander	Not available
Hispanic	Not available
White	Not available
Male	Not available
Female	Not available

Note: This objective currently is being tracked in local health departments in which a racial or ethnic group constitutes more than 10 percent of the population. In future studies, by utilizing census data, local health departments that serve communities in which at least 3,000 people in the county indicate that their primary language is other than English or a similar population meets the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes also should be measured.

Note the following operational definitions: Culturally appropriate refers to an unbiased attitude and organizational policy that values cultural diversity in the population served; reflects an understanding of diverse attitudes, beliefs, behaviors, practices, and communication patterns that could be attributed to race, ethnicity, religion, socioeconomic status, historical and social context, physical or mental ability, age, gender, sexual orientation, or generations and acculturation status; an awareness that cultural differences may affect health and the effectiveness of health care delivery; and knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, disability, or habits. Linguistically competent refers to skills to communicate effectively in the native language or dialect of the targeted population, taking into account general educational level, literacy, and language preferences.

Potential Data Source: National Profile of Local Health Departments, NACCHO.

1 The U.S. population is composed of many diverse groups, and over the next decade, the composition of
2 the Nation will become more diverse than ever before. Mainstream health education activities often fail
3 to reach minority populations.⁸⁷ The inability to effectively communicate the services available and
4 identify the needs of the community are immense barriers that prevent many of this Nation's residents
5 from accessing appropriate health services. This may contribute to minority and disadvantaged
6 communities lagging behind the overall U.S. population on virtually all health status indicators. In 1991,
7 an estimated 78,643 excess deaths occurred among African Americans and an additional 4,485 among
8 Hispanic/Latinos.⁸⁸ Approximately 75 percent of these excess deaths occur in seven categories, all of
9 which have contributing factors that can be controlled or prevented: cancer, cardiovascular disease,
10 cirrhosis, diabetes, HIV/AIDS, homicide, and unintentional injuries.

11
12 Special efforts are needed to develop and disseminate culturally appropriate and linguistically competent
13 health information to address the cultural differences and meet the special language needs of these groups.
14 Community-based health promotion and disease prevention programs have proven to be more effective if
15 they are developed in conjunction with the population to be served.⁸⁹ Community participation in program
16 planning and an understanding of the cultural and linguistic needs of the community are essential in
17 developing effective programs.

Elderly Participation in Community Health Promotion

18
19
20
21 **12. (Former 8.8) Increase to at least 90 percent the proportion of people aged 65 and older who**
22 **have participated during the preceding year in at least one organized health promotion**
23 **program.** (Baseline: 12 percent, NHIS, 1995)

24
25 **Note the following operational definition:** An organized health promotion program is
26 any health class, presentation on a health-related topic, exercise class, or exercise
27 program.

28
29 **Target Setting Method:** 650 percent improvement.

30
31 **Data Source:** National Health Interview Survey (NHIS), CDC, NCHS.

32
33 The older population, persons 65 years or older, numbered 33.9 million in 1996. They represented 12.8
34 percent of the U.S. population, about one in every eight Americans. More than any other age group, older
35 adults are actively seeking health information and are willing to make changes to maintain their health
36 and independence. Prevention efforts should be well focused on modifiable risk behaviors and early
37 diagnosis, matched to the leading problems by age (e.g., aged 60 or 65 through 74, 75 through 84, and 85
38 and older) and functional status. Programs should address these health issues through multiple
39 strategies—education, counseling, screening/chemoprophylaxis, environmental enhancements, and
40 protective services. As with any successful program, those for older adults need to be tailored for the
41 audience.

Related Objectives From Other Focus Areas

Physical Activity and Fitness

- 42
43
44
45
46 11 Inclusion of physical activity in health education
47 13 Worksite physical activity and fitness
48 14 Clinician counseling about physical activity
49

1 **Nutrition**

- 2 15 Nutrition education, middle/junior high schools
3 16 Nutrition education, senior high schools
4 17 Worksite nutrition education and weight management programs
5 19 Nutrition counseling
6

7 **Tobacco Use**

- 8 10 Advice to quit smoking
9 13 Physician inquiries about secondhand smoke
10 14 Tobacco-free schools
11 15 Worksite smoking policies
12 21 Tobacco use prevention education
13 24 State tobacco control programs
14

15 **Oral Health**

- 16 15 School-based health centers with oral health component
17

18 **Family Planning**

- 19 12 School requirement for classes on human sexuality, pregnancy prevention, etc.
20

21 **Public Health Infrastructure**

- 22 11 Health improvement plans
23 16 Collaboration and cooperation in prevention research efforts
24

25 **Health Communication**

- 26 4 Satisfaction with health information
27

28 **Arthritis, Osteoporosis, and Chronic Back Conditions**

- 29 9 Arthritis education among patients
30 10 Provision of arthritis education
31 13 Counseling about prevention, 13 and over (osteoporosis)
32 14 Counseling about prevention, women 50 and over (osteoporosis)
33

34 **Cancer**

- 35 9 Provider counseling about preventive measures
36 14 Physician counseling of high-risk patients
37

38 **Diabetes**

- 39 23 Diabetes education
40

41 **Heart Disease and Stroke**

- 42 4 Provider counseling about early warning symptoms of heart attack
43 16 Provider counseling about early warning symptoms of stroke
44

45 **HIV**

- 46 8 Classroom education on HIV and STDs
47

48 **Mental Health and Mental Disorders**

- 49 23 Consumer satisfaction with services

1 **Respiratory Diseases**

- 2 6 Patient education (asthma)
3 8 Written asthma management plans
4 9 Counseling on early signs of worsening asthma

5
6 **Sexually Transmitted Diseases**

- 7 23 Provider counseling during initial visits

8
9 **Substance Abuse**

- 10 18 Treatment for substance abuse-related problems in school-aged children
11 19 Screening and treatment of patients 60 and older
12 20 Lost productivity
13 21 Community partnerships and coalitions

14
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