# THE SCIENCE OF PREVENTION

Executive Summary of the
Proceedings of the 24th Annual NECON Conference on
Health Promotion and Disease Prevention

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Region I

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The New England Governors' Conference, Inc.
The New England Public Health Association
The New England Community Health Centers Association
The New England AIDS Education & Training Center
The American Cancer Society, New England Division
The American Diabetes Association, New England Affiliate
The American Heart Association, New England Affiliate
The American Lung Association, New England Affiliate

## FOREWORD

This report summarizes proceedings of the NECON/DHHS conference titled The Science of Prevention, held at the Westin Hotel, Providence, Rhode Island, on Friday, October 8, 2004. The text presents edited, and in some instances abbreviated, versions of presentations.

The conference was presented by the New England Coalition for Health Promotion and Disease Prevention (NECON), and the U.S. Department of Health and Human Services, Region I. Co-sponsors included: The New England Governors' Conference, Inc.; The New England Public Health Association; The New England Community Health Centers Association; The New England AIDS Education and Training Center; The American Cancer Society, New England Division; The American Diabetes Association, New England Affiliate; The American Heart Association, New England Affiliate; and The American Lung Association, New England Affiliate.

Special funding for the conference was provided by Glaxo-SmithKline and Blue Cross and Blue Shield of Rhode Island. Additional support came from Pfizer Health Solutions, Health Media, and Health Dialog, Inc. Development of the Strategic Plan for the Prevention and Control of Overweight and Obesity in New England was generously sponsored by Abbott Laboratories and the Harvard School of Public Health Nutrition Round Table.

This is the 24th year in which NECON has presented annual conferences devoted to health promotion and disease prevention in New England. Since 1994, the focus has been on collaboration for public health among the six New England States, the public and private sectors, and between public health and medicine. A series of specialized working groups have made detailed and far-reaching recommendations pertaining to some of the most important health problems facing our society: tobacco use, obesity, racial and ethnic health disparities, inadequate health insurance coverage, domestic and community violence, HIV/AIDS, unmet women's health needs, gaps in mental health services, cancer prevention and control, diabetes control, and prevention and control of cardiovascular disease. In response to a request from the New England Governors' Conference, NECON recommendations have been translated into an action plan for the region.

Early conferences in this series were devoted to framing the issues confronting the region as state governments assumed increasing responsibility for shaping health policy. Subsequent conferences addressed reports of NECON/DHHS working groups, with their recommendations for education, policy change, legislation, and new service programs. Last year's conference focused on how to market action recommendations to policy makers, consumers, health care providers, schools, worksites, and through the media. This year's conference turns to the growing body of science-based research which identifies and documents effective preventive health interventions.

We would like to acknowledge the contribution of the NECON Advisory Group (Appendix 1) which is responsible for planning these conferences. Our thanks, also, to conference presenters (Appendix 2). This report was edited by Avery M. Colt; conference management services were provided by Carol McCullough.

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Bertram A. Yaffe
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## EXECUTIVE SUMMARY

The costs of health care continue to rise, driven in part by the demographics of a progressively older population, in part due to being a labor intensive industry, and in part by continuous expansion of costly new pharmaceuticals, technology, and diagnostic and therapeutic procedures. Nor is there any immediate end in sight to this trend. As a consequence, the burden of financing health care—whether borne by government programs, health maintenance organizations, private sector employee health plans, or private individuals—has become increasingly difficult to bear.

Public health professionals have argued for years that aggressive health promotion and disease prevention efforts could significantly reduce the burden of morbidity, disability, and premature mortality; and in the process could slow the upward spiral of health care spending. But unlike many other developed nations, the United States' investment in prevention is nugatory.

A major barrier to investment in prevention has been an absence of hard scientific proof that preventive interventions work. That is changing, however. On April 24, 2004, NECON sponsored a conference in Sturbridge, Massachusetts, titled Prevention Works: Evidence-Based Programs for the Prevention of Mental and Substance Abuse Disorders. During that conference an array of investigators described their work with effective interventions for prevention of suicide, depression, schizophrenia, and other mental health problems.

This conference, The Science of Prevention, takes a somewhat broader view, describing workable programs in the context of policy makers' expectations, and looking at methods the New England states can use to build interagency and public-private coalitions for health promotion and disease prevention.

### WELCOME
**Bertram A. Yaffe, Chair, NECON**

The costs and burdens of preventable disease are immense and escalating, Mr. Yaffe said. Yet, of the nearly two trillion dollars we spend on health care, less than three percent is directed to disease prevention and health promotion. For nearly a quarter of a century, NECON has been assembling the New England region's public health professionals and policy makers to these annual conferences to focus attention on how to do prevention. Over that same period, the quality of sound scientific research on healthy behaviors and societal health policy has improved significantly, to the point where we have a body of science-based interventions with documented efficacy in preventing disease. The scientific argument for prevention has been made and we need to get the word out to policy makers, providers, and the public.

**The Hon. Donald L. Carcieri**
**Governor, State of Rhode Island**

From a policy viewpoint, the Governor said, there are two components of the health care system: first, that comprised of usage, i.e., the demand for and delivery of services; and second, the

cost-benefit component, i.e., what it costs to obtain the outcomes we desire. Both are important. The challenge is to keep people healthier, longer, through the promotion of wellness.

The goal, he said, is to keep people well, improve the quality of life and improve the health care delivery system. On the usage side, we need to strengthen our assessment capabilities. On the cost-benefit side, we need to increase efficiency and effectiveness. What does it take to do these things?

(1) Sufficient information about individual patients, and the population as a whole, so that providers can identify levels of risk and establish appropriate protocols for medical care, for health promotion, and for disease prevention.

(2) Methods for incentivizing individuals to take responsibility for their own health, and providing community support systems to aid them in doing this.

(3) Easy access for providers to all relevant health information about their patients, regardless of when or where health care services were delivered and recorded.

(4) Reasonable ways to finance the use of proliferating medical technologies, which benefit patients and make providers more efficient, but which also increase the volume and cost of services.

(5) More rational ways of organizing the health care system so that patients obtain appropriate health care in the most appropriate settings.

**PANEL: THE SCIENCE OF PREVENTION**

**Michael Samuelson, Moderator**
**Health and Wellness Division**
**Blue Cross and Blue Shield of Rhode Island**

There is one simple reason for the growing federal interest in prevention, Mr. Samuelson said: treatment alone doesn't seem to be working. People are not getting healthier and the dollars are beginning to shrink. But before we start throwing money at prevention it is important that we know what prevention is, what works, what doesn't work, and who is qualified to tell us. Our panelists this morning are more than qualified to discuss prevention and the science behind it.

Health care spending was $245 billion in 1980, and is now up to $1.9 trillion annually; approaching $6,000 per person in health care costs. At this rate, health care costs will be about $4.3 trillion in 2012. We must do better at prevention.

From the 1930s to the 1970s, we depended on physicians, specialists, and the health care system for prevention, with patients playing a passive role. But starting in the mid 1970s, there was an explosion of information available to the public on health issues, and especially about lifestyle choices that affect health. What is needed now is a "responsibility shift," in which we as individuals take more responsibility for making healthy lifestyle choices.

The business of prevention requires collaboration, a partnership between providers, insurers, employers, government, and individuals—both as community residents and as patients using the health care system.

**David L. Katz, MD, MPH**
**Director, Yale Prevention Research Center**

There are several barriers to securing adequate funding for prevention research, Dr. Katz observed. These include competition from demands for treatment research and service programs, the fact that successful prevention results in no visible outcomes, and the long elapsed time between investment in research and outcomes, which puts prevention research essentially outside a political time table.

There is also an imbalance in where we invest the prevention research dollar. The usual progression is from basic research, through clinical research and bench-to-bedside translation, and eventually, research on how to do community-based intervention. The problem is that we have a bottleneck at the end of the "assembly line," where prevention research fails to focus on how to bring results to the community.

For example, a $174 million project of the National Institute of Diabetes proved convincingly that we can prevent diabetes with appropriate lifestyle interventions. But we still don't know how to actually make it work in the community. We need to focus on building capacity for community translation of knowledge into action.

The Yale Prevention Research Center has carried out several of these kinds of capacity-building studies, involving smoking cessation, physical activity promotion, diabetes prevention, and childhood nutrition education. A common feature of these projects has been a focus on working with the health professionals, consumers, or patients who were study participants to define the core issues at stake.

**Bill Whitmer, MBA**
**President and CEO**
**The Health Enhancement Research Organization (HERO)**

Nearly 7 out of 10 people who have a health insurance plan are insured through their employers. When we look at who is paying the bill in the U.S., Mr. Whitmer said, employers pay 55 percent of the roughly $1.8 trillion in health care expenditures. This is roughly $900 million off the bottom line. HERO is a national coalition of large employers established five years ago to do econometric research, using a 50,000 person database from six companies, relating modifiable health risks (both behavioral and for selected diseases) with individual health care costs.

Two years ago, HERO turned its attention to prevention, to see if employers could develop strategies and policies that would impact on health care costs. The first step was to establish the HERO Forum for Optimum Employee Health as a meeting place for interaction between employers, providers, and other stakeholders. The second step was to form a Strategic Leadership Alliance to

develop specific strategies for implementing workable prevention programs. And third, a HERO Coalition for Education and Networking was created to sponsor small scale regional workshops to look at how to actually implement these in the workplace.

In the process, HERO has developed a four-point definition of what it means to achieve through prevention:

(1) Programs to help low-risk or no-risk workers maintain that status, build wellness awareness in the workplace, provide regular on-site health assessments for workers, and provide education and motivational programs, and innovative incentive programs, for employee health promotion.

(2) Health management programs to prevent or reverse disease through regular employee health screening, and targeted behavioral health programs to reduce major health risks.

(3) Best practices programs, including pharmacologic and behavioral components, to control symptoms of disease and reduce future co-morbidities.

(4) Demand management programs, to help patients resolve health problems without physician or health plan involvement, where appropriate, through self-treatment resources and telephonic nurse advice services.

Other goals are to help companies break down the walls between various corporate divisions that need to work together to make these strategies and programs effective, and to promote self-responsibility in the workforce. Fifty to seventy percent of all disease and illness are associated with modifiable health risk and non-compliant behavior. If we don't start connecting self-responsibility with prevention we will never be able to control health care costs.

**Terrie Fox Wetle, Ph.D.**
**Associate Dean for Public Health and Public Policy**
**Brown University Medical School**

In 1900, the average life expectancy was 47 years. Today it is 77 years. If we reach age 65, we can on average expect to live to age 83. Unfortunately, Dr. Wetle said, with advancing age there is an increase in the burden of disease. Both chronic and acute conditions have a higher prevalence of disease among the elderly, and that, in turn, leads to major, staggering health care costs. Older persons represent 13 percent of the population, but account for roughly one-third of annual health care costs in the U.S. I would argue, she said, that there has been inadequate attention given to health promotion and disease prevention in the elderly. Less than two percent of the overall budget at the Centers for Disease Control, targeted to health promotion intervention research, is allocated to the health of seniors.

Prevention programs for the elderly pay off. For example, influenza vaccine is 56 percent effective in preventing respiratory illness, 53 percent effective in preventing pneumonia, 60 percent effective in preventing hospitalization, and 68 percent effective in preventing mortality in the 65 and over population. It is 80 percent effective in preventing mortality in the nursing home population.

Regular physical activity also promotes health. The benefits of physical exercise include: improved cardiovascular function, pulmonary function, muscular strength; decreased osteoporosis, falls and fractures; reduced constipation; decreased depression; and increased cognitive function. Unfortunately, inactivity increases with age. Persons age 45 and over who are physically inactive have more than double the health care costs of those who remain active—excluding those who have physical activity limitations. Even among inactive older persons, we can reduce the risk of mortality by more than half if we can get them moving.

Promoting health of an aging population can be done. Multifaceted programs work best. But they require that we pay attention to the special concerns, needs, and sensitivities of those to whom the programs are addressed.

**Deborah Riebe, PhD, Associate Professor**
**The University of Rhode Island**

Over the past 20 years, there has been a dramatic increase in the prevalence of obesity in the United States. Sixty-four percent of U.S. adults are either overweight or obese. Obesity is associated with heart disease, some cancers, Type-II diabetes, and other chronic conditions. It also has a negative impact on quality-of-life and psychosocial functioning.. Overweight and obesity also have a significant economic impact, Dr. Riebe said, accounting for 9.1 percent of total U.S. medical expenditures in 1998: $75 billion. Preventing obesity should be a U.S. health priority. However, most obesity research has focused on treatment rather than prevention.

The emphasis on preventing weight gain, in the first place, is an important goal, because the behavior change that is required to prevent small increments in weight is likely to be easier to sustain than behavior change needed to achieve and maintain large amounts of weight loss. A second important intervention goal is to focus on preventing weight re-gain following treatment-induced weight loss. The problem is compounded when overweight or obese persons have unrealistic weight loss expectations, and give up when these are hard to achieve.

Prevention also needs to focus on changing environmental factions, e.g., through nutrition education, healthy food preparation programs, advocacy to improve the quality of fast foods, physical exercise programs, and modification of the physical environment to facilitate walking and other regular physical activity.

**Steven L. Gortmaker, EdD, MS, PhD, Director**
**Society, Human Development, and Health**
**Harvard School of Public Health**

Overweight has been increasing among children for the past 30 years, Dr. Gortmaker said, but especially in the past decade. While we all know that weight gain is due to taking in more calories than we expend, the fact is that the obesity epidemic is being driven by rather small changes in the energy balance on any given day. And extra can of sugar sweetened beverage per day can add about 15 pounds weight over the course of a year.

Planet Health is an interdisciplinary health promotion curriculum for middle-school children, focusing on three educational targets for which there is a scientific basis for preventive interventions: (1) improving food nutrition, (2) reducing television screen time, and (3) increasing physical activity. Educational elements are delivered as part of the regular curriculum, e.g., in social studies, language, math, art, and physical education classes. Other intervention components include teacher training, a two-week TV time reduction campaign, and wellness sessions for teachers. The program avoids talking about overweight or obesity, per se. Rather, it emphasizes active things that students can do, such as healthy eating, reduced TV time, and increased exercise.

In a randomized controlled trial involving 1,400 middle-school children, the program found that Planet Health interventions reduced obesity among girls in the intervention vs. control schools, and reduced television viewing time for both boys and girls in the intervention group.

*Question:* What is the ideal diet?

*Dr. Katz:* In his opinion, 25 percent of calories from fat, 20 to 25 percent from protein, and the bulk of calories from carbohydrates—with the following caveats: fats should be polyunsaturated or monounsaturated, and carbohydrates should be in the form of whole grains, fruits, and vegetables.

*Question:* When people talk about "personal responsibility" it sounds very much like blaming the victim.

*Mr. Samuelson:* The issue of self-responsibility is key. But without awareness, without access, without portability, there will be no opportunities for self-responsibility. We need to provide an appropriate infrastructure, eliminate hunger, provide for the economic needs of the population. There is no such thing as self-responsibility until we have collective responsibility.

## WHAT WORKS IN SUBSTANCE ABUSE AND MENTAL ILLNESS PREVENTION

**Gilbert J. Botvin, PhD**
**Professor, and Director, Institute for Prevention Research**
**Weill Medical College, Cornell University**

The process in prevention research involves trying to understand risk and prevention factors in substance abuse, said Dr. Botvin, to design interventions which may be effective, and then to subject them to methodologically rigorous tests of efficacy. Research in the field begins with small pilot studies and graduates to large randomized trials. The major targets for prevention research have been children, primarily in school settings.

Early prevention interventions were based on efforts to educate children about dangers of tobacco and other substances, on the assumption that knowledge would motivate behavioral change. This approach proved to have limited effectiveness. The Cornell Life Skills Training Program takes a more comprehensive approach, with a focus on building problem-solving and decision-making

capabilities through enhanced cognitive behavioral skills and practice with assertive skills.

The Life Skills Training Program is offered for 15 sessions in the first year of middle school, and is repeated for 10 and 5 sessions respectively in the following two years to reinforce skills learned in the first year. Randomized trials have shown positive results in preventing smoking and drug use behavior.

Similar research by other investigators, using the same approach, has also demonstrated effectiveness in mental health areas, e.g., reducing aggressive behavior, anxiety, and depression.

## WHAT WORKS IN PREVENTION AND CONTROL OF HIV/AIDS

**Donna M. Gallagher, RNC, MS, ANP, FAAN, Director**
**The New England AIDS Education and Training Center**

The AIDS epidemic is getting to be 25 years old. But even with years of knowledge, public education, and highly effective medication, we are still looking at 40,000 new cases every year. In New York City, over the past three years, there has been a 17 percent increase in HIV cases. The good news is that many more people who are HIV positive are living healthy lives. The bad news is that many more people in the population have the potential to transmit HIV, either through sexual contact or IV drug use. Seven out of ten people with HIV are sexually active.

Who is at risk? Young people are particularly at risk. Upward of 79 percent of kids have intercourse before they are 17, and in some urban settings sexual activity begins at age 12 or 13. Clinicians are beginning to see increased STDs associated with oral and anal sex. Adults in communities of color have increasing numbers of new HIV cases. Women, including women over age 50, are increasingly likely to be HIV positive.

Two recent changes in federal health policy have a bearing on prevention. First, there has been a shift in funding from population-based programs, which educate everyone who may be at risk, to programs targeted to known HIV-positive people. The purpose is to reduce risk of transmission at the source. This is not unreasonable. But if it means cutting support for existing and effective population-based prevention programs, that will be counter productive.

Second, there has been a concerted effort to downplay, and reduce support for, using condoms to prevent HIV transmission—despite the fact that they are proven effective in controlling the spread of HIV. This is part of the Administration's overall preference for promoting abstinence. But it doesn't fit well with a prevention approach targeted to known HIV-positive people, 70 percent of whom are sexually active.

Finally, Ms. Gallagher said, we need to reinvigorate school education programs about HIV/AIDS and AIDS prevention. We very much need programs in schools that teach kids the skills they need to be effective and empowered decision-makers, which are essential if we expect them to be, and to become, capable of negotiating their sexual decisions, i.e., whether to have sex at all or to practice safe sex.

*Question*: Does seeing so many people living successfully with HIV reduce concern over getting the disease?

*Gallagher*: The availability of effective treatment has reduced some of the fear of contracting HIV, and there is now even a new population of young gay men who are actively seeking HIV infection.

## KEYNOTE ADDRESS

## THE SCIENCE OF PREVENTION: TRANSLATING DISCOVERY INTO POLICY AND PRACTICE

**Harvey V. Fineberg, MD, PhD**
**President, The Institute of Medicine**

It has been a quarter century or more since we first began thinking seriously about prevention. In that time we have made significant progress in developing a scientific basis for the design, testing, and implementation of health promotion and disease prevention interventions. Nevertheless, the science of prevention faces challenges.

The first challenge is to find ways to persuade people to do what is in their own best interest, and to enable them to do so, without blaming the victim. The science of prevention is partly about what would make a difference if we could do it, and partly about how to go about doing it, which involves social change, influencing individual behavior, allocation resources, and political will.

A second challenge centers around the invisibility of success when prevention works, and equally, the invisibility of costs to society when there is no prevention. We don't count the number of children each year who did not get measles because they were immunized. We need to make the invisible visible.

A third problem, said Dr. Fineberg, is that sometimes what we know is good for health comes into conflict with other values, other preferences, other ideologies. We may have a very clear idea of the value of condoms in preventing HIV transmission, for example, but it is hard to break through the resistance to condoms which is based on policy preferences unrelated to health. There are people who object to fluoridating water supplies, immunizing their children, or laws requiring use of motorcycle helmets, for reasons they believe are more important than the known health advantages.

Fourth, there is a fundamental disconnect between how we regard preventive interventions and therapeutic interventions. If a therapeutic intervention is cost-effective, we are delighted. But preventive interventions are not only expected to be effective, they are also required to save mone and to lower health care costs. That is an unfair double standard.

Fifth, when we talk about preventing conditions such as obesity, we need to understand that

these are not just problems of individuals, they are problems of a whole society. We are not just trying to get a better balance between calorie intake and expenditure for the individual—we need to shift that balance to a whole new spectrum society-wide.

Finally, another challenge to prevention is the delay between investment and return on prevention, which makes it hard for policy makers, operating in a shorter time frame, to give prevention the priority it deserves.

*Question*: How can we translate what is learned from academic research to what is practiced in communities on an everyday basis?

*Fineberg*: That is the $64 trillion question. I think we can propel the translation part if we are invested and systematic in evaluating the things we are already doing, today, and getting feedback regularly and systematically into the minds and practices of those who are delivering health care.

*Question*: What can we do to achieve more substantive collaboration between health professionals and other professional groups?

*Fineberg*: Any time you set up a specialized agency or professional group you are going to have an inherent focus in that organization on its own mission, profession, and expertise. One can try to bridge these "silos" through various collaborative mechanisms, such as interagency task forces or academic centers with specific problem-solving objectives.

## WHAT WORKS IN THE CONTROL OF OVERWEIGHT AND OBESITY

**Walter C. Willett, PhD**
**Professor of Epidemiology and Nutrition**
**Chair, Department of Nutrition**
**Harvard School of Public Health**

Everyone has become aware, said Dr. Willett, that obesity is a major problem in the United States, and this awareness is part of the science for controlling the epidemic. Without that awareness it would be hard to generate the energy or the willingness to invest the resources needed to deal with the problem.

What are the dimensions of the problem? Studies in which subjects are actually weighed and measured show a 30 percent prevalence of obesity, i.e., Body Mass Index (BMI) over 30, and another 34 percent who are overweight, i.e., BMI between 25 and 30. Moreover, many people in the 18 to 25 age range, with a BMI of 25, are still not at their optimal weight and are at risk for adding another 30 to 40 pounds as they grow older. Finally, since the 1960s, there has been a three-to-fourfold increase in the prevalence of overweight in children aged 6–11.

There are various basic science studies that contribute useful information about overweight

and obesity, e.g., test tube studies, animal studies, controlled feeding studies. However, randomized trials and epidemiologic studies are the most useful when it comes to developing and assessing interventions to modify human behavior. This is because they can take into account the physical, social, cultural, and policy environments which facilitate or impede behavior change.

The importance of increasing public awareness is illustrated by the impact of the Surgeon General's 1964 report, Smoking and Health, on tobacco use, notably in subsequent downward trends in smoking, and the organization of advocacy groups to control smoking. Similarly, getting the right information to the public on the relation of excess weight to health is the starting point for preventing obesity. There is ample evidence that obesity increases risk of morbidity, and premature mortality, from heart disease, diabetes, and other chronic conditions.

Several caveats are necessary, however. First, just looking at weight alone is not enough. Men in their 50s and 60s, in particular, can maintain their weight but increase waist size three or four inches, which is very bad for health. Second, it is important to look at weight change since early adulthood, to help define the best weight for an individual. And third, if a person is seriously overweight it is almost impossible to go back to the weight they were, so there is a distinction between goals for prevention and the goals for weight loss in people who are already obese.

What do we do about the epidemic? People can lose weight on both low fat and low carbohydrate diets at 6 months, but they tend to regain it by 12 months and beyond. The Mediterranean diet has proven more effective in losing weight and maintaining that weight loss. A number of studies have shown the value of reducing consumption of sodas and other sugar sweetened beverages.

In addition, there is an extensive literature demonstrating that increased physical activity has a modest beneficial effect on weight loss, but an important benefit in maintaining weight loss. Finally, TV watching is one of the most consistently strong predictors of overweight in children and adults. Turn off the TV.

*Question*: What do you think about the new 2005 dietary guidelines which are just about to be issued?

*Willett*: The new guidelines are an important step forward because they put the emphasis on type of fat being more important than just the percent of fat in the diet. The key message is to choose your fats carefully, choose your carbohydrates carefully. Avoid transfats, avoid foods high in saturated fats. On the carbohydrate side, focus on high fiber whole grains instead of refined starch and sugar.

## PANEL: BUILDING STATE COALITIONS FOR PREVENTION

**Moderator, Patricia Risica, DrPH**
**Assistant Professor, Brown University**
**Institute for Community Health Promotion**

What we learn from research requires collaboration among public, private, and community organizations for implementation. Mr. Whitmer described worksite collaborations, Dean Wetle talked about coalitions for preventing influenza, and Dr. Gortmaker described school-based collaboratives to strengthen students' decision-making skills. Our panelists, this afternoon, will describe coalitions that have been effective in the business of prevention in their states.

**William Gerrish, MBA, Director**
**Office of Planning, Communications, and Workforce Development**
**Connecticut Department of Public Health**

Building and working through coalitions has become increasingly important for the Department of Public Health, said Mr. Gerrish, because it is difficult, and sometimes impossible, for the Department to accomplish public health goals by itself. Consequently, we have been actively pursuing strategies of building and working with coalitions to integrate our programs at the community level.

For example, in 2001, the Department developed an asthma management protocol for integrating and standardizing care across multiple settings. The protocol was presented to providers and stakeholders at a state asthma summit, and a number of task forces were set up to address specific issues, e.g., with regard to clinical medicine, provider education, public education, and environmental issues. Task Force members were charged with developing a state asthma management plan incorporating the new protocol. The plan has now been completed and the Department is meeting with local health directors, and scheduling stakeholder meetings in the state's 10 bioterrorism regions.

Other examples include establishing and staffing a Health Care Advisory Committee for the Homeless, a viral hepatitis collaborative program, and a statewide bioterrorism program.

Finally, collaboration with public health professionals in other states, e.g., through the National Public Health Information Coaliton, and NECON, has been tremendously helpful, he said, in sharing information and coordinating responses to common public health problems.

**Christine C. Ferguson, JD, Commissioner**
**Massachusetts Department of Public Health**

Massachusetts has been very successful, over the past several years, in assembling the expertise to develop and disseminate best practices. For example, we established the Betsy Lehman Center for the Promotion of Patient Safety and the Reduction of Medical Errors. The first thing the Center did was to assemble the best practitioners in the field of weight loss surgery to develop and promote a statement of "Best Practices and Outcomes."

Other efforts, Dr. Ferguson said, include examination of how substance abuse impacts on all of the services the Department provides statewide, exploring opportunities for health department collaboration with law enforcement and criminal justice systems, and an outreach effort to familiarize the public with the relevance of public health to their lives.

Finally, she wanted to say a word about obesity. We have a enormous responsibility to work with people who are overweight in a positive, non-judgmental way. We have a lot of "evidence," e have a lot of information about interventions that work. But we have to be careful how we work with people, and especially kids. How we approach kids is going to affect them for the rest of their lives, not only their weight, but how they are perceived by others and how they perceive themselves.

**Patricia A. Nolan, MD, MPH**
**Director of Health**
**Rhode Island Department of Health**

Public health is about what we do as a society to assure the health of all of the people in society. It is not what we do as health departments, or as researchers, or as physicians, but what we do collectively.

A successful example of long term efforts by a coalition in Rhode Island is the Coalition to End the Scourge of Tobacco, which has just succeeded in getting worksite smoking ban legislation enacted. And the lessons learned in our tobacco initiative can help us in working together in the area of overweight and obesity, that is, in changing our physical activity and eating habits.

We learned two important lessons from the tobacco control campaign, said Dr. Nolan: (1) that advertising works, and that if we don't have advertising to counter the opposition's advertising, we are not going to achieve the goal; (2) we need to remember that it is the goods that is the problem, not the person who consumes the goods.

Dr. Nolan agreed that taking personal responsibility for one's health is important, but we have to recognize that we live in environments which drive behavior, and that we have to modify those environments in order to make it easier for people to take personal responsibility. For example, there are a lot of diets being promoted to lose weight, but low income families often cannot afford to buy the food required by those diets.

Two additional coalitions that have been effective in Rhode Island are the Worksite Wellness Council and Healthy Schools/Healthy Kids. The former gives us access to employers to discuss coverage under employee benefit plans, making the worksite a healthier and safer environment, and programming to promote healthier employee lifestyles. Obviously, healthier worksites and lifestyles will also help control health care costs. The Healthy Schools/Healthy Kids coalition works with schools, both to strengthen health education programs, and to increase student physical activity during the school day.

**Donald Swartz, MD**
**Director of Maternal and Child Health**
**Vermont Department of Health**

Almost half the residents of Vermont are beyond the range of prevention, in that they already have one or more chronic conditions. The cost of maintaining medical services to address their conditions is enormous and crippling. Finding money for prevention, under these circumstances is extremely difficult.

Our response has been to develop the Vermont Blueprint for Health, which includes a broad focus, not just on primary prevention, but also secondary and tertiary prevention throughout the life span.

The Blueprint is designed to do for every Vermonter what we already know how to do around health care and health maintenance. The coalition established under the Blueprint involves all relevant stakeholders: payors, providers, patients, employers, academics, and public agencies. We have organized the coalition, Dr. Swartz said, into six problem-solving committees to move the plan forward on a broad front: (1) self-management, (2) provider practice, (3) information systems, (4) the health care system, (5) improving lifestyles, and (6) the role of government.

In addition, the Department is developing centers of expertise in cross-cutting problem areas such as tobacco control and obesity. In addition to fielding specialized programs these centers will provide technical assistance and support services to chronic disease programs in their fields.

*Question*: Simply pulling people together doesn't make them a coalition. The most successful coalitions are those made up of organizations with strategically recognized shared mutual interests.

*Nolan*: People have to work together, and sometimes you have to work with people with whom you disagree, or who have a totally different outlook or value set. Indeed, sometimes it is more important to work with these people than with those who are your traditional partners.