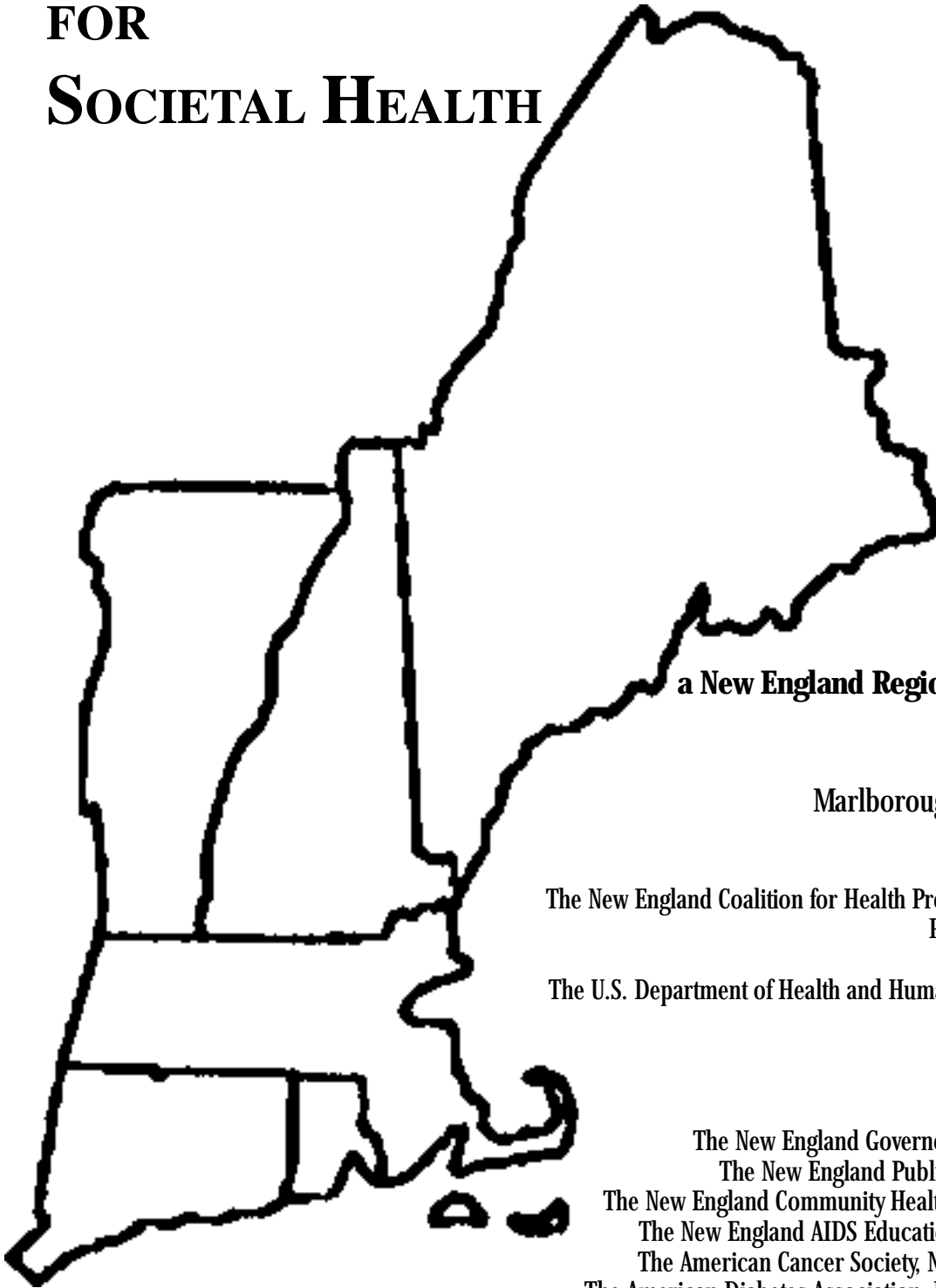


MARKETING PREVENTION FOR SOCIETAL HEALTH



**Proceedings of
a New England Regional Conference**

October 22, 2002
Marlborough, Massachusetts

Presented by:
The New England Coalition for Health Promotion and Disease
Prevention (NECON)

The U.S. Department of Health and Human Services, Region I

Co-Sponsored by:
The New England Governors' Conference, Inc.
The New England Public Health Association
The New England Community Health Center 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 Affiliates

The New England Coalition for Health Promotion & Disease Prevention (NECON), established in 1984, is a coalition of New England state health departments, the region's schools of public health, federal health agencies led by the U.S. Department of Health & Human Services, Region I, as well as educators, legislators and representatives from industry, labor and voluntary associations.

A non-partisan organization, NECON has become a widely respected vehicle for the development of health related public policy in New England, providing recommendations to both the region's governors, through the New England Governors' Conference, Inc., and its legislators, through the Caucus for New England State Legislatures.

Support for NECON activities comes from a variety of public and private sources. Among them are: The Robert Wood Johnson Foundation; the U.S. Department of Health and Human Services; Region I; the New England AIDS Education and Training Center; American Cancer Society, N.E. Division; American Heart Association; GlaxoSmithKline; CVS; PharmaCare; Blue Cross Blue Shield of MA; Citizens Programs Corporation; Bristol-Myers Squibb Co.; Sanofi; the Metropolitan Life Foundation; the Jaffe Foundation; Aventis; Harvard Pilgrim Healthcare Foundation; Abbott Laboratories; Massachusetts Medical Society; Legal Sea Foods; Wyeth-Ayerst Laboratories; the Ira S. and Anna Galkin Charitable Trust; AstraZeneca; the Pierce Foundation; Merck & Co.; Tufts Health Plan; the Donaldson Charitable Trust; the Amelia Peabody Charitable Fund; American Diabetes Association; American Lung Association; and the Yaffe Foundation.

To share your comments or for further information, contact NECON at One Meeting Street, Providence, R.I. 02903 or call (401) 351-5130.

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FOREWORD

This report summarizes proceedings of the NECON/DHHS conference titled *Marketing Prevention for Societal Health*, held at the Royal Plaza Hotel & Trade Center, Marlborough, Massachusetts, October 22, 2002.

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 (DHHS), 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 & 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 Affiliates.

Since 1994, the focus of a succession of NECON annual conferences has been on collaboration for public health -- among the six New England states, between the public and private sectors, and between public health and medicine. A series of specialist working groups and task forces has made detailed and far reaching recommendations pertaining to some of the most important health problems facing our society: tobacco abuse, 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, 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 agenda for the region.

Initial 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 undertook the task, through studies conducted by regional NECON working groups, of specifying strategies for addressing unmet health needs, through education, policy change, legislation, and new service programs. This year's program has focused specifically on how to market action recommendations to policy makers, consumers, schools, worksites, and the health care system.

We would like to acknowledge the contribution of the NECON Working Group (see appendix) which is responsible for planning these conferences. Our thanks, also, to presenters, panelists, and workshop chairs. This report was edited by Avery M. Colt, Executive Director of the Rhode Island Public Health Foundation. Conference management services were provided by Carol McCullough

Brian M. Cresta
Regional Director
DHHS, Region I

Bertram A. Yaffe
Chair, NECON





EXECUTIVE SUMMARY

Overview

Once we know what needs to be done how do we advance to the all-important step of implementation? The challenge put to the participants at this year's conference was to identify the mechanisms for bringing essential resources into play and engaging key decision makers in promoting social health. Put another way, how do we market health promotion and disease prevention recommendations to the policy makers and stakeholders in the New England states who can make recommended policies and programs a reality, especially when state economies are in recession and state budgets are in deficit?

Resource Centers for Generating Action

One of the underlying premises of NECON is that government cannot do it alone but must work with the private sector, the non-profit sector, and with community leaders if we are to realize our common public health objectives. As these proceedings demonstrate, the number of entities whose resources can make a significant contribution, and are potential partners in state and regional efforts to deal with outstanding health issues, are multiple and varied. Conference participants identified a number of key policy makers and stakeholders who are the necessary resource centers for generating action, and who have to be engaged in a coordinated effort to improve the health of New England residents.

The federal government is a major source of policy leadership, model program design, and financial support for research and services. At the state level, governors and legislators are key policy makers and allocators of scarce financial resources; and executive departments of state government play an important role in executing health policy and managing health programs. Local governments occupy a strategic position in the interface between the state and the community, i.e., between those who serve and those who are served.

Hospitals, schools, and employers have been identified as stakeholders whose resources are often unused or underused for health promotion and disease prevention, but whose participation is of particular importance because they have access to large segments of the population as patients, students, employees, and their families.

The region's academic institutions also have the capacity to bring important resources to the table as educators, as sources of specialized expertise, and particularly in developing the data required for effective planning and evaluation.

Finally, the development of state and community level coalitions, involving policy makers, service providers, and consumers, has proven effective in advocating for the public health agenda; a prominent example is tobacco control.

These are the individuals and institutions to which we have to market health promotion and disease prevention if we are to gain their political support, access to their resources, and their active participation in coordinated action.

Marketing Methods

In the course of the conference both presenters and workshop participants identified marketing efforts which have proven effective. These include:

Awareness Building. The first step is to make policy makers, stakeholders, and the public at large aware of unmet health needs and their adverse effects. Publicity in the mass media is particularly effective, so is the convening of statewide conferences involving all of the parties who form the community of solution for a given problem. Benchmarking, identifying solutions that have worked in other jurisdictions, is a way of showing that even hard problems are not insoluble.

Mobilization of Support. In order to get action you have to build a movement. Publicity is useful, but this needs to be combined with outreach to the public, and the establishment of coalitions that can advocate for change with policy makers and stakeholders.

Incentives. The most important incentives involve money: public investment to promote policy objectives, of which federal grant programs offer the classic example; and tax policy, which can be used to raise revenue while furthering public health goals, e.g., cigarette taxes, or tax incentives, which have been proposed for encouraging greater involvement of employers in health promotion programs. But there are also non-financial incentives, such as political support for key policies and acknowledgment of the role played by policy makers in solving public health problems.

Enforcement. Policy makers and stakeholders are in a key position to institute requirements for behavior change, e.g., use of the licensure process in Massachusetts and legislation in Rhode Island to enforce “community benefit” schemes, legislation to prohibit smoking in public spaces, and the designation by employers of “smoke free” worksites. For better or for worse, litigation has also become a means for securing action, in both the public and private arena, on outstanding health problems.

Support Systems. Securing and maintaining public health objectives requires the development of dedicated infrastructure, such as offices of minority health, interdepartmental coordinating committees, and public-private councils and coalitions; development of information systems to support strategic planning and monitor outcomes; and training of personnel.

All of these approaches, and combinations of approaches, can be used to draw attention to health needs of the population and promote remedial action by those who possess the resources needed to resolve them.

Presentations

Over 70 percent of premature deaths can be postponed by implementing health promotion and disease prevention techniques already at our disposal. Indeed, two-thirds of premature deaths and much of the burden of disability are due to just three negative health behaviors: tobacco use, inadequate and inappropriate diet, and physical inactivity. The challenge, Bert Yaffe said in his opening remarks, is to more effectively *market* prevention to the policy makers, the stakeholders, and the consumers of New England.

Over the past year, and especially since September 11th, Americans have become highly aware of the importance of prevention, observed Brian Cresta. Our politics and our policymaking have frequently been reactive. They have been driven by interest groups, sometimes by partisanship, by budget shortfalls, and by stubborn bureaucracies. But our public health system has been sounding the message of prevention for decades: that there is suffering to be prevented, there is money to be saved and spent in better ways, that if we pay attention to bad things before they happen we can sometimes prevent them from happening and almost always make them less bad than they would have been otherwise. And implicit in the idea of prevention is recognition of the power of public-private partnership, and the need to make public investments with a view to long-term rather than just immediate benefits.

Panel Discussion

Prevention is the core of what we do every day, said Dr. Howard Koh, but today prevention is under siege. More and more, as state budget deficits mount, we are being told that these are tough times and the money isn't there for investing in prevention. "Imagine how short sighted that kind of thinking is. If you think prevention is expensive, wait until you see what disease costs you." Prevention has to be built into strategic plans, so that whatever the ups and downs of the appropriation process, the goals of public health are established and carried forward, whether we are talking about health disparities, or upgrading emergency medical services, or training health professionals.

There are three things you have to keep in mind, said Representative Koutoujian, in seeking legislative support for prevention. First, you have to demonstrate the value of your requests for legislation or appropriations. They have to be shown to be effective in terms of both health and costs. Second, proposals have to be presented in ways that are easily understood by legislators who are overloaded with work and are being bombarded by requests. Third, legislators are political beings, and proposals for preventive programs and investments have to show benefits which they can be proud to claim. One of the best ways to get an issue before the legislator is to put a face on it. Reports are dry stuff but the testimony of people in need is immediately understandable and fires the imagination. And in looking for champions, advocates need to go, not only to legislators who are already on their side, but also to legislators who have known political influence.

Dr. Nolan stressed the importance of taking advantage of program and funding opportunities as they arise, even if sometimes they are in areas that seem to be wide of the main thrust of public health. Recent funding for bioterrorism programs, for example, can be used to build and use an improved public health communications infrastructure. She was also concerned that it was so difficult to sell the public health role in chronic disease. It is hard for people to get excited about lifestyle changes today which may not provide benefits for many years. Two things that can be done are to find ways to *show* people the adverse effects of not adopting preventive regimens, and to shift the focus from telling people what they can't do to what they can do.

From Dr. Garcia's point of view one of the most important ways to sell prevention is to go directly to the people, to involve community leaders, and to understand their priorities. Given the financial limitations on the ability of health agencies to develop new programs on their own, he felt that we should identify and replicate programs that have already proven effective elsewhere.

Keynote Address

Reducing and eliminating disparities in health care is one of the top priorities of the Bush Administration, said Secretary Claude Allen. Ever since we began keeping federal health records, our data have shown vast differences in the burden of death and illness experienced by communities of color compared with the nation as a whole. The statistics are simply unacceptable. But the problem cannot be solved by government alone. It is going to require the collective effort of providers, communities, faith institutions, and indeed, all of us as individuals, working with government.

The federal government does have a major role to play in applying its formidable research capabilities to health disparity issues. Under the current administration, the Department of Health and Human Services is moving to address the issue in several ways. These include strategic planning and improved review of budget proposals to assure conformance with national policy, investment in research and demonstration projects, and internal agency performance plans; health promotion using media targeted to disadvantaged populations; efforts to improve literacy; and significant additional investment in direct services with a focus on expansion of the community health centers network in the United States.

Finally, he felt that the concept of cultural *competency* needs to be expanded to a broader concept of cultural *literacy* if we are to make headway against health disparities. The former seeks to improve communications across cultural lines; when what we really need to do is to eliminate those barriers.

Tales from the Trenches

We have a problem in the United States, said Dr. Evans, with an epidemic of obesity. Poor eating habits and lack of exercise have resulted in significant increases in Body Mass Index readings in the population. Sixty-five percent of Americans are overweight (BMI >25) and 30 percent are frankly obese (BMI >30). These are powerful risk factors for Type II diabetes and cardiovascular disease.

The driving force behind the rising costs of cardiovascular disease reflects the widespread use of expensive pharmaceuticals and rapidly expanding utilization of interventional technology. Yet we have known for a long time that risks of cardiovascular disease, and subsequent costs of care can be sharply reduced, and early signs of cardiovascular disease can actually be reversed, by changing people's eating habits and increasing their level of physical activity.

There are only three sources of calories in the world, he said, "protein, carbohydrates and fat." We shouldn't have more than 30 or 40 grams of fat a day. The rest of our calories have to come from carbohydrates, and the amount people eat will determine their weight. Red meats and processed meats should be avoided, and eggs, whole milk, butter, cheese, and margarine should be strictly limited, because they contain saturated and trans fats. What fats we do eat should come from plants and fish.

Ms. Cone has spent 23 years helping companies, nonprofits, foundations, and government agencies communicate health messages to consumers. She wanted to discuss certain precepts that

she had found were keys to success, based on programs she had designed, e.g., the Massachusetts Tobacco Control Program and the Rockport Walking Promotion Program.

Romance the Issue. Find methods that are appropriate and relevant to reach the target population, and remember that this population is diverse, and can no longer be reached through only one general channel of communication. Make it personal and exciting.

Start a Movement. If you want people to start walking you have to start a walking movement, and the movement has to have a face on it, like Robert Sweetgall who walked across America stopping at schools along the way to promote physical exercise. And the movement has to have a clever slogan, like “Walk for the Health of it,” or “Let’s Make Smoking History.”

Use the Science. Know how to use “science” to legitimate the social issue you are marketing. To promote walking she commissioned studies of the health benefits and then promoted them through the media.

Have a Call to Action. Consumers need more than information and exhortations. You have to give them tools to work with, simple things they can do for a start and from which they can see results.

Grassroots Communication. You can’t just preach at people from a distance, you have to communicate with them face to face, where they live, and engage participation.

Surround the Issue. No one approach works by itself. You have to surround the issue. You have to imbue the effort with passion. You need to find partners with whom to create a movement. You need to put a face on it. And you have to use the popular culture because it influences so much of what people do.

Luncheon Address

The breadth of traditional and new emerging challenges to the health of our nation, said Senator Reed, requires that we have a strong and flexible public health system, for both prevention and response. As our population grows older, health care costs can be expected to continue rising. We face a shortage of skilled health care professionals, which also has an impact on costs. Controlling costs, and financing increased costs, will be major issues in the new century and will affect the public health system’s ability to do its job effectively.

What are some of those challenges? One priority, certainly, is prevention of disease and disability through conversion of the population to healthier living: proper nutrition, adequate exercise, weight and blood pressure control; responsible sexual behavior; avoidance of tobacco and controlled substances, use of alcohol in moderation; stress and violence control; age-appropriate immunization. All of these are areas in which choices made by individuals are the key to positive action and outcomes. Beginning with *Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention* (1979), the federal government has provided continuing leadership in the effort to promote prevention: to the public, to health care providers, and to the public health system. The publication of *Healthy People 2010*, with its documentation of health disparities and its health behavior and outcome targets, has given new specificity to this effort.

Other challenges are new and unexpected — the emergence of West Nile Virus, the growing resistance of diseases such as tuberculosis to antibiotics, the threat of biological or chemical attack by terrorists — and require public health system response. As we move into the 21st century we need to keep in mind that our major health gains in the past hundred years have largely been victories of public health, and that it continues to be a powerful and essential tool for the future well being of our citizens.

Workshop Sessions

Mental Health

For many years the stigma attached to mental and behavioral disorders has led people to believe that nothing could be done in the field of prevention, and indeed, until recently there wasn't much scientific evidence that health promotion and disease prevention were possible. However, a 1996 study, *The Global Burden of Disease*, has changed the way in which we look at statistics and has emphasized the importance of promoting mental health. For example, psychiatric conditions were responsible for only 1.4 percent of deaths world wide in 1995, but accounted for 11 percent of mortality plus disability, and were expected to account for 28 percent of all years of life lived with a disability. Moreover, new research in recent years has begun providing scientific evidence that mental health promotion and prevention programs, such as nurse home visiting, alternate thinking strategies, and depression control, can achieve positive outcomes and are cost-beneficial.

The State of Connecticut has made significant progress in prevention by establishing an interdepartmental effort to promote prevention collaboratively and across the board. Following the establishment of a Blue Ribbon Task Force on Substance Abuse, and then a Blue Ribbon Panel on Mental Health, the state gave new prominence to mental health by establishing the Connecticut Prevention Council, which is currently in the process of preparing a prevention plan for submission to the legislature.

Within the Department of Mental Health and Addiction Services, Connecticut is following the guidance from the Blue Ribbon panels in several ways: developing partnerships with public agencies at the state and local level, community-based organizations, non-profits, and providers; piloting or replicating science-based programs and best practice models; and through local capacity-building efforts.

Racial and Ethnic Disparities

Geographically, Maine is as large as all the other New England states put together, but has a population of only 1.27 million people, of whom 96.8 percent are white. The minority population is so small that it often goes unnoticed. At the same time it is remarkably diverse. In the Portland school system, for example, students come from families that speak 57 different languages. Southern Maine has a relatively comprehensive health care system but the minority populations, especially new immigrants, have difficulty accessing health care services due to cost, language barriers, and lack of familiarity with the system.

Largely for financial reasons Maine has not yet established a state office for minority health. However, the Office of Rural and Primary Health Care, in the Bureau of Public Health, has assumed responsibility for minority health and contracted with the Muskie Institute at the University of Southern Maine for data collection and analysis, the Center for Transcultural Health at the University of New England to identify health needs of minority populations in the southern part of the state, and the Wabenaki Mental Health Center to do the same for the Native American tribes in the state. The University of New England is an important resource because it houses most of the health professions education schools in Maine.

Of particular interest is the Race, Class, and Health Community Partnership established at the Center for Transcultural Health, involving all major public and private stakeholders with a role to play in addressing minority health issues. The Partnership has established a working relationship with the Parent-Community Specialist Team at the Portland School Department, a group of 12 to 16 individuals representing 20 different cultural groups that have relocated to Maine, and provides direct assistance in identifying unmet health needs of these populations. An initial effort of the Partnership has been to facilitate access of minority groups to dental services in southern Maine.

Obesity Prevention and Control

NECON's Regional Prevention and Control of Obesity Working Group has developed a first draft strategic plan for obesity prevention and control, under the leadership of Dr. Walter Willett, Chair of the Department of Nutrition at the Harvard School of Public Health. Workshop participants were asked to divide into groups to develop priority recommendations for inclusion in the plan. Some of the major proposals included:

Nutrition. Enact legislation requiring chain restaurants to provide information on calorie content on menus and nutrition labeling on food wrappers; develop partnerships with private sector providers of food at public venues to improve nutritional value of food served; place a tax on sugar sweetened beverages such as sodas and use revenues to support nutrition education programs; expand state infrastructures and subsidies to support expansion of "farmers' markets."

Physical Activity. Develop and fund state and regional weight control programs; provide tax incentives to encourage large employers to provide weight management programs at worksites; secure health insurance premium discounts for employers offering certified worksite fitness programs; promote worksite-based health risk assessment programs.

School and Community-Based Programs. Establish community report cards on obesity so communities can see where they rank and repeat periodically so that communities can monitor their progress; improve the nutritional value of food served in schools; enhance school facilities and physical environments that promote physical activity; strengthen health education programs in schools with regard to nutrition, physical activity, and obesity control; improve training and credentialing of school staff.

Information Systems. Agree on consistent methods and use of comparable health indicators across jurisdictions reporting obesity data; develop data reports reflecting trends with a view to use by a broad range of public and private users, and assist them in analyzing and applying these data; work with health maintenance organizations and health insurers to gain access to the data they maintain on populations they serve.

Women's Health

The workshop opened with a review of key recommendations of the Women's Health Task Force to the six New England governors and directors of state health departments. This was followed by a report on progress in each of the New England states in establishing an infrastructure to promote women's health, e.g., an office of women's health or otherwise assigned personnel, state reports on women's health statistical data, and convening of statewide stakeholder groups. All of the states have made important progress since establishment of the Task Force. The workshop closed with a review of progress in development of a regional women's health data system and interpretation of preliminary data.

Cardiovascular Health

The Berkshire County Medical Center has developed a program that takes advantage of inpatient stays for cardiovascular conditions to institute primary and secondary prevention, including patient education on cardiovascular risk factors and prevention methods, and education of medical personnel in appropriate prescription of medications. The latter is particularly important because recent research indicates that prescription of combinations of medications (aspirin, statins, Beta Blockers, Ace Inhibitors) have a cumulative preventive effect that reduces likelihood of subsequent cardiac events.

The Maine Cardiovascular Health Council, established in 1977, has been effective in bringing relevant stakeholders together to develop statewide standards for hypertension control, securing major investment of Tobacco Settlement monies in smoking control programs, raising funds to match Medicaid support for cardiovascular screening and nurse case management programs in Maine hospitals, worksite health promotion activities, and securing federal grants.

A major focus of the Cardiovascular Health Initiative of the Massachusetts Department of Health has been to modify public and private policies in areas that affect cardiovascular health. A statewide coalition has been established whose first task has been to conduct surveys to identify targets for policy change in worksites, the health system, and in communities. Initial survey results indicate that 86 percent of industries with 50 or more employees have smoke-free workplace policies, but fewer than half have effective systems in place for enforcement; that hospitals were fairly effective in establishing clinical preventive practices, e.g. screening and health education policies, but that relatively few medical group practices were actively engaged in primary or secondary prevention, or tracked patients who had experienced heart attacks or stroke; and that in community settings, town planners were largely unaware of the opportunities they had to promote improved health behaviors in the population.

Cancer Prevention and Control

A review of state action to implement recommendations of the NECON Cancer Working Group indicates a certain level of progress but much still to be done. Rhode Island has enacted legislation requiring health insurance coverage for participation in clinical trials and a similar bill has been introduced in Maine; each of the New England states has enacted a Patient's Bill of Rights but they vary in inclusiveness; there are still variations in the structure of state tumor registries, e.g., with regard to staging systems, which prevents comparable analysis across jurisdictions; Maine has a fully funded 5-a-day nutrition program; New Hampshire has banned smoking on school property, indoors and out; none of the states has yet established tax incentives for employers who establish physical activity and wellness programs.

Panelists reporting on cancer control efforts in their states indicated that Rhode Island has begun responding to a state initiative requiring the establishment of community cancer control task forces in each city and town; Connecticut has established a comprehensive cancer consortium to analyze cancer data and has received a \$147,000 federal grant to develop a state cancer control plan; a Cancer Consortium has been established in Maine and is conducting a retrospective chart audit at 10 hospitals to determine adequacy of pain management efforts with funds from the American Cancer Society and a major managed care organization; Vermont has applied to the Centers for Disease Control for a cancer planning grant and has an on-going tobacco control program; New Hampshire's cancer planning grant proposal was approved but not funded, but planning efforts are being continued under the auspices of the Division of Chronic Disease Prevention; and Massachusetts has developed a comprehensive cancer control program and a statewide coalition has been established to further its implementation.

Adolescents Living with HIV

With the introduction of HIV reporting in Massachusetts, a clearer picture of the epidemic is emerging. Of particular concern is the increasing number of youth who are living with HIV, of whom a disproportionate share are adolescents of color, and an increasing proportion are female. Like all adolescents, those who are living with HIV are vulnerable to psychosocial pressures and engage in risk-taking behavior. In their case, however, there is elevated potential for harm to themselves and to others due to being HIV positive.

The states must address the needs of adolescents living with HIV through a comprehensive effort with the following components: training primary care physicians to recognize and respond to the psychosocial concerns of their HIV patients; developing outreach programs to establish relationships with HIV positive adolescents and educate them to methods for preventing transmission and the availability of health and social services; providing supportive counseling and case management systems to address personal issues and access a comprehensive range of services; developing more effective health education programs with HIV/AIDS information in schools; establishing programs to assure that these youth have stable positive home environments and accessible social and athletic activities. Adequate and sustained funding for these programs must be provided by the states.

MARKETING PREVENTION FOR SOCIETAL HEALTH

WELCOME AND INTRODUCTION

Bertram A. Yaffe, Chair, NECON

On behalf of the U.S. Department of Health and Human Services, and our many supporting sponsors, we welcome you to NECON's annual conference. Today's program is dedicated to reaffirming our commitment to NECON's core mission: promoting prevention. To that end our agenda is divided among three equally important segments. The morning segment specifically addresses the reality that the *reach* of our knowledge base about the benefits of health promotion and disease prevention far exceeds the *grasp* of our ability to effectively market these programs.

The Centers for Disease Control estimates that over 70 percent of all premature deaths can be postponed by implementing health promotion and disease prevention lessons that we have already learned. Indeed, two-thirds of premature deaths and much of the burden of disability are due to just three negative health behaviors: (1) tobacco use, (2) inadequate and inappropriate diet, and (3) physical inactivity.

The costs of preventable diseases are immense and escalating. We are committed to the primacy of prevention, however, not because it saves money, although it will do that in many cases, but because it prevents suffering and enriches the quality of life and improves the efficiency of our society.

The noon segment celebrates the value-added benefits of regional collaboration to the health of all New Englanders. Our region has always led the country in public health expertise, research, and premier medical care institutions. Rhode Island Senator Jack Reed, a member of the U.S. Senate Health Care Committee, will explore the advantages of our unique-in-the-nation cross-border sharing of expertise and experiences. Senator Reed's perspective is particularly pertinent because of his leadership role in the field, and because New England has six members on the Health Care Committee, one-third of the membership of that group. A collective New England voice for health care will resonate among the members of that committee.

The third segment, our workshop group breakouts, is devoted to evaluating and enhancing implementation of the strategies we have proposed in the action recommendations NECON has placed before the New England governors, legislators, and policy makers. In August we gave our annual report to the governors as they met with the Eastern Canadian premiers in Quebec City. Chair of the Women's Health Care Task Force, Laurie Robinson, presented an overview of advances in the development of an infrastructure for women's health in the New England states, and emphasized that a community of healthy families depends on a community of healthy women.

Durell Fox, Project Director of the New England HIV/AIDS Education Consortium, and a member of NECON's HIV Working Group, reported that due to advances in treatment and care, children born with HIV are increasingly living into adulthood. There are more HIV positive youth in the nation, and in New England, than at any time in history. They are going through the normal cycle of adolescent development, which includes risk-taking, and this requires that we allocate increased resources for both primary and secondary prevention.

As Chair of NECON, I gave a report on the implementation program for what we call our *hexagon of health*, the six priority health recommendations plus the cross-cutting issue of mental health that we presented to the governors in the year 2002. In that report we emphasized the devastating health effects and economic impact of rampant obesity in the nation, and in this region. We also stressed that obesity is eminently preventable and reported that NECON has received funding from Abbott Laboratories and the National Institutes of Health to create a Regional Prevention and Control of Obesity Working Group.

This group, under Dr. Walter C. Willett, Chair of the Department of Nutrition at the Harvard School of Public Health, will present to the governors in 2003 a strategic plan for increasing the proportion of each state's population that consumes a nutritionally appropriate diet and is engaged in daily physical activity.

Prior to that, on February 11th, there will be a NECON legislators' and health policy makers' forum on nutrition, physical activity, and obesity control. The purpose of that event will be to invite the policy makers' response to a draft of the NECON/Harvard School of Public Health obesity control strategic plan.

Another significant step toward implementation since we last met was a New England state legislators mental health seminar that was held last November at Sturbridge, Massachusetts. Fourteen legislators from the six states met with New England's mental health policy makers to consider strategies for implementing recommendations set forth in *The Time Is Now*, the report of the NECON working group on mental health which was presented by Chair, Dr. Joseph Bevilacqua, to the Governors Conference last year. That report, and the seminar, attracted the attention of the Center for Mental Health Services, in the U.S. Substance Abuse and Mental Health Services Administration. We are pleased to welcome Dr. Nancy Davis, who is here with us today, who is a public health advisor to that agency.

This has also been a year in which we have strengthened our bonds of partnership among the public, private, and voluntary sectors, as well as academe. We are pleased to announce that the President and CEO of Legal Seafoods, Roger Berkowitz, has informed us that his restaurant chain will be sponsoring an evening with Florine Mark, President and CEO of Weight Watchers on November 7th, and will be donating the proceeds to the NECON Prevention and Control of Obesity Working Group.

And now we ask that you join us in our annual celebration, share your insights and recommendations, and know that we shall present them to the New England Governors' Conference, as well as to other regional health policy makers, as catalysts to accomplish the NECON vision. It is a vision of increased public, private, and voluntary sector collaboration; enhanced effectiveness of prevention programs; and a robust political will to improve the health of all New Englanders.

Brian M. Cresta

Regional Director, Region I, US DHHS

A year ago I stood here, very new in the position, and at the time all I could pledge in the shadow of days after September 11th was my continued support and commitment to public health, not really knowing what was facing our region and our country. In the year that has passed, our world has changed and changed radically. In some cases it is a world we can't even recognize.

There are two lessons, I think, that are worth noting as we gather to take stock of the progress we have made on public health issues.

The first is the lesson of prevention which has been taught to us in the cruelest of ways imaginable, a lesson American government and politics have just learned but which the public health world has known for a long time; that there is no response, there is no reaction, there is no mitigation that can match the power of preventing something that can happen in the first place.

Our politics, our policy making, have always been reactive. They have been driven by interest groups, sometimes by partisanship, and something we all know these days, budget shortfalls, and by stubborn bureaucracies. But our public health system has been sounding the message of prevention for decades: that there is suffering to be prevented; there is money to be saved and spent in better ways; that if we pay attention to bad things before they happen we can sometimes prevent them from happening, and almost always make them less bad than they would have been otherwise.

That requires planning and investment in the long view, which is hard in politics, but is absolutely critical for social progress. It also requires accepting that bad things can, and will, and do happen and that the uniqueness of our humanity is our ability to see that, plan for it, and prevent the suffering and disability and death that doesn't need to happen.

As our country continues to face grave and wrenching decisions about preparedness, a faltering economy, and acts of violence every single day, we need to stop and remember that the principles which underlie public health and our public health system can guide us into making decisions which can take into account long term consequences, unexpected results, and the meaningfulness of investing in change which, in many cases, cannot be seen right away.

The second lesson that the past year has brought home is the power of partnership. I don't know anyone, anywhere, no matter what his or her political stripes are who thinks that government can succeed on its own. If you look at any of the NECON working groups — obesity, women's health, health disparities — you will see collaboration across many more disciplines and interests than many of us ever knew existed around one subject matter, coming together because they can accomplish much more working together than they can alone.

And again, it is a lesson our country has taken to heart in the last year, from the extraordinary private non-governmental responses to September 11th and the anthrax attacks on our nation, to the activities around emergency preparedness today all across America, which involve the corporate and private sectors. Our culture is learning the value of what public health has known for a long time, that the most enduring change comes from a combination of governmental leadership, backed by the broadest possible involvement of all sectors of society.

Public health has often been revered for, and occasionally ribbed about, the way it takes into account all aspects of population health, from unemployment to education, to personal health care services. That is the lesson our country needs to learn from its public health professionals, now more than ever. Real progress requires partnership beyond your immediate discipline and traditional scope of work.

So those seem to be our most valuable lessons over the past year, whether we are talking about cancer or bioterrorism or economic growth; that prevention is primary and that it cannot be achieved without real, strong partnerships.

PANEL: MARKETING PREVENTION FOR SOCIETAL HEALTH

Moderator: Deborah Prothrow-Stith, MD
Associate Dean of Faculty Development
Division of Public Health Practice
Harvard School of Public Health

Dr. Prothrow-Stith expressed her appreciation to Bert Yaffe for his continuing leadership in addressing issues of health promotion and disease prevention. The most difficult issue facing public health professionals, she said, was how to market prevention: to consumers, employers, and policy makers. This panel was composed of some of the true heroes of prevention and she was glad to introduce them.

Howard Koh, MD, MPH
Commissioner, Massachusetts Department of Public Health

Prevention continues to be the core of what we do every day in public health, and right now prevention is absolutely taking a beating. Let's face it; prevention is under siege. So if we can come out of today with a renewed commitment to the mission of prevention, and with better ideas about how to get our message out, we will be helping in terms of promoting a public health legacy for the future.

When I graduated from medical school some 25 years ago I had no idea what a department of public health was. I never thought I would be a Commissioner, I didn't know what that was either. But everyone who has ever worked in health care knows that every day you see people suffering, you see people dying, of preventable diseases. And for a while you get frustrated. But afterwards you get angry. Because it doesn't have to be like this. And the reason we have made so much progress in public health in our region, and in our country, is that people like you, like all of us, have channeled that anger and frustration into something very positive, and that's called public health.

The challenge for us is that people take prevention and public health for granted. And perhaps in our part of the country in particular, where there is so much medical and public health expertise, people assume that public health is always going to be there, the medical system is always going to be there. That whatever gets thrown at the system we will always come forward and do the work. And we always do! That's part of our mission, our responsibility; it's what drives us every day.

In Massachusetts, the first line of our mission statement is "We believe in the power of prevention." If you come to visit our department you will see that our mission statement hangs on the wall on every floor of the building. I would say that everyone in our Department of Public Health believes passionately in the power of prevention, and I can assure you that this is what keeps us going in times like this.

After September 11th, when people ask me what public health is about, I tell them that's easy:

Public health protects people from threats. And some of those threats are proven, like cancer, heart disease, HIV, substance abuse. And some of the threats are potential, like bioterrorism, and more recently West Nile Virus. But when threats come, the public expects, the public demands, and the public deserves protection. And when protection works we have the power of prevention at its very best.

We have a strategic plan that our senior managers worked very hard to craft over about a one-year period. We live by our mission statement and we try to adhere to the strategic plan every day. And throughout the entire plan is the theme of prevention. Certainly around communicable diseases, particularly around HIV and now West Nile Virus. We are obviously doing our best to prepare a bioterrorism preparedness system.

But I am also very committed to building a better public health infrastructure through our bioterrorism efforts. We can't get too focused on things like smallpox, which has not existed on our planet for 25 years, while we are cutting back on immunization against flu, which kills 20,000 people a year in our country. We need to keep things in balance.

We need to build a better public health workforce, with an emphasis on alleviating our nursing shortages. The emphasis on data is very important, and in times like this getting information out to the public about a range of public health threats, not just bioterrorism. We are hearing less about health disparities, unfortunately, since Surgeon General David Satcher left office, but this has got to be the key issue for public health in the 21st century. Improving and upgrading emergency medical services is also fundamentally a preventive intervention, and we have a hospital system which is very fragile right now. And so we have a very strong commitment from people in the Department to maintain a sense of balance in pressing ahead with prevention.

What has concerned me greatly as Commissioner, and as one who has made now thousands of visits to the statehouse, and this year not terribly successfully I'm sorry to say, is that covertly or even overtly, prevention has been denigrated lately. It has taken a back seat. And I have been told: Oh, well, this is a tough time and we don't have the money for prevention. I can't imagine how shortsighted that kind of thinking is. Because if you think prevention is expensive wait till you see what disease costs you. At the start of the 20th century the typical life expectancy for a person born in the United States was age 45; at the start of the 21st century the average life expectancy is age 78. That's 33 additional years of life we have gained. And how did we get there? We got there through advances in medical care and better hospital systems, but most fundamentally because of our emphasis on public health and prevention. And if we don't uphold that passion and priority, especially in difficult times like this, all we're going to do is slip back and lose the progress we have made.

*Representative Peter J. Koutoujian
Vice Chair, Massachusetts Joint Committee on Health Care*

I am here to tell you how to sell public health to your legislators and policy makers, so that maybe you can begin to implement some of our prevention initiatives. Legislators are political animals and I would like to give you an insight into the mindset of this animal. Some of this you may like and some of this you may not like, but it is better to understand so that you know how to use your legislators.

In my experience only initiatives which are presented as: (1) effective in terms of both

health and cost, (2) easily understood by overloaded and pressed for time legislators, and (3) in a way that the political salience of the issue is clear, will be successful.

One thing that people have to understand, in Massachusetts at least, is that spending on health care takes up about one fourth of the state's non-discretionary budget. And I have the feeling that under these new economic conditions, that will be dealt with in a way that a lot of people will not be pleased with. With regard to the Medicaid budget, for example, people say that for every dollar the state spends it gets a matching dollar from the federal government. On the other side of the argument, however, people say: Yes, but we don't have that dollar to spend; Yes, prevention is important but we also have other things we need to spend our scarce dollars on. And it is important to understand that for legislators, prevention is not something that is immediate. It does not provide immediate gratification. During a budget crisis there is a temptation to invest in things that have an immediate payoff.

You have to understand that for politicians to continue in office immediacy is important to their viability as political candidates. We have to show the immediacy of something we vote for, how it will help our constituency and our district, now, not 10 or 20 years down the line.

When dealing with legislators you have to understand that we are every day flooded with information, letter after letter, report after report. Some are important, some are not important, and it is difficult to get through to the important ones. We do not have a lot of time to read through everything we receive. Six months ago I ran into a woman who was very interested in childhood obesity. I was able to educate myself about the issue, and become an advocate, because two volunteers who were interested in the subject provided the assistance I needed to understand and act on the issue.

We are also very sensitive to public perception, which makes policy makers reluctant to push for policy choices which appear to be misguided or ineffective, so you have to show us that the issue you are pushing is well founded and effective. I became involved with obesity before it became a hot issue. When it did we had a window of opportunity for taking action. When you have a window of opportunity you have to move quickly to take advantage of it.

Put a face on it. The most compelling thing for a legislator is to see a true story, about a child perhaps and how obesity has affected his or her life. Many times you can tie your issue to other issues which are already important to legislators. Education is always important to legislators. Show a legislator a true story and he will always remember the issue. He will be on your side. Reports are dry, but a family telling you how an issue has affected their life is compelling.

You have to show the legislator the political value of supporting your cause, and you have to allow the legislator to look good in the process of supporting your cause. And get media coverage, which both makes the legislator look good and educates the public to the importance of the issue.

To repeat, the issue you are working on must be perceived as effective in terms of health and cost, must be understood by legislators who are overloaded and pressed for time, and must be presented in ways that have political salience.

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

My favorite book title is *When You Have a Lemon, Make Lemonade*. This year we have bioterrorism. Bioterrorism is bringing us a lot of money, a lot of attention, and it really is about prevention. I keep saying to people that public health is not in the business of preventing bioterrorism, that is the job of law enforcement and the Department of Defense. But everybody thinks we are in the business of preventing bioterrorism and they are sending us lots of resources to do that at a time when they're not sending us resources to do much else. So how do we make lemonade out of this set of lemons?

As a society, and particularly in the State of Rhode Island, we are huge believers in prevention. All I have to do is wave a sign that says "immunization" and people will show up in droves. We have very high infant immunization rates, and with a coalition approach to adult immunization we're getting really rapid changes in the uptake of influenza and pneumonia vaccines. When *Prevnar* was introduced on the market we called a meeting of the leading health insurers in our state and said: "You guys pay for all the vaccines. This vaccine is coming. It's going to cost what all the rest of our vaccines cost. What do you think?"

We have a universal purchase system in Rhode Island, and they agreed to cover the cost of *Prevnar* because they could see very quickly how much benefit they were going to get from rapid uptake of this vaccine. Families would benefit from the prevention, and there would be cost savings from the avoided hospitalizations for meningitis, because after all, pneumonia is a major cause of meningitis in little children. Obviously *Prevnar* is going to be a success, but I was taken aback by the speed of their response. I hadn't expected the insurers to just say: Yes. Let's do it.

One of our major prevention issues in Rhode Island is childhood lead poisoning. We thought we had done something about it in the Seventies, when we said you can't paint with lead paint any more; and in the Eighties, when we got rid of leaded gasoline; but it took us well into the Nineties to recognize that childhood lead poisoning was also a *housing* problem, and that dealing with residential lead was the legitimate business of a public health agency. As Representative Koutoujian said, it took the appearance of families to make the point, explaining what actually happened to lead poisoned children, how lead poisoning affected their lives, and the connection with education, the impaired ability to learn.

Why is it so hard to sell the public health role in chronic disease? Part of it, I think, is the difficulty we have in showing the connection between what we are asking people to do now and the chronic disease which can or will surface later. We are doing a little better with obesity because you can actually *see* obesity, but when all we were talking about was that if you eat too much you'll get diabetes, heart disease, high blood pressure, it was harder to make the connection.

We have got to think more about why people adopt prevention strategies. Because they do. They will pay a lot to adopt prevention strategies, although not always the ones we want them to. People do think that health is important and are willing to pay for it. But they aren't sold on some of our approaches. Perhaps it's because we so often sell our product negatively. Most of our products are something you are not supposed to do when we're talking about chronic disease.

What if I told you there was a pill that would increase your mobility, improve your heart function, improve your lung function, and help you control your weight and your blood pressure, prevent osteoporosis, and improve your mood? How many of you would want to buy it? It costs 30 minutes a day. Think about it. It's called walking. We really have to consider how we can tell people what they *can* do for good health and not what they shouldn't do. We have to learn how to define the public health product in a way that people really want to buy it.

We have been fairly successful in selling prevention of West Nile Virus. Yes, we have had a few cases. But we have succeeded in selling mosquito control. The municipalities are all signing up to get their larvacide at the beginning of the mosquito-breeding season. We have sold the concept of habitat control. People know it's important. They don't always do it in their back yards but the ethos of what you are supposed to do is there. And we have had some success in selling personal protection, although when we talk to people who actually get West Nile Virus, most of them say: Oh yes, I didn't actually think that I would get bitten by one of those mosquitoes.

Tobacco is another major issue for us. I think it is serendipity that we've sold one of the most important ways of controlling tobacco, that is, increasing the price. We know that one of the things that really affect tobacco consumption is the price, and tobacco taxes are an effective way of doing that. And look at the collateral benefits.

What I'm concerned about is that we have had a much harder time selling tobacco treatment. Here we are, we've just raised the price again in Rhode Island. Now some people must be thinking: This is costing me too much; it's no longer worth my while to smoke these cigarettes; I can't afford them any more. Well now is the time to be offering these folks treatment. But we aren't doing a good job of it. Our physicians don't believe in it. Our health insurance plans don't cover it. And we haven't sold tobacco treatment yet. What we are trying to do is to sell a variety of ways in which people can get access to treatment.

So I suggest to you that we in public health have to find new ways of selling our conception of prevention, and not wait for people to read all those scientific studies that public health professionals like to read but legislators don't. We need to repackage the product. And all the things we want to talk about, all of the underlying messages are right there in bioterrorism. We have a lemon. Let's make lemonade.

Joxel Garcia, MD, MBA
Commissioner, Connecticut Department of Public Health

I want to give you the background to my becoming a Commissioner of Health, and it has to do significantly with social marketing and the marketing of prevention.

My specialty, and there were only four specialists in Connecticut, was in pelvic reconstruction and relief of pelvic pain. And I was involved in administration, and I was involved in research. But what brought me to do a Masters in Business Administration was that I did not understand why, as an industry, we were a pathologic industry, in a pathologic society. We do not want to go into the prevention process, make those sacrifices that actually have good outcomes at the end. We want to take the easy way out. When we get sick we want to have our procedure. I, as an administrator, wanted to sell more procedures so people would come to our doors. We do not sell prevention, we sell procedures.

With regard to Medicaid. In my state we put close to one billion dollars into medications in the Medicaid prescription program, out of a total program budget of six billion. If the health status of my state is improving it is because of our prevention and other public health programs. If we put more money and more energy into prevention I think we will succeed.

We have been successful in getting the Health Department's bills passed in the legislature, but one thing you have to understand is that legislators have to get reelected. There is a new election every two years in my state. And let's assume that each legislator has \$60,000 to put into his or her district. And you come to them with an incredible plan to prevent cancer, obesity, and asthma. You have to present it to them in 15 minutes, in a way that will capture their attention. And then the idea has to go through committee, and get the approval of the leadership, and become a bill. And you bring in the families who have stories to tell about the need for prevention. All well and good. But what happens if then five residents from a legislator's district come to see him, with signatures from 20 other constituents, and they tell him that what they really need is a stoplight. I can tell you that the legislator is going to say to himself that the cancer prevention program is going to have outcomes 30 years from now. He will be retired by that time. The stoplight can be installed in six months. Prior to the next election. This is a reality we have to deal with.

I was asked earlier why I went into public health. Well, public health is like a virus, you become infected and then you become contagious; you want everybody to become interested in public health. And one of the things I find hard to understand is why, since public health has accomplished so many great things through decades, centuries, it has so little respect. Here we are sitting in ergonomically sound chairs because of public health, and drinking safe water because of public health, and so on. So why when they are cooking up the financial pie aren't we involved in the baking? We don't mix the dough, or put it in the oven; we don't even get to help slice up the pie. If we stay at the table we get to pick up the crumbs, and we have to fight for those. I'm not sure why I went to get an MBA instead of an MPH, but one of the things I learned from the MBA is the importance of economic power, and that with economic power you can change a lot of things.

And you have to understand people. I am writing a book related to social marketing and leadership, and one of the subjects is the importance of knowing the people you serve. I want to give you two examples.

Two months after my appointment as Commissioner of Health I wanted to address a meeting in a Latino community. Being the first Latino Commissioner I thought this was going to be cool. They were having some problems with the WIC program and I was going to go and show up there. And of course, since the Department of Health is a government agency we think we know everything, and we can impose everything in the community, and the community is a blank and they have to follow what we say because we have the knowledge. So we spent about \$5,000 on a marketing campaign for a small community, mostly radio advertising, and when I showed up for the meeting there were three people there! It was a fiasco.

So then I asked one of the three people who was there why no one had come. "Well, he said, you didn't use the means of communication that we use here in this community." But, I told him, we put a lot of money into this campaign. And then he told me: "Look, just talk to this person, and this person, and this person." And we did that. Two months later we came to a meeting in a room the

size of this one and there was standing room only. And they brought food. It cost the State of Connecticut zero.

We spent nothing and we created significant change. We created so much change that we had two congressional delegations supporting one of our bills. It was the most amazing thing. And then we realized, before we go out to inform the community (because we have all the science, we have all the data; we may not have all the resources but we have more sometimes) that we have to meet with the people.

The products we have developed are called *Door to Door* and *House Calls for Seniors*, and they are exhausting to implement. We go to a lot of different towns and we meet with a lot of people and we ask them what they think related to health, and they can say anything. Forty percent of the people blasted me because they thought I had cut the health budget (which I never did). So we listen to them. And then we present our data and our information, and then they own the product. In other words, you create a process by which the people you want to serve in a community can own and implement change.

My second example is from the *5-a-Day* program. We try to tell people to eat five fruits and vegetables a day. Has anyone gone to the supermarket and found out what five fruits or five vegetables cost? Can you imagine a college student, an inner city person, or a senior having to spend that kind of money? McDonalds, meanwhile, gives you a complete meal for \$2.95, and if you are a kid they give you a toy. We have to find a way to deal with this if we want to improve nutrition.

McDonalds is not our enemy, and I think we can learn from them. Before McDonalds opens a new store, they do market research. They find out what the consumers like and how they like it, and where the store will be successful, and they put it there. And you don't read in the papers that McDonalds went bankrupt.

We have all the data, we have all the research, but we have to do the same marketing analysis that McDonalds does before we open our own campaign. The only thing is we don't have the kind of money that McDonalds has. So we have to follow the example of Burger King, wait for McDonalds to open a store and then we open one within a one-mile radius. That's called "benchmarking." So we need to benchmark what other people have done and has been successful and then apply it in our communities.

Dr. Prothrow-Stith:

One of the things I have often thought is that public health is the merger of science and politics, in the same way that clinical medicine is the merger of science and the art of medicine. We have heard quite a bit about the politics of public health today, and what emerges, I think, is that we are strong on the science and weak on the politics, and we have a history of not really liking the politics and the economics of public health. I would like to ask panel members what they think we can do to enhance our political skills.

Representative Koutoujian:

First of all, public health practitioners have to make connections with the people who have political influence, many of whom do not know our world, do not understand the subtleties of our issues. And you have to make those connections on a very personal level.

Your best advocates in the statehouse are those who have been directly and personally affected by the issues; for example, a legislator who has had experience in his family with cancer, or hepatitis. If that legislator happens to have command of resources, or is the head of a committee, or is a political leader, that helps a lot.

Issues have to be presented in a concrete form. One of the things which concerns me, is that we tend to talk in our own lingo. We have to keep it simple, and we have to put a face on it. Having a specific anecdote to illustrate the point is very important.

Making sure the politician gets recognition and thanks for his efforts is also very important, especially if it is covered in the media, and it is crucial to show how initiatives whose payoff may not come for a number of years is nevertheless relevant today.

Finally, community advocates have to be willing to do the work. The best lobbyists I know will track the legislation for you, they will remind the legislator when to make calls, they will help draft letters that his busy staff may not be able to get to for weeks.

Dr. Nolan:

One of the issues that Commissioners face is that they are also in a political position, and that things they may want or do or espouse are things they cannot do or espouse directly. One of the important issues, then, is to be able to collaborate with others outside of government, to build coalitions, work with those who are in a position to lobby. And the important thing is not to collaborate only with those who agree with you on all things, but to collaborate with those with whom you are in agreement on an issue-by-issue basis.

• *Question from the floor:* We often look at poor communities or communities of color as those that we serve, but not as those that can help us organize around an agenda.

Dr. Garcia:

Yes, that's very important. In urban centers in Connecticut you have the Asian American population, the Latino population, the African American population, the West Indian population, and they are very well organized. And there is a large population from Eastern Europe that is organizing. Some of the legislators are not yet aware of the political power these groups have. Sometimes they do not vote. In the City of Hartford less than 50 percent of the people vote, and 70 percent of that population is not Caucasian. I am not supposed to lobby, but I can facilitate. One of the things we do is to identify a major employer in a district and bring them into the equation as a partner to the group.

• *Question from the floor:* How can bioterrorism dollars be made to support the broader public health agenda?

Dr. Nolan:

I said there is a funding stream in bioterrorism and that we ought to take advantage of it to carry out the whole public health mission. The question is: how can we use bioterrorism dollars to address everyday public health problems.

First, the funding which is coming from the CDC, and to some extent from HRSA, is carefully labeled bioterrorism and public health infrastructure money. Second, one of the primary issues that we are seeing in the whole business of responding to bioterrorism is having an appropriate way to quickly communicate public health issues. In a conversation I had with one of our hospital presidents on how to get prepared to respond to bioterrorism in an already very stressed hospital system, his comment was one I found very useful. "If in an emergency you ask us to ramp up something we do every day we can do that very successfully, but if in an emergency you ask us to do something that is completely different from what we do every day we won't be able to do that successfully." For me that is a tool for us to use in plugging bioterrorism money into our infrastructure and use it every day.

If we build a communication system to transfer important health messages only in the event of an outbreak of some exotic pathogen released by a terrorist, and we don't use that system every day, then when the time comes when we actually have to use it during a bioterrorism event, we won't know how to turn on the radio or put a message up on the web site, or we won't even have a web site. If we build and use a communication infrastructure for our everyday messages we will in fact be preparing for the emergency eventuality.

- *Question from the floor:* How can we deal with the cutbacks in funding for preventive health programs?

Dr. Koh:

I would love to answer that question! In Massachusetts, 90 percent of our tobacco control program has been defunded. But our passion and our energy have not been affected. We will rebuild the program. You respond to budget cuts today with the determination to rebuild.

- *Question from the floor:* How can we make more progress in eliminating racial and ethnic health disparities?

Dr. Garcia:

One of the ways is to train people from the urban centers to work in health care organizations. When you change the work force you create opportunities for change. We saw this in the field of obstetrics and gynecology, where major change and improvement occurred when the number of women OB/GYNs increased. When we have more minorities working in nursing homes, in hospital emergency rooms, the quality of care for minorities will improve.

KEYNOTE ADDRESS

Claude A. Allen

Deputy Secretary, U.S. Department of Health and Human Services

The violence of September 11th, the anthrax attacks, and the sniper attacks in Maryland and Virginia, not only affect our cohesion as a society, but also have a direct impact on the health and well being of our citizens. There is an important public health issue here, and our goal must be to build the strongest and most effective public health infrastructure possible.

This is a national issue, not just a federal issue, and while the federal government has an important role to play, the states have to be in the driver's seat when it comes to making decisions which affect individual states and regions. That is why the administration moved so quickly in distributing congressional appropriations of bioterrorism money to the states for strengthening the public health infrastructure.

Bioterrorism had occupied a large proportion of my time since September 11th, but those who know me would know that my passion does not lie only with the urgent but also, and especially, with the important. Reducing and eliminating disparities in health care is important. It is one of the top priorities of the Bush Administration and the President and Secretary Thompson have asked me to oversee this effort.

Ever since we began keeping federal health records our statistics have shown vast differences in the burdens of death and illness experienced by communities of color compared with the nation as a whole. This problem cannot be solved simply by government, however. It is going to require the collective effort of providers, communities, and faith institutions working together with government, and indeed, all of us as individuals, to end health disparities.

The statistics are simply unacceptable. Right now a baby born to an African American mother has more than twice the risk of dying in the first year as that of a white baby. An American Indian baby is more than one and a half times as likely to die in that first year. Additionally, African American women are four times as likely to die during pregnancy or shortly thereafter as a white woman. Vietnamese women living in this country experience cervical cancer at five times the rate of white women. Hispanic women over 65 years of age have twice the risk. An African American woman is more likely to die of breast cancer than a white woman, though the incidence of disease is greater for white women.

African American men under 65 years of age suffer from prostate cancer at nearly twice the rate of white men, while men of Japanese descent have the highest rate of prostate cancer, but their survival rates exceed those of African Americans. The rate of death for African American men from cerebrovascular disease at 45 to 54 years of age is four times that of white men. Native American men suffer from diabetes at nearly three times the average rate, while the prevalence among some Native Americans and American Alaskan Native tribes is as high as 50 percent. Indeed, there is one tribe, the Pima Tribe, where on this side of the border, there is a prevalence of greater than 50 percent, yet you go just across the border in Mexico and it is almost non-existent. Hispanics are almost twice as likely as whites to have diabetes, and African Americans suffer 70 percent higher rates of diabetes than whites and have the highest death rates.

The HIV/AIDS crisis in communities of color is even more troubling. Through December of last year, African Americans represented an overwhelming 38 percent of reported cases of AIDS. African American and Hispanic women represent only 25 percent of all U.S. women, but account for 78 percent of AIDS cases reported to date among women in this country. Even more alarming, 65 percent of all pediatric AIDS cases involve African American children.

And while 59 percent of elderly whites reported receiving influenza vaccination in 1999, less than half of elderly African Americans did so. These are sobering numbers. They suggest a health care system in crisis.

The Department of Health and Human Services is determined to end this situation, but government cannot do it alone. To begin with, individuals need to be given control of their own health and health care decision-making. Any policy or plan that is developed at the federal level must complement individual and community efforts. And indeed, communities across the nation are already doing extraordinary things to provide health care to underserved populations. The Bush Administration wants to support, not supplant, these efforts.

A major role for the federal government is to apply its formidable research capabilities to health disparity issues and to make its findings available to both health care providers and consumers. For example, recent research has shown that Beta Blockers are successful in controlling hypertension in about 85 percent of the population, but that the overwhelming majority of those in the 15 percent for whom Beta Blockers are *not* effective are African Americans. Both African American patients and their physicians need to have and act on this information.

Consumers of color need to understand their options. For example, many times people in their communities are not aware of the health care resources which are available to them in their localities, such as community health centers and free clinics. We need to find more effective ways to inform them and encourage them to use these resources.

The Administration has a strategy for reducing and eliminating health disparities.

Strategic Planning. The Department of Health and Human Services is revising its strategic plan and is making the elimination of health disparities a priority across all program areas. This will include the regular review of budget proposals, research and evaluation plans, and agency and office performance plans. The Department has established a new Research Coordination Council charged with reviewing all DHHS research, demonstration, and evaluation activities to assure consistency with the President's priorities and to inform the budgetary process. The elimination of health disparities is one of the ten research themes that this council will be addressing. Emphasis will be placed on expanding and coordinating support for Centers of Excellence in academic institutions and community-based organizations serving significant numbers of racial and ethnic minorities.

Health Promotion. Improving communication of information to consumers is an important goal. Last November Secretary Thompson announced that the Department of Health and Human Services would be partnering with the ABC Radio Network to launch "Closing the Health Gap," an educational campaign directed to the African American community. ABC Radio has some 240 Urban Advantage network affiliates around the country, which can be heard by 93 percent of all

African Americans. One important part of the campaign will stress the importance of getting regular medical checkups. We know that many individuals who suffer from chronic conditions in communities of color often have to resort to more drastic treatment options because they delayed seeking care in the very beginning. As part of this effort, September 24th has been designated as “Take a Loved One to the Doctor Day.”

The Administration’s FY 2003 budget proposal includes \$20 million for the Healthy Communities Initiative. The purpose of this program is to bring federal and community resources together to fund demonstration projects that enhance access to health care. Related to this, the President’s Healthier U.S. Initiative will promote the importance of eating more healthy meals and staying physically active.

Improving Literacy. Low literacy levels impede the ability of people of color to take charge of their own health. As the President has said: “Almost two-thirds of African American children in the fourth grade cannot read at basic grade level. For white children that figure is 27 percent. The gap is wide and troubling and is not getting better. That gap leads to personal tragedy and social injustice.” The President’s education agenda is addressed to improving literacy from the earliest grades.

Direct Services. In addition, President Bush has asked the Department to expand the number of community health centers across this country to reach individuals who lack access to quality medical care. The current network of more than 3,300 community health centers serves some 11 million people. Earlier this year, Secretary Thompson announced a third round of expansion grants to health centers, totaling \$16 million, to expand access to health services for Americans in rural and inner city areas. The FY 2003 budget calls for an additional 260 new and expanded centers that will serve an additional 1.25 million persons. The Department’s target for this overall five-year effort is to expand health center sites by more than 1,200, serving 22 million people through the community health center system each year.

This year’s budget proposal will make available to the states an estimated \$3.2 billion in unused CHIP funds that would otherwise return to the Treasury and be spent on other priorities. In addition, the Secretary of Health and Human Services has approved more than 1,400 state plan amendments and waivers since taking office, and soon we will have approved waivers for all 50 states, expanding coverage to more than 1.8 million people, and expanding benefits to 4.5 million.

In closing, there are two points which have specific relevance to eliminating health disparities. First, as the member of a large multi-generational family, I am especially cognizant of the value of inter-generational learning. Second, with regard to the way in which the American health system works I feel that cultural *competency* is not enough, i.e., trying to communicate across cultural lines. What we need to achieve is true cultural *literacy*, in which cultural lines simply cease to be barriers.

TALES FROM THE TRENCHES

Gerald L. Evans, MD

Director, Heart Ventures, Framingham, MA

We have a problem in the United States, said Dr. Evans, with an epidemic of obesity. Poor eating habits and lack of exercise have resulted in significant increases in Body Mass Index readings in the population. Sixty-five percent of Americans are overweight (BMI >25), and 30 percent are frankly, obese (BMI >30). These are powerful risk factors for Type II Diabetes and cardiovascular disease.

People who are overweight increase their risk of developing diabetes. And people with diabetes have a significantly greater risk of myocardial infarction, and a significantly greater risk of death during a first heart attack, than people without diabetes. For example, the risk of having a major myocardial infarction is 45 percent for diabetic men but only 20 percent in non-diabetic males. The comparable figures for women are 20 percent and 4 percent.

Educating people to improve their eating and exercise habits is important, not only in order to prevent cardiovascular disease, but in order to control costs of expensive medications and interventional procedures. These costs are rising at greater than 18% per year and there is no end in sight unless behaviors are changed significantly. We have become very good at keeping people with heart disease alive. The cost of doing this is incredibly expensive economically.

The driving force behind rising costs of treating cardiovascular disease is the undoubted improvement in clinical care. These include pharmacological advances; medications for controlling cholesterol and blood pressure, which can cost seven or eight dollars a day for the rest of the patient's life. The cholesterol lowering drugs, Lipitor and Zocor, are the first and fourth most commonly prescribed drugs in the U.S.

Emergency treatments such as drugs to dissolve blood clots in patients acutely suffering a heart attack cost \$2,300 per dose.

They also include technological advances in diagnosis and treatment: CAT scans, MRIs, angiograms; defibrillators; angioplasty and the insertion of stents; and bypass surgery. The equipment costs dwarf the professional fees. A defibrillator costs \$30,000. A cardiac catheterization with an angioplasty costs \$15,000 and stents they may insert cost \$3,000 each; the average patient needs five of them. The cost of equipment, professional fees, and lost productivity for a heart attack episode may total \$100,000 and \$150,000.

We have known for a long time that risks of cardiovascular disease can be sharply reduced, and early signs of cardiovascular disease can actually be reversed, by changing people's eating habits and increasing their level of physical exercise. This isn't rocket science, Dr. Evans said.

There are only three sources of calories he said, "protein, carbohydrates, and fat." We need three or four ounces of protein a day (from chicken, turkey, and fish). We shouldn't have more than 30 or 40 grams of fat a day. The rest of our calories have to be from carbohydrates, and the amount people eat will determine their weight. Red meats and processed meats (bacon, sausage, pastrami, hot dogs) should be avoided. Large amounts of saturated fat and eggs, whole milk, butter, cheese,

and margarine should be strictly limited because they contain saturated and trans fats. What fats we do eat should come from plants (nuts, olives, and avocados) and fish (salmon, herring, mackerel, tuna) sources. A meal where the main course is complex carbohydrates prepared with sautéed vegetables of your choice and garnished with chicken, turkey, or fish is a heart healthy meal.

Weight reduction and exercise are also important for lowering blood pressure. Many people think they are doing fine by keeping their pressure under 140/90, but a “high normal” pressure is nowhere near as good as what we call “normal”, 120/80 and what we call “low” blood pressure, 100/70, is even better.

The adverse health effects of tobacco use are well known. Dr. Evans said he maintained a smoke-free medical practice. He told his patients that if they want to continue having him as their physician they had to give up cigarettes. More than ninety percent of them did.

He is a great believer in promoting healthier lifestyles in the workplace. Certainly employers have a stake in keeping their workforce healthy, both in terms of health insurance costs and productivity. In a sense the workforce is a captive audience. To make worksite programs work, management has to be seen as strongly supportive. Education has to be personal, face to face; just distributing flyers doesn't work. And there had to be periodic screening to document improvement and reinforce the message.

Finally, Dr. Evans was concerned about the new emphasis on consumer driven health care, in which the consumer will be more responsible for his or her health choices. Certainly the consumer has to take more responsibility, but to assume that that will happen without education and urging is a mistake.

Carol Cone
CEO, Cone Inc.

Ms. Cone has spent 23 years helping companies, non-profits, foundations, and government agencies to communicate with consumers around important social issues affecting health. Her company had been the lead agency in developing the Massachusetts tobacco control program, for example. No one should think that changing health behaviors is easy. Based on her experience she recommended several strategies:

Romance the Issue. To begin with, prevention programs need to develop methods that are appropriate and relevant to reach the target population, at a time when they want to hear it. There is a lot of communications clutter today, people receive thousands of messages on a daily basis, and they have learned how to shut out a lot of those messages. Moreover, there are a lot of diverse audiences. No longer can you put something on television and reach everyone, because a lot of people are reading, or on the computer, or playing video games. Programs have to deliver multiple communications, at multiple points, to reach different audiences.

When she first tried to develop a campaign to encourage walking, people said why do that? People walk the same way they breathe, it's automatic. It didn't seem compelling. The challenge was to make it compelling. Her approach was to romance the issue, with a gentleman named Robert

Sweetgall, who walked 11,508 miles alone around America for 363 days. He would stop in at middle schools across the country and deliver three simple messages: don't smoke, eat properly, and walk. When he had finished, he had written a book, he was on the Today Show, and that started a walking movement in the United States.

Start a Movement. If we want people to act, we have to start a movement; if we want people to start walking, we have to start a walking movement. But when we create a movement, it can't just be done with TV advertising, because a movement has to have both air cover and ground troops. It has to include one-on-one community-based advocacy, providing people with information and the tools they need to act on that information. We have to create programs that people can touch and feel.

The movement has to have a face on it, such as Robert Sweetgall's, and it has to have a slogan, something with a punch, such as "Walk for the Health of It," or "It's Time We Made Smoking History." The strategy is to catch people's attention, to educate them to the issues, and then give them something simple they can try. Then when they try the small things and get good results the message is reinforced, the activity is rewarded, and people begin to adopt new behaviors as a lifelong thing.

Movements are based on partnerships with agencies, with organizations, with communities. The good news was that more and more business leaders are motivated by a sense of *corporate* social responsibility and want to participate in community partnerships. And corporate philanthropy is increasingly available to support partnerships which are organizing movements for better health.

Use the Science. It is important to use "science" to legitimate the social issue we are marketing. Research tells us what the risks are, and the rewards that come from change, and this helps in identifying target populations and designing messages.

As part of her firm's walking promotion program Ms. Cone commissioned a series of studies by the Massachusetts Medical Center. The theme was: Walking is good for you, let me show you why. Every year the Rockport Walking Institute funded these studies and disseminated the information. Results of each new study went to the media, were reported at conferences, and went on the web site. And because there was always new information, the movement got a lot of media coverage.

The Call to Action. If we want people to change their behaviors, we have to urge them to change, explain the benefits of change, and give them the tools to change. In the walking campaign she asked the Massachusetts Medical Center to develop an easy to use, science-based, fitness test. The test was described on Good Morning America. Within two weeks the campaign received 50,000 requests for information about the test. In other words, 50,000 people had to write a letter, put it in an envelope, put a stamp on it, and put it in the mail. America *wanted* to do exercise.

Grassroots Communications. Getting teens to eat right and exercise isn't going to be easy. However, some of the lessons learned from the National Tobacco Control Program may be applicable. The first thing that was done in that effort was to find a name for it that would mean some-

thing to youth. It was called the Truth Campaign, and it focused on the egregious manipulative activities of the tobacco companies. Young people hate deceit and manipulation.

The campaign operated at three levels: massive TV advertising, interactive Internet communications, and a multi-city grassroots effort with teen ambassadors, and special events with bands and video games. The initiative sponsored 200 special events around the country and the results were amazing. There was an 18 percent reduction in smoking by teens involved in the program overall, and a 30 percent reduction among teens who were most intensively involved.

Surround the Issue. When we create a program to market behavior change, there are no easy solutions. We have to surround the issue. We have to imbue the effort with passion. We need to find partners with whom to create a movement. We need to put a face on it. And we have to deal with the popular culture because it influences so much of what people do.

LUNCHEON ADDRESS

Rhode Island Senator Jack Reed

We are all here today because we are committed to improving the health of our neighbors, and the citizens of this great country. Last May I had a chance to co-host a regional meeting with my colleague in the United States Senate, Susan Collins, at Harvard. Like our conference today, it brought together a wide range of experts, and advocates, and public health officials to consider ways we can work together as a region to improve our public health systems and the quality of health care.

One of the things we recognize in Rhode Island, and regionally, is that our population is getting older, and that as a result health care costs continue to rise. We are also facing a shortage of skilled health care professionals, and that too adds costs. We are facing budget crises in every one of our states, and frankly at the federal level we are not able to respond, as I believe we should, to keep our commitments to health care. So these are difficult times.

There is a growing realization that many of our public health issues have to do with promoting individual behaviors that contribute to good health, and I will want to talk about some of those in a moment. But I think it is important to remember that public health has a much broader societal aspect. The Institute of Medicine defined public health as “what we as a society do collectively to insure the conditions in which people can be healthy.” It also underscores the concept that this has to be a collaborative effort, bringing together not only the various levels of government, but also private and non-profit entities, community organizations, and must ultimately involve individual citizens as well.

Finally, as we move into the 21st century, I think it is important that we keep clearly in mind that our major health gains in the 20th century have largely been victories of public health, and that it continues to be a powerful and essential tool for the future well being of our citizens. Yes, there have been significant clinical breakthroughs, important new pharmaceuticals, and new techniques for treating disease, but it has been advances in public health that have been most broadly effective in improving the quality of life, our standard of living, and our increased longevity. We must continue and enhance our support for public health.

The emphasis on improving healthy lifestyles really began with two reports from the Office of the Surgeon General: *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (1979), and *Promoting Health and Preventing Disease: Objectives for the Nation* (1980). And over the past 20 years we have been developing more and more detailed documentation of health status issues in the United States, and sharpening our goals for the United States. *Healthy People 2000* and *Healthy People 2010* have been major steps in this direction, and have been the models for state Healthy People documents across the country.

Priorities which have emerged from this process have focused on the need for increased physical activity, control of obesity, reduction in the use of tobacco, prevention and control of substance abuse, promotion of responsible sexual behavior, a renewed emphasis on mental health, reduction in the prevalence of injury and violence, increased rates of immunization, improved access to health care, and increased utilization of health care services for all Americans.

These are the parameters that have been laid down as our national policy objectives for public health. We have seen some dramatic improvements in some of these areas. In others we have barely managed to maintain the *status quo* or have actually lost ground. We have recorded some successes in reducing mortality from cancer and heart disease, and we have made advances in the prevention and treatment of AIDS. But we have lost ground when it comes to the prevalence of obesity, and in smoking by young people. So we need to emphasize public health programs which promote individual choices to lead healthier lives.

But there are new challenges to public health which have to be recognized. One of the most distressing realities is that a biological or chemical attack on the United States has become a real threat. After September 11th, any sense of invulnerability we may have had must be dismissed, and we have to recognize that the public health system is an integral part, not only of prevention, but also of response. After the building in which my office is located was attacked by Anthrax, it was the public health authorities who treated those who were exposed, and who sealed and decontaminated the building. And now, every public health agency in this country has to be prepared to respond to possible similar attacks. The federal government has provided funds to help take the necessary steps: to strengthen the public health infrastructure, to attract highly qualified, highly skilled personnel, and to give them the training they need to respond quickly and effectively.

Another area of concern is the growing resistance to antibiotics of disease. Today, for example, 20 percent of tuberculosis cases around the world are resistant to the drugs which were previously used to treat this disease. And we have seen that infectious disease is claiming more and more American lives. Between 1980 and 2000, infectious disease deaths doubled on an annual basis. Some of that was attributable to AIDS, but even as we are gaining ground in treatment of AIDS, we are still seeing the death rate from infectious disease increase. In partnership with Senator Ted Kennedy, I have submitted legislation that will restrict the use of antibiotics on healthy animals as a way of protecting the effectiveness of our pharmaceutical products.

The breadth of traditional and emerging challenges to the health of our nation requires that we assure that we have a strong and flexible public health system, for both prevention and response, in this new century.

SUMMARY OF WORKSHOP MEETINGS

MENTAL HEALTH

Workshop Leader: Joseph Bevilacqua, PHD, Chair
Mental Health Promotion and Disease Prevention Task Force

Current CMHS Promotion and Prevention Activities

Nancy Davis, EdD

Public Health Advisor

Substance Abuse and Mental Health Services Administration (SAMHSA)

Center for Mental Health Services

Interest in mental health promotion and disease prevention has waxed and waned over the years for three reasons. First, the stigma attached to mental and behavioral disorders has led people to believe that nothing could be done. Second, until recently there wasn't much scientific evidence that promotion and prevention were possible. And third, there is a false dichotomy between the concepts of prevention and treatment, which is reinforced by competition between advocates of prevention and treatment for the limited funding available for mental health. However, staff at the U.S. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (CMHS) believe that mental health promotion, disease prevention, treatment, and recovery are inextricably linked, and that from a service point of view they represent a necessary continuum of activities.

A 1996 study conducted by the Harvard School of Public Health, the World Health Organization, and the World Bank, *The Global Burden of Disease*, has changed the way in which we look at health statistics, and emphasized the importance of efforts to promote mental health. It used to be that mortality data were the major indicators for determining health of nations. Increasingly, however, as the prevalence of chronic conditions has risen, the significance of rates of disability as national health indicators has become apparent.

The global burden of disease caused by mental and psychiatric disorders is substantial. Psychiatric conditions were responsible for only 1.4 percent of deaths world wide in 1995, but accounted for 11 percent of mortality plus disability, and were expected to account for 28 percent of all years of life lived with a disability. Looking at overall causes of disability world wide, major depression leads the list; and alcohol use, bi-polar disorder, schizophrenia, and obsessive-compulsive disorders follow in short order. Mental and behavioral disorders are associated with many causes of death.

New research in recent years has begun providing scientific evidence, however, that mental health promotion and prevention programs (e.g., nurse home visiting, alternate thinking strategies, depression control) can achieve positive outcomes and be cost-beneficial.

One of the primary objectives of SAMHSA CMHS is to speed the translation of scientific findings into community programs. The agency has been active in monitoring the literature for workable interventions, supporting the introduction of these interventions in the field, monitoring intervention programs for fidelity (i.e., adherence to protocol) and outcomes, and just recently, contracting with the Educational Development Corporation to provide capacity-building technical

assistance to SAMHSA grantees and potential grant applicants in disadvantaged communities. The agency has also been active in supporting consultants who are working with grantees to address issues of sustainability, i.e., how to fund and maintain workable programs after initial federal funding has expired.

Another important aspect of promotion and prevention is the development of partnerships. At the federal level, the Safe Schools/Healthy Children initiative represents a landmark collaboration among the Department of Health and Human Services, the Department of Education, and the Department of Justice to reduce youth violence. This program has broad bi-partisan support in the Congress, and has funded 143 sites across the country.

A new program, Building Mentally Healthy Communities, represents the first time CMHS has received money specifically for prevention and early intervention. Only SAMHSA governmental entities may apply for funding under this program, but they are required to secure local partnerships through which to coordinate and carry out their programs.

- *Question:* What can we do to eliminate the dichotomy between prevention and treatment?

The important thing is to bring advocates for prevention and advocates for treatment into the same room and give them something they can work on together, such as ways of reducing the stigma attached to mental illness. The fact is that mental health promotion is not only a matter of preventing initial onset of disease (primary prevention). Treatment to prevent co-morbidities, to modify the behavioral expression of mental conditions, and to prevent relapse and disability, is also part of the continuum of mental health promotion (secondary and tertiary prevention). Looking at things from this perspective may help to work out acceptable future adjustments.

Connecticut's Statewide Approach to Prevention

Thomas Kirk, Jr., Commissioner

Connecticut Department of Mental Health & Addiction Services

Connecticut has made significant progress towards implementing a comprehensive approach to prevention. It has been able to do so thanks to gubernatorial and legislative leadership, the creation of an entirely new culture in the state with regard to prevention, the creation of a conceptual framework for designing and implementing prevention programs, and creation of an institutional infrastructure devoted to keeping on focus and sustaining effort over time.

In October 1995, Governor Roland established a Blue Ribbon Task Force on Substance Abuse, with high-level representation from government agencies, the health care and health insurance industries, and academia. The Task Force was given 90 days in which to develop a report with specific recommendations. One recommendation, which was implemented through legislation, was the establishment of a permanent Alcohol and Drug Policy Council. And one of the Council's first orders of business was to establish three areas of emphasis: (1) prevention, (2) treatment, and (3) enforcement. This designation raised prevention to a whole new level of awareness and importance, and began the process of creating a culture which would support investment in prevention programs.

Following the U.S. Surgeon General's report in 1999, the Governor established a similar Blue Ribbon Panel on Mental Health, chaired by David Kessler, former head of the U.S. Food and Drug Administration. One result was the formation, again through legislative action, of a Mental Health Policy Council. And again, prevention was one of three priority areas, together with treatment and advocacy.

The recommendations from the two Blue Ribbon Panels continue to guide what Connecticut does in terms of substance abuse and mental health, and the relationships which were established when members of these panels were working together have continued to support many of our programmatic activities. One important outcome was the establishment by the legislature of the Mental Health Strategy Board, which was appropriated \$25 million for residential resources and \$21 million for services, to implement the recommendations of the Blue Ribbon Panel on Mental Health.

At its last session the legislature moved the importance of prevention up another notch, by creating an entity known as the Prevention Council. This Council has several key characteristics. (1) It has a small and quite powerful membership: the state commissioners of Mental Retardation, Public Health, Social Services, Children and Families, Mental Health and Addictions, and Education; the senior judge who oversees the judicial system; and the Chair of the Governor's Office of Policy and Management, which oversees the state budget. (2) By law, members cannot designate someone to represent them at meetings but must attend in person. (3) Meetings are held once every two or three months, and focus on a content-heavy agenda. (4) The work of the Council is staffed by program and fiscal personnel from the member agencies. (5) In order to speed its deliberations, prior to each meeting the Chair of the Office of Policy and Management meets individually with each of the other members, and then based on their input creates a draft consensus document which is put on the agenda.

The first order of business was to create a basic framework in the form of a vision statement, mission statement, and definition of prevention to guide the work of the Council.

Vision. A Connecticut where children, young people, and their families will be safe, healthy, educated, socially and culturally aware, and leading productive lives in their communities.

Mission. Develop an effective, comprehensive, and sustainable prevention framework that raises awareness of the value of prevention, fosters partnerships and coordination, and promotes safe and healthy environments for individuals and families in their communities.

Definition. Prevention refers to policies and programs that promote healthy, safe, and productive lives and reduce the likelihood of crime, violence, substance abuse, illness, academic failure, and other socially destructive behaviors.

The Council is now working on a statewide prevention plan that will pull together the things that member agencies are currently doing. The plan will be submitted to the legislature when it reconvenes in January 2003, at which time it will be preparing the state's budget for fiscal years

2004 and 2005. Certain features of the planning process are of particular relevance in thinking about how to present the results to the legislature.

- (1) Given the diversity of missions of the participating agencies, and the multiplicity of programs whose outcomes need to be measured, it was agreed that the plan should have a limited number of shared or agreed indicators which could be reported to the legislature without overwhelming them.
- (2) The plan should focus on science-based programs and practices in selecting priority courses of action, and use this to justify program elements in proposed budgets.
- (3) Given the current financial climate, prevention programs should be presented as revenue enhancing, considering that any program which returns five or ten dollars for every dollar invested is, in effect, expanding state purchasing power.
- (4) What we are really talking about here is state systems change, and if change is to happen then the legislature needs to look at what the agencies are doing *together* on prevention, not just individual agency prevention budgets.
- (5) Finally, we want to present a statewide framework for prevention so that over time, and regardless of personnel changes, the overall mission will move forward.

As members of the Council work together they are identifying areas in which they can achieve mutual benefits from substantive collaboration. Clearly it is dysfunctional for different agencies to be providing different services to the same families, and this is one area where collaboration can be cost-effective and provide consumers with the benefits of entering a seamless system of services. Ultimately it may be possible to move from thinking in terms of traditional programs of individual agencies to thinking the way health care plans do, in terms of defined services which the state as a whole wants to provide for its covered population of three and a half million people.

Prevention Program of the Department of Mental Health & Addictions

Dianne Harnad, MSW

Director, Prevention Services

Connecticut Department of Mental Health & Addiction Services

The Department's core infrastructure for prevention began with the substance abuse prevention system, but it was soon apparent that all of that system's risk and protection elements had application to mental health as well. Following the guidance of the Blue Ribbon Panels on Substance Abuse and Mental Health, the Department's activities are focused on: (1) integrating primary prevention into the state system, (2) establishing best practice primary prevention programs, and (3) creating a prevention strategy that advances and sustains the visibility of mental health promotion and disease prevention.

Everything the Department does is based on prevention planning, needs assessment, and data collection; and these are what drive the resource allocation process. Planning is designed to align the Department's activities with recommendations of the State Prevention Council. By the

same token, the Department does not apply for every available federal or foundation grant, but only for those which support the programmatic objectives set by the state's prevention agenda.

Developing partnerships with public agencies at the state and local level, community-based organizations, non-profits and providers, is an important part of the prevention effort. For example, the Department administers the Governor's Prevention Initiative for Youth, a CSAP-funded state incentive grant, which collaborates with schools, colleges, worksites, and media; provides training in science-based prevention techniques to mental health professionals; administers the state's tobacco control and quality assurance programs; provides information services to a wide array of users through a clearinghouse and resource library; and collaborates with the state's Regional Mental Health Boards in prevention planning. Connecticut takes a lifespan approach to prevention, with programs ranging from early childhood interventions, through school-based programs, to services for adults at worksites and in senior centers.

A major effort is being devoted to bridging the gap between research and practice, i.e., piloting or replicating science-based programs, including monitoring components to assure fidelity to the model and evaluate performance. Best practice models being tested or implemented as part of this process include: strengthening families, mentoring programs, life skills counseling, a Grandparents Raising Grandchildren program, a CMHS-funded K through 5 violence prevention program, a residential student assistance program, an education and advocacy program for gay, lesbian, transgendered, and questioning youth, and a prevention and preparedness program focusing on community development relative to disasters, such as the events of 9/11. Federal grants have been an important source of support; in particular, grants from U.S. Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Center for Mental Health Services.

Major issues the Department is currently working on include: local capacity building, training in science-based prevention methods; designing culturally appropriate prevention strategies; bringing demonstrated workable programs to scale statewide; and planning for sustainability of current programs.

There have been some promising areas of achievement. The Department's tobacco enforcement and control program has reduced youth access to purchasing tobacco from 70 percent in 1996 to 12 percent in 2002. Additionally the State Prevention Council is developing plans for inter-agency collaboration on a unified system for surveying school populations.

RACIAL AND ETHNIC DISPARITIES

*Moderator: Janet Scott-Harris
Regional Consultant for Minority Health
Office of Minority Health, US DHHS Region I*

*Sophie Glidden, Director
Office of Rural and Primary Health Care
Maine Bureau of Health
Carl M. Toney, PA, Project Director
University of New England Center for Transcultural Health*

In geographic extent, Maine is as large as all the other New England states put together, but has a population of only 1.27 million people. The population is 96.8 percent white; 0.7 percent are Hispanic, 0.7 percent are Asian/Pacific Islander, 0.6 percent are Native American, and 0.5 percent are African-American. Most of the Latino, Asian, and African American populations live in the southern part of the state.

The minority population is so small that it often goes unnoticed. At the same time, it is remarkably diverse. In the late 1970s there were essentially three languages spoken by families of children in the Portland school system: English, Spanish, and French; last year there were 57 languages spoken by these children. Today there are recent arrivals in Maine from all over the world: Sub-Saharan Africa, Southeast Asia, Mexico and Central America, Middle and Eastern Europe.

Southern Maine has a relatively comprehensive health care system but the minority populations, especially new immigrants, have difficulty accessing health care services. The major problems they face are cost, language barriers, and lack of familiarity with the system. There are also cultural barriers to understanding the American health system, e.g., accepting nurses as part of the medical decision-making team, accepting that American physicians will tell them frankly when they don't know the answer to a patient's questions.

Organization for the Initiative

Largely for financial reasons Maine has not yet established a State Office of Minority Health. Nevertheless, the Bureau of Public Health, Office of Rural and Primary Health Care, has taken steps to coordinate the efforts of the various agencies and divisions of state government around issues of minority health, and to reach out to private sector partners, through the creation of a State Health Disparities Task Force.

An initial requirement was to develop a better sense of the unmet needs of minority populations and the health issues confronting them. As a starting point, therefore, the Bureau contracted with three non-governmental entities to start developing better information. These included: (1) a contract with the Muskie Institute at the University of Southern Maine to develop strategies for collecting and analyzing health data, (2) a contract with the Center for Transcultural Health at the University of New England to identify needs and issues confronting minority populations in the southern part of the state, and (3) a contract with the Wabenaki Mental Health Center to do the same for the Native American tribes.

The University of New England was a particularly important player because it houses most of the state's health professions education programs, and the Center for Transcultural Health, which in addition to work under the contract also provided technical assistance to the Bureau of Public Health.

The Center's first step was to co-sponsor, with the Office of Multi-Cultural Affairs of the City of Portland, a collaborative effort titled the Race, Class, and Health Community Partnership, involving all major public and private stakeholders with a role to play in addressing minority health issues. The mission statement of the Partnership stated that:

The Community Partnership is committed to reducing health disparities through: (1) development of culturally and linguistically appropriate health services, (2) catalyzing local and state action and resources, (3) facilitating equity-based health care relationships, (4) advocating for improved data collection and release, and (5) encouraging education and dialogue regarding the health needs of our underserved communities throughout the State of Maine.

A major challenge was to reach and involve representatives of the many minority communities. The Partnership was able to establish a relationship with the Portland public school system's Parent/Community Specialist Team, a group of 12 to 16 individuals representing 20 different cultural groups which had relocated to Maine. Initially created 10 years ago to help families and their children transition to American life, they had subsequently become involved in a wide range of service activities relating to education, employment, housing, and negotiating the social service system.

Dental Care

The Parent/Community Specialist Team was at first somewhat distrustful of the Partnership, having seen numerous groups come to study their work or offer help without subsequent benefit to their communities. After several meetings, however, they asked the Partnership to assist in addressing a specific problem: minority access to dental care.

The Partnership went to the Dental Hygiene program at the University of New England, which already provided low-cost care on a sliding fee scale basis, and asked them to expand their hours and services. The Program agreed, but asked in turn for help in expediting state approval as a Medicaid vendor so that they could bill for services to Medicaid eligible patients. The Partnership then went to the Bureau of Health and asked if the Bureau would use its good offices to facilitate the approval by the Bureau of Medical Services. At the next meeting with the Parent/Community Specialist Team, the Partnership was able to report that both tasks had been accomplished.

A larger issue was the need to increase the number of dentists practicing in the state, an objective supported by the State Dental Society. Maine participates in the federal loan repayment program, which covers 36 of the state's 47 health professions planning areas. Working with a state legislator, the Bureau of Public Health was able to secure passage of a State Dental Education and Loan Repayment Program which would cover the 11 planning areas which were not eligible for the federal program. The State Dental Society has promoted the program in the United States and Canada.

Other Activities

The Race, Class, and Health Community Partnership has also undertaken a series of educational and infrastructure development activities. These have included: (1) meeting with candidates at national and local levels to discuss ethnic and cultural health, and the need to establish a State Office of Minority Health, (2) introducing community leaders to the legislative process and preparing them to become advocates, (3) holding an HIV/AIDS community forum in the African-American community, with plans for a similar forum in the Hispanic community, and (4) hosting a multi-cultural career day.

The Center for Transcultural Health has been active in developing a cultural competency curriculum for health professions schools at the University of New England, which focuses on enabling health professionals to understand the different perspectives of patients from diverse cultural communities. The Center continues to provide advice and technical assistance to the Bureau of Public Health, and is working on methods to establish networks of health care providers so that patients can enter a seamless system of care through multiple portals.

OBESITY PREVENTION AND CONTROL

*Workshop Leader, Walter C. Willett, MD, Dr. PH
Chair, Department of Nutrition
Harvard School of Public Health*

It is no secret that obesity is a large and rapidly increasing problem in the United States. According to the Behavioral Risk Factor Surveillance System (BRFSS), two-thirds of Americans are overweight, and 20 percent of adults in the U.S. are obese. Rates differ by region, and New England has the lowest rate, but we are only about two years behind the rest of the nation. Moreover, a recent article suggests that the rate of obesity may actually be higher than indicated by the BRFSS data, because people who answer survey questions tend to under report weight and over report height, the two factors used to calculate the body mass index, which is the tool we use for assessing whether a person is overweight or obese. The article reports on a study in which subjects were actually weighed and measured, and suggests that at the most extreme end of the spectrum, grade III obesity is twice as prevalent as reported on surveys.

NECON's Regional Prevention and Control of Obesity Working Group has been charged with developing a strategic plan for addressing this problem, and has made considerable progress in developing a draft report. There has been some discussion of whether the group should wait until there was hard scientific evidence as to the effectiveness of various intervention programs before recommending them. But this is misguided, for two reasons. First, looking at the experience with tobacco control, it is apparent that numerous studies of prevention and control programs failed to document their utility, yet the sum total of all of those efforts has been a marked reduction in smoking across the country. The same can be true of obesity control. Second, if we wait until we have documented proof of program effectiveness we will have wasted a great deal of time.

Given the breadth of the topic, the Working Group has divided its members into a number of sub-groups working on different aspects of the problem. Subject areas include: school nutrition, health care providers, worksite wellness programs, epidemiologic surveillance, utilization of mass

media, exercise and physical environment, food and social environment, and obesity and medical economics, i.e., costs of prevention compared with costs of illness.

Workshop members were divided into similar groups and asked to return and report a few top priority recommendations. A list of recommendations is given below.

- Enact legislation requiring chain restaurants to provide information on calorie content on menus and menu boards, and nutrition labeling on food wrappers.
- Develop partnerships with private sector providers of food at public venues, such as sporting events, to improve the nutritional value of food served.
- Improve the nutritional content of food served in government facilities, e.g., Veterans Administration hospitals, office building cafeterias.
- Place a tax on sugar sweetened beverages, such as sodas, and use the funds raised to support enhanced nutrition and nutrition education.
- Expand state infrastructures and subsidies to support expansion of “farmer’s markets” to promote more extensive distribution of fruits and vegetables.
- Develop and fund state and regional weight control programs.
- Provide tax incentives to encourage large employers to provide weight management programs at the worksite.
- Secure health insurance premium discounts for employers offering certified worksite fitness and weight management programs.
- Promote worksite-based health risk assessment programs.
- Facilitate collaboration among small employers so that they can afford to offer physical activity and nutrition programs to their workers.
- Establish community report cards on obesity so communities can see where they rank, and repeat periodically to assess trends.
- Work with the entertainment industry to build obesity control messages into their products, and harness stars as champions.
- Improve the nutritional value of food served in schools.
- Enhance school facilities and the physical environment, e.g., to promote physical activity.
- Strengthen school curricula with regard to nutrition, exercise, and obesity, e.g., health education, physical education, and family consumer sciences.

- Establish more before and after school programs with nutrition and exercise components.
- Engage health care providers in compassionate weight control counseling and support providers with readily acceptable information about best counseling practices.
- Mandate dedicated reimbursement for weight control counseling by providers.
- Enhance weight control education of providers in medical school curricula and continuing medical education offerings.
- Issue annual or biennial reports of progress in reducing prevalence of obesity.
- Agree on consistent methods and use of comparable indicators across jurisdictions for reporting obesity data.
- Develop data with a view to use by a broad range of public and private users, and assist them in utilizing these data in their programs.
- Work with health maintenance organizations and health insurers to gain access to data for the populations they serve.

WOMEN'S HEALTH

*Workshop Leader: Laurie Robinson, MTS
Regional Coordinator, Office of Women's Health
US DHHS Region I*

*Jacqueline P. Fields, Ph.D., Visiting Scholar
Center for Research on Women, Wellesley College*

Task Force Recommendations

The workshop session opened with a review of four major recommendations made by the Women's Health Task Force to the New England Governors and Commissioners of Public Health.

- (1) Recommend and support a base infrastructure for women's health in each New England state's public health agency, that promotes primary prevention and a coordinated comprehensive approach to health across the lifespan.
- (2) Focus attention in the public, private, and academic sectors on critical women's health issues across the lifespan, which can be impacted by prevention strategies and systems interventions:
 - (A) Develop a policy statement prioritizing improvements in health status for female adolescents and elderly women.

- (B) Identify outcome health indicators for adolescent and elderly women that, if achieved, will reflect improvement of women in these age groups in New England.
- (3) Advocate for shared data monitoring and information dissemination among public, private, and academic sectors.
- (4) Promote improvement in the identified indicators through the development of public/private strategies, partnerships, and policies.

Status of State Infrastructure for Women's Health

Ms. Robinson reported on progress made to date in establishing an infrastructure for women's health in the States.

Connecticut. The Department of Public Health sponsored two statewide conferences on women's health, and issued a data book on Connecticut Women's Health, in 2001. The Department has also promoted programs at the community level, providing educational outreach to women about their health concerns. The Permanent Commission on the Status of Women in Connecticut has focused on women's health as a key concern. Griffin Hospital has recently received a grant from the Office of Women's Health, US DHHS, to become a national Community Center of Excellence in Women's Health.

Massachusetts. The Massachusetts Department of Public Health is one of two health departments in New England to receive a HRSA funded grant to develop infrastructure for comprehensive women's health. Under this grant, Massachusetts has established an Office of Women's Health Policy within the Department of Public Health, and convened key stakeholders from across the state to provide input on women's health planning and program development.

Maine. The Bureau of Health in Maine has also received a HRSA grant, which has been used to hire a full-time staff person, building on the work of the Women's Health Campaign in Maine. This public/private initiative has developed two reports on the health of women and adolescent girls, and developed strategic plans for health improvement for both target populations. The legislature has provided one-time funds to implement some of the elements of these plans, including a cardiovascular disease prevention plan.

New Hampshire. The Women's Legislative Caucus in New Hampshire has previously taken an active interest in women's health issues. The Department of Health developed a two-day conference on Adolescent Health, one of the priority areas recommended for action by the NECON Women's Health Task Force.

Rhode Island. Rhode Island is the only New England state to have a legislatively mandated State Office on Women's Health, established within the state Health Department, with a full-time staff person. The OWH has established an active Advisory Committee on Women's Health, and sponsored a conference on the health of older women.

Vermont. The Vermont Department of Health has assigned a part-time staff person to work on comprehensive women's health issues. Activities include a recent conference on Women and Cardiovascular Health, and analysis of data on women's health in the state. In addition, the Bi-State Primary Care Association is concluding work under a HRSA grant which has facilitated development of a statewide coalition (Women's Health Vermont) to address women's health issues. Vermont also has a community center of excellence in women's health run by the Northeastern Vermont AHEC, which promotes a community-based model of comprehensive women's health.

Data Project

The second part of the workshop session focused on progress of the Women's Health Task Force Data Project, funded by DHHS. As part of this project Jacqueline Fields, a Visiting Scholar and Senior Research Scientist with the Center for Research on Women at Wellesley College, has been developing and evaluating baseline data on women's health using indicators recommended by the Women's Health Task Force. Dr. Fields made a report to the workshop on methodology and preliminary findings.

Adolescent health indicators included: (1) measures of health insurance coverage that included comprehensive preventive services, and percent of adolescent women receiving an annual preventive visit, (2) percent of adolescent women experiencing physical, sexual, or dating abuse or violence, (3) percent of adolescent women using tobacco, alcohol, or drugs, (4) percent of adolescent women with eating disorders, and (5) percent of adolescent women experiencing unsafe sex.

Elder women's health indicators included: (1) percent of women aged 60 and over covered by any insurance, and percent using their Medicare preventive benefits, (2) percent of women receiving an annual flu shot and pneumonia vaccination, (3) percent who experience falls resulting in hospitalization, (4) percent suffering from depression, and (5) percent with acute myocardial infarction.

A major concern was quality, completeness, and comparability of key data sets for developing indicators, e.g., BRFSS, YRBS, and Hospital Discharge Data Systems. A fuller progress report on the data project will be presented at next year's NECON regional conference.

CARDIOVASCULAR HEALTH

*Facilitator: David Chatel
Senior Vice President for Health Marketing
American Heart Association*

Initiating Prevention from the Acute Care Setting

*Mark C. Pettus, MD, Associate Chair
Department of Medicine, Berkshire Medical Center*

Berkshire County, Massachusetts, has a population of 135,000, with a somewhat larger proportion of elderly than the state as a whole: 18 percent of the population is covered by Medicare. The county is served by a "dominant" health care system with two hospitals (providing 80 percent of acute care), operates over 50 percent of skilled nursing beds, is affiliated with visiting nurse

associations, and is developing an information system which links to primary care providers. In short, the system is strategically placed to provide health care across the continuum of services from prevention, through ambulatory care, to acute and long-term care.

The overlapping problems of obesity, diabetes, and cardiovascular disease have reached epidemic proportions in Berkshire County. Based on the prevalence of Type II diabetes it is estimated that there may be as many as 11,000 diabetics in the area. As in most communities, cardiovascular disease is the number one cause of death. According to data collected in 1999, the County has one of the highest cardiovascular mortality rates in Massachusetts, only partially accounted for by the high proportion of elderly.

The Medical Center's response has been a program in which the acute care episode is used as an opportunity for implementing the prevention guidelines of the American Heart Association. The Center sees 120 admissions annually of patients with an acute coronary syndrome, myocardial infarction, or unstable angina; roughly 240 have an admitting diagnosis of congestive heart failure; about 200 are stroke patients; and roughly 120 patients per year have surgery for peripheral vascular disease. This is a captive population with known cardiovascular risk, which should be responsive to education and counseling about lifestyle changes, and to whom the health system should be providing better management, with a focus on prevention.

Evidence from a recent Scandinavian trial has demonstrated the additive benefit of multiple pharmaceutical interventions in preventing cardiovascular events. In other words, prescribing statins is effective, also prescribing aspirin yields further reduction in subsequent cardiovascular events, and adding a Beta Blocker can result in a 70 percent reduction over all. These are very powerful numbers.

The challenge is to get providers to prescribe appropriately. Baseline data from a study at UCLA found that at hospital discharge, 78 percent of cardiovascular patients had been prescribed aspirin, 12 percent were on Beta Blockers, fewer than 5 percent were on Ace inhibitors, and 5 percent were on statins. By establishing systems improvements in the hospital setting, after 12 months the proportion of discharged heart patients on an appropriate combination of medications increased significantly.

The Berkshire Medical Center is working to apply these lessons. To begin with, the Center established a multi-disciplinary cardiovascular team with representatives from cardiology, nursing, primary care providers, surgeons, educators, and administrators. To educate the health care community, the program makes presentations at staff meetings and grand rounds, and there is a heavy emphasis on academic detailing.

Within the hospitals, systems have been set up involving physicians, surgeons, nurses, residents, and even secretaries, to constantly and repeatedly promote an awareness of prevention, organized around check lists, pre-printed order sheets, and access to databases; with follow-up calls to primary care providers for patients who fall through the cracks. In short, it is very difficult for a patient to come through the hospital setting without someone recognizing and acting on the opportunity for prevention.

The premise is that with multiple redundant systems of care, any patient admitted to the hospital will interface with staff who recognize when patients are at risk and will take advantage of opportunities to intervene, supported by an institutionalized system of reminders and prompts.

A key factor is that the program is not blame-oriented but is defined as an issue of patient safety: failure to start a patient on appropriate preventive therapies is a treatment error. Once the therapeutic culture is changed, prevention happens. It helps that the program is structured as a research effort with emphasis on outcomes. It is very hard for a resident who is sleep deprived, and is caring for 12 or 14 patients, to appreciate that preventive medication can actually save lives. The opportunity to show them the results in terms of survival gives them a broader vision of their mission as house officers and future practicing physicians.

Facilitating Prevention through a Statewide Non-Profit

John Lacasse, ENG.D.SC.

President, Medical Care Development

The Maine Cardiovascular Health Council was originally established in 1977, as the Maine High Blood Pressure Council, as the result of a demonstration project funded by the National Heart, Lung, and Blood Institute. The purpose of the project was to determine whether improved coordination of the state's resources for blood pressure control could achieve a one-third reduction in the rate of uncontrolled blood pressure in the adult population. Maine was one of seven states participating in the demonstration, and one of only three that achieved its goal.

The purpose of the Council is to bring together all the relevant policy makers and stakeholders concerned with cardiovascular health; for example, hospitals, physicians, health associations, and private sector entities. Major functions include advising the Maine Bureau of Health, in the Department of Human Services; helping facilitate consumer access to treatment resources and information on making health-enhancing lifestyle choices; and to promote policies which affect prevention of cardiovascular disease.

Maine was one of the first states to establish statewide standards of hypertension control. This was achieved when the Council convened a group of cardiologists in the state to write standards, and then actively promoted these standards to health care providers.

The Council has been instrumental in developing support for using Tobacco Settlement money for smoking control programs in the state. Maine devotes a larger proportion of these funds to tobacco control than any other state. These funds support 31 local coalitions which focus on prevention activities targeted to cardiovascular risk factors in their communities.

In 1998 the Council raised \$300,000 from managed care companies, hospitals, and a number of smaller foundations. These funds were used as a private sector match to state Medicaid dollars, which were then used to fund cardiovascular screening programs and establish nurse case management programs in 32 of the state's 35 hospitals. The program was based on a highly successful model developed in Farmington, Maine by Burgess and Sandy Record in which area hospitals partner with local physicians and community coalitions, providing educational outreach, screen-

ing services, acute inpatient care, and cardiovascular case management when patients are discharged from the hospital

Another achievement has been the establishment of a standardized data system to support the nurse case management systems in hospitals. In large part because this information system was in place, Maine was selected as one of 15 states to conduct a randomized trial to demonstrate the effectiveness of the nurse case management model.

The Council has also been engaged in worksite health promotion. As of this date 25 employers have implemented workplace programs to promote increased physical activity and smoking cessation.

In short, the Council has been an active non-profit facilitator of state efforts to develop an improved infrastructure for cardiovascular service delivery and health promotion across the state.

Implementing Prevention by Changing Public Policy

Kathy Foell, MS, RD

Director, Cardiovascular Health Initiative

Massachusetts Department of Health

When Ms. Foell first became involved with the Policy Environmental Change Initiative she wasn't sure just what that might involve. She had always been involved with service programs and this seemed more nebulous.

It takes a moment's thought to recognize how much impact public policy choices can have on health. Service programs are important because they meet the needs of individuals. The decision to implement new public health policies, through legislation and/or regulation, can improve the environment for an entire population. Some examples include policies relating to smoke-free public spaces, pasteurization of milk, seat belt laws, putting nutritional information on food packaging, and setting auto emission standards.

Ms. Foell's first step was to form a coalition, like the one in Maine, to determine what public health policies needed to be changed or established to promote cardiovascular health. The coalition defined four target groups of concern: the general population, the at-risk population, persons who have had a heart attack or stroke, and the population with heart disease. The coalition also identified four sites for implementation of new policies: schools, worksites, the health care system, and local communities. An advisory group was established for each site, and conducted a survey of its site to identify policies currently in place.

- * A survey of 423 industries with 50 or more employees found that less than half had healthy foods available at the worksite. Eighty-six (86) percent had smoke-free worksite policies, but fewer than half had effective systems in place for enforcement.
- * In the health care system, hospitals were found to be most effective in establishing clinical preventive practices, e.g., screening and health education policies. A survey of medical group practices, however, found that relatively few were actively engaged in primary or secondary prevention. Very few tracked patients who had experienced a heart attack or stroke.

- * The survey of community settings found that when town planners think about public health they think mainly about such things as cesspool inspection and restaurant inspection by local health departments. They don't think about the impact of sidewalks on walking promotion, or the nutritional content of food served by restaurants, or community basketball courts for youth, or creating spaces for farmers' markets.

Ms. Foell asked the workshop members to suggest their own ideas for policy changes which could improve cardiovascular health. Major responses included:

- The New England governors should ask all department heads in their states to identify policies they could implement that would promote improved nutrition and increased physical activity.
- Transportation planners should be encouraged to develop intermodal transportation systems which would permit workers to walk or bike part of the way to their place of employment, and inner city walking paths.
- Employers should be encouraged to identify workers with cardiovascular health risks.
- Schools should be required to reinstate regular physical education classes and to improve the nutritional content of school food programs.
- Since HMO and third-party payor reimbursement for health promotion is limited, the state should reimburse providers for these activities.
- Tobacco taxes should be increased and should be uniform across the New England states.
- Tax incentives should be offered to employers to expand their health promotion activities, e.g., establish gyms and exercise programs.

CANCER PREVENTION AND CONTROL

Moderator: Janet McGrail

VP for Prevention and Detection

American Cancer Society, New England Division

Graham Colditz, MD, Dr. PH

Harvard Center for Cancer Prevention and

Chair, NECON Cancer Working Group

Dr. Colditz reviewed progress in the New England states in meeting the NECON Cancer Working Group objectives set forth two years ago. In most instances states were working on the objectives and some progress was being made, but there was still much to do. Cigarette taxes had been raised across the region but were still not uniform, and the resulting funds were not by and large being devoted to tobacco control. Maine had allocated significant Tobacco Settlement funds to tobacco control, and had invested the highest *per capita* amount to smoking control programs. Other states were not up to that level.

Two years ago the Commonwealth of Massachusetts had a model comprehensive school health education program, but state budget cuts bar any serious funding at the present time. Rhode Island has enacted model legislation requiring health insurance coverage for participation in clinical trials. A similar bill has been introduced in Maine.

Each of the New England states has enacted a version of the Patient's Bill of Rights. Only Vermont's Bill of Rights, however, contains all of the main provisions.

Another recommendation called for "adequate sustained funding for tumor registries at the same operational level in all New England states," which is key to looking at progress in cancer trends across the region as a whole. A challenge appeared to be determining what an "adequate minimum standard" ought to be, yet the need for having compatible standards was clear. At the present time, different state tumor registries had different staging systems.

The goal of banning smoking on school property, indoors and outdoors, has been achieved in New Hampshire, and other states are working on it. Progress is also being made on efforts to prohibit free distribution of tobacco products for promotional purposes.

The Cancer Working Group's recommendation for tax incentives to encourage employers to establish physical activity and wellness programs has not been acted on, but Rhode Island has had success in developing a *voluntary* program with some of its industries.

With regard to funding for nutrition education programs, Maine has a fully funded 5-a-Day program, and Massachusetts has a funded nutrition program. In Rhode Island nutrition is part of the Health Department's agenda but has no separate funding at this time.

At this point panelists from the various states reported on progress in developing comprehensive state cancer plans.

Rhode Island. The Rhode Island Department of Health, American Cancer Society, and Rhode Island Cancer Council collaborated on submission of an implementation grant but was not funded. In the meantime they have been responding to a mandate from the General Assembly to establish community task forces in all of the state's 39 cities and towns, working initially with the political leadership and key stakeholders in 15 priority communities embracing the most heavily populated communities. The first step in each community will be for the task force to conduct a needs assessment and establish community priorities.

Connecticut. In 1998 the state established a comprehensive cancer consortium to study cancer data. Initial members of the consortium were the State Office of Policy Planning, the Department of Public Health, the State Medical Society, the Yale Comprehensive Cancer Center, and the University of Connecticut; later joined by the American Cancer Society. This group put together a preliminary outline, which provided the basis for a federal grant proposal for funds to develop a comprehensive cancer plan. This proposal was funded for \$147,000. The focus will be on design and enhancement of critical elements of the plan, assessment of the cancer control infrastructure at state and local levels, and identification of specific cancer sites for priority action.

Maine. A meeting of all major stakeholders was held in 1999. A Maine Cancer Consortium was founded, charged with developing and implementing a state cancer plan, using the CDC's definitions of integration and coordination of cancer prevention, detection, treatment, rehabilitation, and palliation. The consortium's report was completed in January, 2001, and identified skin cancer, colon cancer, and improved data and surveillance as its priorities. The state has received no federal funds but the American Cancer Society and one of the state's leading managed care organizations have provided significant financial support. These funds are being used for a retrospective chart audit at 10 hospitals to determine adequacy of pain management, and to develop a standardized data collection tool for use by hospitals in the state.

Vermont. The state is at an early stage but has applied to the CDC for a planning grant. Cancer control programs include a cervical and breast cancer screening program. The cancer registry is in place. And the state's tobacco control program is funded, although not at the level recommended by the CDC.

New Hampshire. The state's comprehensive cancer control planning grant application to the CDC was approved but not funded. Planning efforts are being continued, largely under the auspices of the Division of Chronic Disease Prevention.

Massachusetts. The state has drawn up a comprehensive plan which focuses on diagnosis, access to treatment, and quality of life. A state coalition has been formed whose goals include: reduction in cancer incidence, morbidity, and mortality; public education to enhance understanding of risk factors; training for health care providers; advocacy; and support for cancer patients and their families.

ADOLESCENTS LIVING WITH HIV

*Workshop Leader: Donna Gallagher, RNC, MS, ANP, FAAN
Director, New England AIDS Education & Training Center*

*Durrell Fox, Director
New England HIV Education Consortium*

With the introduction of HIV reporting in Massachusetts a clearer picture of the epidemic is emerging. Of particular concern is the increasing number of youth who are living with HIV, which underscores the need for intensified programs of primary and secondary education targeted to this population, which is at once particularly vulnerable and prone to risk-taking.

- * Twenty-five (25) percent of new cases of HIV are in the 13 to 24 age group in the population, and it is estimated that one out of five adults who are living with HIV were infected as adolescents.
- * While unprotected sex and needle sharing continue to be the primary source of transmission, a growing number of adolescents living with HIV were born with the condition, and with improved medical care can be expected to have longer lives. Some are already parents with children of their own.

- * Almost 60 percent of young people who test positive for HIV are people of color. The proportion of those testing positive for HIV who are female is increasing.
- * Adolescence is a period of psychosocial vulnerability, especially for disadvantaged youth. It is also a period of greatest involvement in risk-taking behavior, which is of particular significance for those who are HIV positive.
- * There is a pressing need for secondary prevention programs for adolescents living with HIV to reduce the harm they can do to themselves, e.g., through failure to follow medical regimens, or to others, through further transmission of HIV infection.
- * Unfortunately, it is estimated that over 90 percent of adolescents with HIV, who know their condition, are not in care.

Psychosocial Risk Factors

Adolescents with HIV are more likely to be raised by non-biologic parents. They are more likely to have lived in multiple homes, and many are homeless. Many are school dropouts, and when they do go to school, few schools provide adequate instruction about AIDS and prevention of HIV infection. Relatively few physicians who provide medical care to adolescents with HIV provide or refer to social services and support systems for these patients. In other words, many adolescents living with HIV, in addition to bearing the combined psychosocial burdens of adolescence and HIV, live in disorganized social environments and have limited access to comprehensive care.

What Adolescents Living With HIV Need

All of the services which are provided to adults with HIV are also needed by adolescents — and more: medical care, access to public benefit programs, transportation, support groups; but also AIDS education in schools, supportive counseling, a caring home environment, extracurricular activities, help in academics, and youth support groups.

Primary care physicians need to be trained to recognize the needs of their adolescent HIV patients for psychosocial services and to provide or refer to these services. The optimum approach would be for medical care providers to work in multi-disciplinary teams with a case manager, outreach workers, counselors, and health educators. A single comprehensive source of care is critical, since many adolescents will not follow up on referrals to a number of different sites for care.

Outreach services are essential to identifying and engaging the 90 percent of HIV positive adolescents who know their condition but remain outside the system of care, and this is particularly true of the homeless. Passing out condoms and providing educational materials is only a small part of an outreach effort. The real objective is to build a relationship with the HIV positive adolescent which can bring him or her into a comprehensive system of care. Finding homes for the homeless, which provide a healthy environment, is a key objective.

Case management is key to keeping the HIV positive adolescent in the system of care once he or she has entered it. And it is critical that the adolescent with HIV have supportive counseling from a trusted person who is not a family member, with whom they can discuss their feelings and issues.

Although the health care system has developed medical interventions which are increasingly effective in maintaining health and extending life, the medical model *per se* is not sufficient to meet the needs of adolescents living with HIV. Medical care must be combined with outreach, case management, and supportive counseling.

Primary prevention needs to be taught in the schools, and secondary prevention taught at all teachable moments in the system of care for HIV positive youth.

Every effort needs to be made to provide HIV positive youth with stable nurturing environments to reduce opportunities for risky behavior, and to help them avoid co-morbid risk factors such as alcohol and drug dependence, and the consequences of unprotected sex.

Finally, policies must be put in place in the New England states to provide sustained funding for prevention and care programs which have proven effective for this population.



NECON Advisory Group

- Carlos Alvarez
ALA OF MA
- Kathleen Atkinson
MA DPH
- Patti Baum
NH DHHS
- Joanne Bean, R.N., M.B.A., B.S.N.
AMERICAN DIABETES ASSN.
- Joseph Bevilacqua, Ph.D.
MENTAL HEALTH PROMOTION &
SUBSTANCE ABUSE PREV (RI)
- James P. Campbell
NAT'L ASSN HIV OVER FIFTY (MA)
- David A. Chatel
AMERICAN HEART ASSN (MA)
- Graham A. Colditz, MD, DrPH
HARVARD SCHOOL OF PUBLIC HEALTH
- Avery Colt
RI PUBLIC HEALTH FOUNDATION
- MaryAnn Cooney, RN, MS
NH DHHS, OFFICE OF COMM & PH
- Charles Deutsch
HARVARD SCHOOL OF PUBLIC HEALTH
- Linda Downing
AON CONSULTING (MA)
- Janet Edmunson, M.Ed.
BC/BS OF MA
- Kathy Foell, MS, RD
MA DEPARTMENT OF HEALTH
- Ralph Fuccillo, MA
HARVARD PILGRIM HEALTH CARE FOUND
- Donna Gallagher, RNC, MS, ANP, FAAN
NEW ENGLAND AIDS EDUC & TRAIN CTR.
- William Gerrish
CT OFFICE OF HEALTH COMMUNICATIONS
- William Gildea
N E GOVERNORS' CONE, INC. (MA)
- Margaret E. Kane
AMERICAN LUNG ASSN OF RI
- Fran M. Kochman
GLAXOSMITHKLINE (CT)
- Judith Kurland
HUNT ALTERNATIVES (MA)
- Barbara Leonard, MPH
MAINE BUREAU OF HEALTH
- John E. McDonough, Dr. P.H.
BRANDEIS UNIVERSITY (MA)
- Kirk Morgan
AVENTIS PHARMACEUTICALS (NY)
- Carolyn Morwick
NE BOARD OF HIGHER EDUCATION (MA)
- Catherine O'Connor, MA
MA DEPT OF PUBLIC HEALTH
- Helen Riehle
VT PROG. FOR QUALITY IN HEALTH CARE
- Laurie L. Robinson, MTS
WOMEN'S HLTH, US DHHS, REGION I(MA)
- Betsy Rosenfeld, JD
US DHHS/OFF PUB HLTH & SCIENCE
- Randy Schwartz, MSPH
AMERICAN CANCER SOCIETY, NE DIV (ME)
- Janet L. Scott-Harris
US DHHS/MINORITY HEALTH, REGION I
- Kevin Sullivan
CT OFFICE OF HEALTH COMMUNICATIONS
- Donald Swartz, MD
VT DEPT OF HEALTH
- Gisele A. Thornhill, MD, MPH
MA LEAGUE OF COMM HEALTH CENTERS
- Charles C. Tretter
N E GOVERNORS' CONE, INC. (MA)
- E Randy Vogenberg, R.Ph., Ph.D.
AON CONSULTING (MA)
- William Waters, Jr., Ph.D.
RI DOH
- Katherine Wells Wheeler
NH PUBLIC HEALTH ASSN.
- Walter C. Willett, MD, Dr. PH
DEPT. OF NUTRITION
HARVARD SCHOOL OF PUBLIC HEALTH
- Bertram A. Yaffe, CHAIR
NECON



N•E•C•O•N

established 1984

The New England Coalition for Health Promotion and Disease Prevention

Marketing Prevention for Societal Health

October 22, 2002 • Royal Plaza Hotel & Trade Center • Marlborough, MA

8:00 Registration -- Coffee & light refreshments

8:30 Welcome & Introductions

Bertram Yaffe, Chair, NECON

Brian M. Cresta, Regional Director, Region One (New England), US DHHS

Betsy Rosenfeld, JD, Acting Regional Health Administrator, US Public Health Service, Region One (New England), US DHHS

9:00 Panel: Marketing Prevention for Societal Health

Joxel Garcia, MD, MBA, Commissioner, State of CT, DPH

Patricia A. Nolan, MD, MPH, Director of Health, RI DOH

Howard Koh, MD, MPH, Commissioner, MA DPH

Rep. Peter J. Koutoujian, Vice Chair, Joint Committee on Health Care (MA)

Moderator: Deborah Prothrow-Stith, MD, Assoc. Dean of Faculty Development, Division of Public Health Practice, Harvard School of Public Health

10:30 Break

10:45 Keynote Address

Claude A. Allen, Deputy Secretary, US Dept. of Health & Human Services

Introduction: Brian M. Cresta, Regional Director, Region One (New England), US DHHS

11:30 Tales From the Trenches

Gerald L. Evans, MD, Director, HeartVentures, Framingham, MA

Introduction: Mary Ann Cooney, BNC, MS, Director, NH DHHS, Div. of Chronic Disease Prev.

Carol Cone, Chief Executive Officer, Cone, Inc.

Introduction: Bertram Yaffe, Chair, NECON

12:45 Lunch

Sen. Jack Reed (RI), US Senate Healthcare Committee

Introduction: Bertram Yaffe, Chair, NECON

2:00 Working Groups & Task Forces: Confronting the Challenges

• Eliminating Disparities

"The Community-Academic-Public Policy [CAPP] Team - Addressing Health Disparities in ME"

Moderator: Janet Scott-Harris, Regional Consultant for Minority Health,

US DHHS/Office of Minority Health, Region One

Carl M. Toney, P.A., Project Director, Univ. of New England Center for Transcultural Health

Sophie Glidden, Director, Office of Primary and Rural Health Care, Co-Director,

Health Disparities Task Force, ME Bureau of Health

• Obesity

"Control and Prevention of Obesity"

Workshop Leader, Walter C. Willett, MD, Dr.PH, Chair, Dept. of Nutrition, Harvard School of Public Health

- **HIV/AIDS**

"AIDS and Adolescents"

Workshop Leader, Donna Gallagher, RNC, MS, ANP, FAAN, Director, New England AIDS Education & Training Center

Durrell Fox, Director, New England HIV Education Consortium

- **Heart**

Facilitator: David Chatel, Sr. VP for Health Marketing, American Heart Association

Kathy Foell, MS, RD, Director, Cardiovascular Health Initiative, MA Department of Health

John Lacasse, ENG.D.SC., President, Medical Care Development

Mark C. Pettus, MD, Associate Chair, Dept. of Medicine, Berkshire Medical Center

- **Cancer**

"The NECON Cancer Working Group: Collective Action Toward Accomplishments and Future Directions in State-based Comprehensive Cancer Planning"

Moderator: Janet McGrail, VP for Prevention and Detection, American Cancer Society, New England Division

"NECON Cancer Working Group: Progress on Priorities Through Collective Action"

Graham Colditz, MD, DrPH, Harvard Center for Cancer Prevention

Chair, NECON Cancer Working Group

"State Comprehensive Cancer Control Planning: Progress and Prospects for Enhancing the Future of Collective Action For Cancer Control Initiatives"

Panel:

John Fulton, RI Dept of Health

Adrienne Walsh, American Cancer Society, NE Division, Providence, RI

Cheryl Haller, ACS New England Division, Montpelier, VT

Barbara Moeykens, VT Dept of Health

Mary Ann Cooney, NH Dept of Health

Penny Maliska, ACS, New England Division, Bedford, NH

Anita Ruff, CDC/ME Bureau of Health

Marty Mancuso, ACS, New England Division, Meriden, CT

Janet McGrail, ACS, New England Division, Framingham, MA

Graham Colditz, MD, DrPH, Harvard Center for Cancer Prevention

Chair, NECON Cancer Working Group

- **Mental Health**

"Brief Review of Current CMHS Promotion and Prevention Activities"

Nancy Davis, Ed.D., Public Health Advisor, SAMHSA/Ctr. for Mental Health Services

"Next Generation - A Statewide Approach to Prevention"

Workshop Leader, Joe Bevilacqua, Ph.D., Chair,

Mental Health Promotion & Substance Abuse Prevention Task Force

Thomas Kirk, Jr., Commissioner, CT Dept. of Mental Health & Addiction Services

Dianne Harnad, MSW, Director, Prevention Services, CT DMH&AS

Wayne Dailey, Ph.D. Senior Policy Advisor, CT DMH&AS

- **Women's Health**

Workshop Leader, Laurie Robinson, Women's Health Coordinator, Region I, US DHHS

Jacqueline P. Fields, Ph.D., Visiting Scholar, Ctr. for Research on Women, Wellesley College

4:00 Closing Remarks and Next Steps

MASSACHUSETTS

The The Massachusetts Department of Public Health is continuing to implement a strategic plan that identifies its mission, priorities, guiding principles, goals and activities for the 2001-2005 period.

The Mission of the Massachusetts Department of Public Health

- * We believe in the power of prevention.
- * We work to help all people reach their full potential for health.
- * We ensure that the people of the Commonwealth receive quality healthcare and live in a safe and healthy environment.
- * We build partnerships to maximize access to affordable, high quality health care.
- * We are especially dedicated to the health concerns of those most in need.
- * We empower our communities to help themselves.
- * We protect, preserve, and improve the health of all the Commonwealth's residents.

2001 - 2005 Public Health Priorities

The Massachusetts Department of Public Health will work in collaboration with federal, state and local officials, public health practitioners, healthcare providers, communities, consumers, and health advocates to:

- * Protect the public from disease, injury, and environmental health hazards;
- * Upgrade the public health infrastructure to meet the needs of the 21st century;
- * Educate the public and providers about health issues and services;
- * Improve access to services and the quality of care; and
- * Promote health status improvement and eliminate health disparities.

Guiding Principles for Public Health Programs and Services

- * Develop and implement comprehensive service systems that are fully integrated, easily understood, and accessible to the public.
- * Consult and include consumers and communities in the design, delivery, and evaluation of services and programs.
- * Value diversity and promote competency in understanding factors of culture, language, disability, sexual orientation and gender identity that impact health status.
- * Establish standards of accountability to consumers and the public in the planning and delivery of services, including implementation of quality improvement and "best practices" in programmatic, administrative, and financial matters.

Elements of the Public Health Strategic Plan

Priority #1: Protect the Public from Disease, Injury, and Environmental Health Hazards

- * Prevent foodborne illness.
- * Prevent the spread of communicable disease.
- * Prevent exposure to environmental health hazards, injury, and unsanitary conditions in both the community and the workplace.

Priority #2: Upgrade the Public Health Infrastructure to Meet the Needs of the 21st Century

- * Ensure high quality, culturally competent, public health workforce.
- * Upgrade the quality of health information and access to public health data systems.
- * Upgrade state and local capacity to respond to bioterrorism and infectious disease emergencies.
- * Increase communication and coordination between and among state agencies, local health departments, and community-based organizations.

Priority #3: Educate the Public and Providers about Health Issues and Services

- * Prepare and disseminate reports that identify and track health disparities related to gender, race, ethnicity, age, geographic location, economic status and sexual orientation.
- * Conduct, support, and publish public health research.
- * Develop and implement education, training and outreach initiatives re. the public health system, alcohol, tobacco, and other drugs, cancer prevention and early detection, environmental health, cardiovascular disease prevention, infectious disease control, genetic testing, patient protection initiatives, HIV prevention, responsible sexual behavior, injury prevention, domestic violence, health care coverage and healthy behaviors.

Priority #4: Improve Access to Services and the Quality of Care

- * Upgrade emergency medical services.
- * Increase patient protection.
- * Increase access to linguistically and culturally competent healthcare.
- * Upgrade patient care at the four public health hospitals.
- * Increase access to health care for children and to screening and treatment programs for adults.
- * Increase access to a continuum of treatment and recovery services for alcohol, tobacco, and other drugs.

Priority #5: Promote Health Status Improvement

Our goal is to meet or exceed the targets outlined in Healthy People 2010 and eliminate health disparities in the following areas: nutrition and physical activity, tobacco use, substance abuse, responsible sexual behavior, communicable disease, environmental health, immunization, access to care, injury and quality of care.

VERMONT

The Vermont Department of Health is the state's public health agency that works to protect and improve the health of Vermont's population through its core public health functions that include:

- o Preventing epidemics and the spread of disease
- o Protecting health through the environment, housing, food and water
- o Promoting healthy behaviors
- o Responding to disasters and assisting communities in recovery
- o Assuring the quality and accessibility of medical care
- o Reaching out to link special populations to services
- o Providing direct services as needed
- o Providing sound public health policy and planning

Bioterrorism and Emergency Response

Over the past year, a great deal of time and effort has gone into planning for and responding to emergencies. Following the identification of anthrax as a cause of death of a patient in Florida and other cases in New York City, public health played an integral part of the state's team--evaluating suspicious powders, providing patient and provider education and information and addressing public concerns. Fortunately, no cases of anthrax were identified in Vermont.

Vermont has received approximately \$6.3 million from CDC to assure the Vermont's overall public health system is able to respond rapidly and effectively to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.

Potassium Iodide Distribution

Since April 2002 the Department of Health has been making available one dose of potassium iodide to any person who lives or works in the towns within the emergency planning zone for the Vermont Yankee Nuclear Power Station. This voluntary pre-distribution program is part of Vermont's terrorism preparedness effort; it comes as a result of the Nuclear Regulatory Commission's offer in late 2001 to provide pills free to any of the 34 state with people living within 10 miles of nuclear power plants. Forms and information are available on the department's website: www.HealthyVermonters.info.

Healthy Vermonters 2010 Highlights

The department's activities are guided by the goals and objectives laid out in Healthy Vermonters 2010, the state's blueprint for improving public health. Over the past 10 years, public health has improved in many areas. We have met or made substantial progress towards more than two-thirds of the goals established in Healthy Vermonters 2000, the predecessor to Healthy Vermonters 2010. Specifically, breast cancer screening has increased and death rates have come down; more children are being screened for lead poisoning and fewer poisoned; and the teen pregnancy rate among 15- to 17-year-olds is the lowest in the nation. We have achieved a substantial reduction in cigarette smoking among teenagers, and are starting to see declines in alcohol and marijuana use among young Vermonters as well.

Alcohol & Other Drug Use

Vermont has seen a dramatic decline in drinking, smoking and marijuana use among 8th graders. Attitudes toward these behaviors are changing as well with a higher percentage of youth thinking it's wrong to drink alcohol, smoke cigarettes and use marijuana.

At the request of the Governor, the Commissioner of Health led the Heroin Action Committee—a group of 39 people representing a wide range of organizations with expertise in prevention, treatment, and enforcement—to come up with a plan for addressing a growing heroin problem in Vermont. The committee included representation from state and local police, judges, treatment providers, physicians, schools, health care, teen centers, public health, corrections, public safety, and other organizations dealing with problems associated with heroin.

At the heart of the committee's recommendations is agreement that a comprehensive approach that includes prevention, treatment and enforcement is needed and that actions must focus not only on heroin, but also on alcohol, marijuana and other drugs. The final report includes a set of recommendations based on committee meetings and six public forums held around the state and attended by about 400 Vermonters. Among the recommendations:

- o Put a student assistance counselor in every school
- o Improve early intervention resources for kids identified in elementary school as being high risk
- o Start an in-state residential youth treatment program
- o Increase treatment options for addicts
- o Set up/support drug courts
- o Improve resources for parents of "unmanageable" teens

Cancer

Vermont's ongoing efforts in the area of cancer prevention have led to dramatic increases in breast cancer screening and a significant drop in breast cancer deaths. The Vermont Ladies First program continues to promote early detection and screening of those at risk.

The Vermont Cancer Registry published its first report, *Cancer in Vermont*, in 2000. One finding of this report was that Vermont's colorectal cancer incidence is statistically worse than the U.S. rate. Planning has begun to develop new efforts to help people lower their risks by getting regular screening, being more physically active and improving their diets.

Diabetes

Like the rest of the nation, Vermont's diabetes-related death rate is rising. The most recent effort of our very active Diabetes Control Program is *Learning to Live Well with Diabetes*, a booklet and website designed to help people with diabetes take steps to improve their own health. In addition, we have published clinical guidelines for diabetes management and guidelines to assist school staff assure that children with diabetes get the help and services they need.

Heart Disease and Stroke

Nationally and in Vermont, death rates from heart disease and stroke have been steadily declining over the past 30 years. Still, heart disease is the leading cause of death in Vermont and stroke is the third leading cause. More women than men die from cardiovascular disease. Vermont has a strong

new coalition working to address this issue. One early step was a conference on Women and Heart Disease that was attended by more than 150 heart disease experts, health professionals and community leaders.

Immunization and Infectious Disease

Vermont has been able to maintain high levels of childhood immunization, even as the country faces vaccine shortages.

Like many other states, Vermont had its first confirmed human cases of West Nile virus this year, with no deaths. Public health activities have focussed on public education about preventing mosquito bites and removing mosquito habitat around homes, dead bird surveillance, testing mosquito pools, and educating health care providers. Along with the human cases, there were positive birds, mosquito pools and horses confirmed in Vermont this year.

An investigation into an outbreak of Legionnaires' disease confirmed 18 cases of Legionnaires' disease, with an additional 12 cases of milder illness caused by the Legionella bacteria. More than 180 people with a range of symptoms were tested and found to be negative for Legionnaires' disease. Evidence from the investigation found that a cooling tower in a State Office Complex was the likely source of the outbreak. New cleaning and maintenance practices have been implemented to prevent any future outbreaks.

Injury and Violence

Nearly 300 Vermonters lose their lives to injuries each year and thousands more suffer serious, sometimes permanent, disabilities as a result of their injuries. Injuries—not disease—are the leading killer of Vermont children, adolescents and young adults. We are continuing efforts begun in 1999 with a grant from the Centers for Disease Control and Prevention to focus public attention and prevention efforts on the problem of injury. The Vermont Injury Prevention Advisory Committee was formed in 2000 to help guide the department in forming an action plan, which we released this year--The Vermont Injury Prevention Plan.

Maternal, Infant & Child Health

This year, the Vermont Healthy Babies program has grown into Healthy Babies, Kids & Families. A new guidebook for new families, Growing Up Healthy, was recently published along with a series of Growing Up Healthy newsletters. Vermont has become a "Touchpoints" site in which many multi-disciplinary health care provider groups are trained in the Touchpoints model created by Dr. T. Berry Brazelton and faculty at the Brazelton Touchpoints Center in Boston.

Overweight, Nutrition and Physical Activity

Like the rest of the country, the percentage of Vermont adults who are obese continues to rise. In 2001, 52 percent of Vermont adults and 23 percent of students in grades 8 through 12 were over healthy weight. The Vermont Department of Health has developed and piloted FIT WIC Activities, a program to help parents and preschool children become more physically active. Another new initiative this year is the Run Girl Run program which promotes physical activity among tweens or young teenagers.

Respiratory Disease

Last year, the department convened a Leadership Conference on Asthma to bring together experts and leaders in the area of asthma. The conference was a first step in identifying issues and needs with regard to educational materials for providers and patients, clinical practice guidelines and other resources. Since then, we have launched an Asthma Media campaign to educate parents and children about how to avoid asthma triggers and recognize and treat episodes.

Tobacco

According to the Vermont Youth Risk Behavior Survey, cigarette smoking has declined across all grades, particularly among younger students—22 percent of students reported smoking in 2001, down from 36 percent in 1997.

For the past several years, Vermont communities have been building local partnerships and coalitions to work on reducing tobacco, alcohol and other drug use. With a portion of the state's share of the 1998 Master Settlement Agreement, the department supports new and existing anti-tobacco efforts through approximately 20 Tobacco-Free Community grants, 60 Tobacco-Free School grants, 39 Vermont Kids Against Tobacco (VKAT) groups for 5th to 8th graders, and 27 OVX (OurVoicesExposed) groups for teens. Vermont established the Vermont Quitline, making state-of-the-art cessation services widely available and affordable to smokers throughout the state. In addition, several countermarketing efforts are underway, including one designed to dispel the myth that most kids smoke.

MAINE

Bioterrorism Preparedness

After September 11, 2001, the Maine Department of Human Services, Bureau of Health, in collaboration with Maine's Emergency Management Agency and Department of Public Safety, responded to over 500 reports of suspicious substances. This represented the most intensive collaboration among these three agencies since the ice storm in January 1998 left hundreds of thousands of Maine homes without power for many days. Extensive planning over the past year has resulted in development of a new Office of Public Health Emergency Preparedness that is closely linked to the existing Division of Disease Control. The Weapons of Mass Destruction Plan has been significantly revised. Maine does not have a statewide network of county or local health departments, so to meet the challenge of assuring real-time surveillance of infectious diseases (and thus assure preparedness for detection of biological agents), a new structure of regional epidemiologists and medical directors has been established. Staff throughout the Bureau has been trained to enhance their skills in addressing weapons of mass destruction, including training for the Radiation Control Program in radiological accidents and medical response to a radiation-contaminated patient and training for Public Health Nurses so that now all are certified as Disaster Health Service Nurses.

Healthy Maine 2010

Maine's health goals and objectives for the decade will be released in early November 2002. The publication was delayed by the events of September 2001 and the need to focus attention on assuring appropriate response and planning for preparedness. Healthy Maine 2010 features two companion documents, one that describes trends, current status, goals, and objectives in ten general categories, and a second that describes the impact of health disparities ranging from race and ethnicity

to gender and socio-economic status. The publications will be available on the Maine Department of Human Services, Bureau of Health website in late November.

New Initiatives

Environmental Public Health Tracking: The Maine Environmental Public Health Tracking and Surveillance System was funded for three years through a cooperative agreement the Centers for Disease Control and Prevention (CDC). The funds will support development of components of a standards-based, coordinated, and integrated system that allows linkage and reporting of health effects data with human exposure and environmental hazard data. This will be done in the context of the development of a planned Maine Public Health Information System (MPHIS), which will link and integrate various public health data sets.

Suicide Prevention: The Maine Injury Prevention Program was awarded a cooperative agreement with CDC to conduct comprehensive suicide prevention interventions in 10 Maine schools.

Bladder Cancer: The Maine Cancer Registry is participating with the National Cancer Institute and the states of Vermont and New Hampshire in *The New England Study of Environment and Health*, a population-based case-control study of urinary bladder cancer. The goal is to identify whether common environmental factors increase the risk of bladder cancer in Northern New England. Over 210 Maine cases have already been identified and agreed to participate in the study.

HIV Waiver: The Bureau of Health worked with two other parts of the Department of Human Services (the Bureau of Medical Services and the Bureau of Family Independence) to establish and implement a Medicaid waiver to financially assist HIV-infected persons with high medication expenses.

West Nile Virus: A multi-media educational campaign to increase public awareness of and knowledge about West Nile Virus was implemented in the summer of 2002. Although no human cases have been diagnosed in Maine (as of October 1, 2002), infected birds have been found in nine of sixteen counties, ranging from towns in southern York County to Penobscot to coastal Hancock Counties.

Birth Defects Registry: The Maine Genetics Program was awarded a cooperative agreement with the CDC to continue the development of a birth defects surveillance program. Mandatory reporting will begin in early 2003.

Newborn Hearing Screening Program: The Maine Genetics Program was awarded a Maternal and Child Health Bureau grant to establish a system for the detection and treatment of newborns with hearing disorders.

National Recognition

Maine received an award for having the highest immunization rate in the country for the most basic set of childhood immunizations (tied with three other states). It also received an award for outstanding work on injury statistics (CODES data). Finally, Maine's WIC program has the lowest

food package costs in the nation. This has been achieved by instituting food program policies that hold down costs while providing participants with the same food packages and choice.

Child Passenger Safety Legislation

The Bureau of Health worked closely with the Maine Transportation Safety Coalition for the successful passage of Maine's comprehensive Child Safety Restraint law, which takes effect in January 2003. The law will require that any child who is under the age of eight or under 80 pounds be restrained in a federally approved car safety or booster seat. Through a grant from State Farm Insurance, 190,000 cards explaining the changes in the law have been printed and distributed to all schools, law enforcement agencies, regional offices of the Department of Motor Vehicles and Emergency Medical Services, day care centers, and the general public.

Maine Turning Point

The Maine Turning Point initiative continues to explore the potential of and options for public health infrastructure in Maine. Several options for regional infrastructure have been proposed and potential pilot sites to try these models are being identified.

Childhood Overweight and Obesity

A broad group of partners is working to address childhood overweight and obesity and related issues. The Bureau of Health will be starting a media campaign about the negative aspects of soda drinking in late October. To complement this effort, representatives from the Cardiovascular Health, Diabetes, Maternal and Child Nutrition, and Oral Health Programs in the Bureau of Health have worked with the Maine Center for Public Health, the Maine Nutrition Network, the Department of Education and the American Dental Association of Maine to develop model policies for schools regarding vending machines. The Maine-Harvard Prevention Research Center, located at the Maine Center for Public Health sponsored a statewide meeting on the effects of soda last December. Many of these programs and organizations, along with the Maine Asthma Program (which supports child health surveys in kindergarten and grade five that include height and weight measurement) are working together to determine the feasibility of developing a surveillance system for childhood obesity in Maine. These efforts are closely linked with the Healthy Maine Partnerships described under the Tobacco Settlement, below.

Coordinated Women's Health Initiative

Through this initiative a task force is developing a pilot to test materials for increasing coordination of direct health services contracted for by Bureau of Health programs. The task force is composed of staff from Bureau programs as well as staff from the contract agencies. In addition, an interdepartmental women's health committee is being convened, with a kick-off meeting planned for November 6, 2002.

Tobacco Settlement

Maine's Tobacco Settlement funds support a broad range of public health initiatives, with a primary focus on prevention of tobacco use and tobacco-related chronic disease risk factors (particularly physical inactivity and poor nutrition). Additional funds overseen by the Bureau of Health address issues ranging from oral health and school-based health centers to home visitation programs for families of newborns and family planning outreach programs. Selected highlights in each area follow.

Youth Tobacco Use: In January 2002, the Bureau of Health's Partnership For A Tobacco-Free Maine announced that over the previous four years, tobacco use among Maine high school students dropped by a dramatic 36%.

Tobacco Treatment: The tobacco treatment program is supported by a contract with the Center for Tobacco Independence at MaineHealth. The toll-free Maine Tobacco HelpLine was initiated in September 2001. Evaluation of six-month quit rates among those callers who received an intervention indicates a remarkable 33% rate of success (defined as not smoking for the past 30 days). In September 2002 a tobacco treatment medication voucher program was made available statewide. Through the voucher program, nicotine replacement therapy (NRT) is available at no cost to Maine citizens who have no insurance for tobacco treatment medications. NRT is in the form of gum and patches and is available to those individuals who receive telephone counseling from the Tobacco HelpLine. Zyban will be phased into the medication voucher program at a later date.

Healthy Maine Partnerships: Thirty-one community grantees in 30 regions of the state, in collaboration with 54 school administration units are working to address tobacco use, poor nutrition and physical inactivity through changes in policies and environments. Schools are developing coordinated school health programs with an emphasis on these three risk factors, but also with a comprehensive approach to general school health issues. Communities are also working to enhance tobacco treatment resources in their areas by fostering training of tobacco treatment specialists and linking people in need of counseling with appropriate health care providers.

School-Based Health Centers: Funds support nine additional school based health centers, a 33% increase in the number of health centers in the past two years. This has increased access to approximately 4,150 students enrolled in new SBHCs and ensures sustainability of programs in schools where these services existed before.

Oral Health: Funds support both a Dental Services Subsidy Program and a Dental Services Development Program. The subsidy program allows agencies to treat individuals who could not otherwise afford dental care by offsetting the deficit they incur while providing services to MaineCare (Maine's Medicaid program) patients and those who qualify at the low ends of their sliding fee scales. The Dental Services Development Program support grants to agencies to develop and expand community-based oral health programs, oral health case management programs, and community education programs.

Home Visitation: This initiative provides parent education and support of first time families through agencies. Services are based on one of three approved models: Healthy Families, Parents as Teachers, and Parents Are Teachers Too. A contract for a multi-year evaluation of process and outcome measures was awarded in June 2002.

Family Planning Outreach: Community education and outreach are provided through the Family Planning Association of Maine and seven community agencies to 29 clinics located throughout the state. The activities are targeted to communities where teen pregnancy rates are higher than the state average. In addition, the programs work with local business and community groups to increase access to reproductive care, information and services within Maine communities and to develop community-based pregnancy prevention strategies.

CONNECTICUT

AGENCY MISSION

- Protect the health and safety of the people of Connecticut
- Actively work to prevent disease and promote wellness through education and programs such as prenatal care, immunizations, AIDS awareness, supplemental foods, and cancer screening
- Monitor infectious diseases, environmental and occupational health hazards
- Regulate health care providers such as health facilities, health professionals, and emergency medical services
- Provide testing and monitoring support through the state laboratory
- Collect and analyze health data to help plan policy for the future
- Be the repository for all birth, marriage and death certificates

RECENT HIGHLIGHTS

The following are some of the major achievements of the department for 2001-2002 that assured and improved services to the people of Connecticut:

Bioterrorism & Infectious Diseases

The CT Department of Public Health (DPH) successfully applied for more than \$14 million in federal funding from CDC and HRSA for bioterrorism preparedness and response capacities.

Centers of Excellence for Bioterrorism

DPH has established hospital-based Centers of Excellence for Bioterrorism Preparedness and Response. The Centers of Excellence are tertiary and quaternary hospitals that will take a leadership role in serving as centers to plan for the regional coordination, education, clinical care and research to improve Connecticut's ability to respond to a large-scale bioterrorism or other catastrophic event. The regional centers will work in conjunction with the state's other hospitals, health care facilities and fire, police and municipal governments, to provide a coordinated and consistent response to bioterrorism and improve our ability to create a 'surge' capacity to handle a bioterrorism event.

Childhood Day Care

DPH implemented an aggressive public outreach initiative to enhance the understanding of licensed childcare providers regarding Connecticut's regulatory framework and to promote the health and safety of children being cared for by day care and youth camp providers. Activities included improvements to the DPH web site, provision of technical assistance for site visits, participation in conferences and workshops which addressed abuse and neglect, emergency preparedness, and workforce development. Licensing promotional materials were printed in both English and Spanish and articles were published in appropriate newsletters. Partnerships were created with other state agencies, provider groups, trade organizations and educational facilities to ensure licensing and childcare information is widely distributed.

Childhood Immunizations

Connecticut's early childhood immunization rate ranked second in the nation in 2001. For children who were born between February 1998 and May 2000, the completion of a basic immunization series by age 2 years was 86%. Connecticut has now been ranked among the top five states for the past seven years.

The occurrence of invasive pneumococcal disease in infants, a particular problem in urban areas with poverty and crowded living conditions, dropped 65% overall in 2001 with the largest decreases in black and Hispanic infants in the wake of the Department distributing the new conjugate pneumococcal vaccine through the Vaccines for Children Program beginning in September 2000.

HIV Reporting

A new HIV infection reporting system was implemented on January 1, 2002,. The new system uses patient identifiers to help eliminate duplicate reports, obtain complete risk information and demographics on each newly-detected person, and integrate with the AIDS case reporting system. The data obtained will provide a complete and ongoing picture of the HIV/AIDS problem in Connecticut in an era where the course of HIV infection can be greatly modified by therapy.

Local Health Administration

Through grants from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration, DPH is providing over \$6M to local health districts, hospitals and other key emergency response partners within the public health system for the purpose of developing public health emergency preparedness and response capacities. Working collaboratively, efforts are being coordinated at local, regional, and statewide levels. Grant funding will enable detailed needs assessments, planning, capacity-building, education and training.

Office of Public Health Communications

The OPHC coordinated two successful public health conferences, the Multicultural Health Summit and the Women's Health Summit, which assembled public health professionals and national leaders to discuss strategies for interventions and education to eliminate health disparities.

DPH earned a Gold Mercury Award from the Public Relations Society of America for its outstanding multicultural health campaign "Healthy Families Day." DPH partnered with HOPE *worldwide* New England - a faith-based charity, area health professionals, businesses, local media and the City of Hartford. Health information and free health screenings, such as blood pressure, glaucoma, nutrition counseling, and body fat testing were available as well as food, fun and games.

Oral Health

DPH implemented OPENWIDE, an oral health training program for non-dental health and human services providers, including physicians, nurses, nutritionists, childcare and outreach workers, and others throughout Connecticut. OPENWIDE training is designed to educate, build awareness and integrate oral health into existing health systems, enable non-dental providers to recognize and understand oral diseases and conditions, engage in anticipatory guidance and prevention interventions, and make appropriate referral for improved oral health

State Laboratory

The DPH Laboratory continues to upgrade its testing methods to newer, more sensitive and specific technologies that take advantage of the advances in digital information and molecular methods. These new methods are now in place for the rapid detection of the most common causes of sexually transmitted disease, West Nile virus and a growing number of arboviruses and several foodborne pathogens. Computer-assisted automated instruments are improving laboratory production and data quality.

Vital Records

DPH completed statewide implementation of the Electronic Vital Records System (EVRS) at all Connecticut birthing hospitals and associated towns. EVRS enables hospitals to electronically create birth certificates and allows local vital records registrars to electronically review, correct and register these birth certificates. All transactions are processed through the central repository at DPH, allowing immediate access to EVRS-generated birth certificates.

Water Supplies

DPH achieved a heightened awareness and response to safeguarding and securing Connecticut's public drinking water supplies. This was accomplished through the development of internal and external emergency response procedures, public and industry forums which have promoted water supply security, establishment of an industry wide security committee, advising U.S. EPA on water supplies system vulnerabilities and states' security resource needs, active participation in National and International conferences relative to water system operational security and securing federal funds to develop a security procedures manual for Connecticut's water supply systems. DPH was also successful in enacting legislation this session which protects sensitive water security plans from public access.

Workforce Development

DPH, in partnership and collaboration with federal, state and local agencies, educational facilities and health care providers has addressed Connecticut's public health work force shortages. This has been accomplished through the provision of educational programs in local schools and at community forums, job shadowing opportunities, and regional seminars for identifying work force barriers to hiring and retention of a public health workforce. Shortages have also been addressed by providing marketing materials regarding health care career opportunities as well as linking individuals with training opportunities leading to careers in public health.

NEW HAMPSHIRE

The Division of Chronic Disease: Bridging Resources to Maximize Prevention and Promotion Effectiveness

Changes have occurred over the past year. The Division of Chronic Disease Prevention is a newly created division within the NHDHHS Office of Community and Public Health. The division brings together a bureau and 4 programs that seek to reduce the human and financial burden of chronic diseases, such as cancer, diabetes, tobacco related illness and asthma, as well as to improve the quality and years of healthy life for NH citizens.

Today, 7 out of 10 New Hampshire adults die from chronic disease and its related health consequences. Obesity impacts 50% of our current NH adult population and, while data for children is not collected statewide, the long term health risks of overweight and physical inactivity for youth is substantial. Therefore, the Division of Chronic Disease is committed to developing a long-range goal to reduce the burden of chronic illness in New Hampshire. We intend to establish bridges between our current program areas and create new alliances statewide in our efforts to enact programs that will address the behavioral risks associated with unhealthy diets and lack of physical activity.

Healthy New Hampshire 2010. Healthy New Hampshire 2010 is NH’s first disease prevention and health promotion agenda, and is a product of a collaborative effort of NH leaders and citizens under the direction of the Healthy New Hampshire Leadership Council. As a private-public initiative, this agenda represents a shared vision and shared responsibility for improving the health and quality of life for all NH citizens. The mission of Healthy New Hampshire 2010 is to inspire action, focus resources and engage private and public partners to improve the quality of life and years of healthy life for the NH public.

The Bureau of Nutrition and Health Promotion

The **Health Promotion Unit** develops, coordinates, and monitors health risk factor reduction projects across the State. The primary focus of efforts is on high-risk groups and prevention of overweight and obesity through physical activity and other factors.

Major focus areas are:

- Σ Healthy NH 2010 promotion, coordination, and facilitation.
- Σ 5 A Day for Better Health Program
- Σ Promotion of Increasing Physical Activity in children, adult and older populations.
- Σ Osteoporosis prevention and education.

The **Nutrition Services Unit** administers a variety of federally funded nutrition programs designed to improve the health and nutritional status pregnant women, new mothers, infants, preschool children, and low-income elderly as well as to provide population-based nutrition education services including:

- Σ Special Supplemental Nutrition Program for Women Infants and Children
- Σ Commodity Supplemental Food Program
- Σ Farmers Market Nutrition Program
- Σ Folic Acid Education Program

The **New England PARTNERS Project** is a pilot initiative to test the feasibility of using “smartcards” in the delivery of WIC and FMNP food benefits and case management services for a variety of programs serving low-income families and seniors. New Hampshire is the lead state for this six-state consortium Funds have been provided by USDA, CDC and private sector sources.

The Tobacco Prevention and Control Program (TPCP): A new “Smoker’s Resource Information Center

The TPCP works to reduce the adverse health effects resulting from tobacco use. Program goals are to:1) Prevent youth from starting to use tobacco, 2) Promote quitting among tobacco users, 3) Eliminate exposure to secondhand smoke, and 4) Decrease use among those most affected by tobacco.

The Centers for Disease Control and Prevention estimated that the economic costs of smoking totaled \$3,391 per smoker per year. New Hampshire TPCP per capita cost for Tobacco prevention efforts is under \$4.00.

As recommended by the Centers for Disease Control and Prevention, the TPCP uses a comprehensive approach to achieve its goals. As part of a comprehensive program, the NH TPCP recently launched its Smokers Resource or Quitline: a toll-free telephone-based, an interactive tobacco ces-



sation website, and an information clearinghouse. How this works in practice is that the tobacco user calls the resource center. If the person is not yet ready to quit, they are referred on to the web site and the information-clearing house to learn more about preparing to quit. If the person has reached the stage of being ready to quit, they are referred to the quitline, which then connects them to local clinical services.

The Breast and Cervical Cancer Program: Meets It's Goal! The Breast and Cervical Cancer Program is responsible for increasing the number of low-income women age 18-64 being screened for breast and cervical cancer, and ultimately increases the number of early stage cancers detected in the population, thereby reducing the number of deaths. This past year the Program met its goal of screening over 3000 women for breast and cervical cancer! This achievement demonstrates the commitment of our partners in prevention of cancer.

The Diabetes Education Program: The Diabetes Education Program conducts statewide public education campaigns; coordinates professional continuing education trainings; develops and disseminates science based professional education materials; funds and monitors capacity building diabetes projects at community health centers and supports diabetes surveillance activities. The overall program design focuses on integrating diabetes prevention and control objectives into existing health care delivery and community based systems. The program also completed the New Hampshire Guidelines for Gestational Diabetes Care and promotes inclusion of these and other national guidelines in a statewide series of professional workshops. The completion of a school nurse survey and needs assessment has led to the beginning development of school health guidelines for children in school with diabetes.

The Asthma Control Program: In 2001 the Centers for Disease Control and Prevention awarded DHHS a three-year grant to establish an Asthma Control Program. The program is designed to control asthma from a public health perspective and to focus on asthma prevention.

The main objectives for the first year of the program are to:

- β Establish a statewide asthma coalition;
- β Develop an action plan for controlling asthma in NH; and
- β Create a surveillance system for monitoring asthma in the state.

The program action plan will be implemented during the second and third years of the grant award period.

The Division of Family and Community Health oversees grants to community-based agencies for medical and preventive health services, sets policy, provides technical assistance and education, and carries out quality assurance activities in its programmatic areas of expertise. DFCH is comprised of two bureaus and four programs.

Major Bureaus and Programs:

- β Bureau of Maternal & Child Health
- β Bureau of Rural Health & Primary Care
- β Human Immunodeficiency Virus (HIV) Prevention Program
- β Immunization Program
- β Ryan White CARE Program
- β Sexually Transmitted Disease (STD) Prevention Program

The **Child Health Program** is part of the Bureau of Maternal and Child Health within the Division of Family and Community Health. Nine local community health agencies and eight community health centers administer the Child Health Program. The CHP allows these health care providers to offer comprehensive, preventive direct health care to low-income children through clinic and home visits. Services include physical exams, health screenings, immunizations, anticipatory guidance, social services, and case management.

Four community health agencies offer Child and Family Health Support Services to families where children may access a medical provider but need additional services. Additional services include assistance with health care enrollment, referrals, case management, care coordination, and education and counseling relative to the child and family. These services are conducted in person or by telephone.

The Injury Prevention Program's mission is to reduce death and disabilities stemming from intentional and unintentional injuries. The Injury Prevention Program places a priority on the leading causes of both intentional and unintentional injuries. Intentional injuries include suicide, homicide, and interpersonal violence. Activities to reduce unintentional injuries focus on car passenger safety, sports-related helmet use, home fire safety, poisoning prevention and preventing falls among senior citizens. Major activities of the Injury Prevention Program include:

- β Educating the public and others about the scope and major causes of death and disability from intentional and unintentional injuries;
- β Identifying and implementing effective prevention programs and strategies;
- β Collaborating with private and public sector stakeholders to increase the effectiveness of Injury Prevention Program work; and
- β Enhancing effective public policies to reduce injuries.

Other NH DHHS Highlights within the Office of Community and Public Health

New Hampshire Turning Point Initiative: The DHHS has been successfully completed its four-year implementation grant from the Robert Wood Johnson Foundation for the NH Turning Point Initiative and is now focusing on building capacity and community based initiatives at the community level to enhance the public health. The initiative seeks to design and pilot effective service delivery models for local public health that are broad-based and regional in scope. These efforts will also be supported by participation in two national initiatives – performance management and information technology - convened by the Robert Wood Johnson Foundation.

The **Bioterrorism and Public Health Emergencies** unit within the OCPH Director's Office is leading the DHHS initiatives to insure that NH citizens are protected in the event of Bioterrorism or other public health emergency. The primary goal of efforts by this unit is to ensure the readiness of NH to respond to public health emergencies such as Bioterrorism, chemical or radiologic threats or other natural disasters, in order to prevent and reduce illness and death associated with disasters and terrorist attacks.

Child Health Insurance Program: The CHIP program, which has been rolled into a joint effort with *NH Healthy Kids*, continues to make health and dental care available to all children in New Hampshire up to 400% of poverty through a combination of expanded Medicaid subsidized coverage, and full premium options for families. In four years of operation, we have found and enrolled

over 10,000 Medicaid and CHIP eligible children. This year's expansion of NH Healthy Kids dental benefits seems to have made the program more attractive to families and led to an increase in enrollment rates.

Other Department of Health and Human Services Programs for Prevention:

The Division of Alcohol and Drug Abuse Prevention and Recovery (DADAPR) is responsible for public education about alcohol and drug abuse and to develop a system for prevention and treatment services. DADAPR financially supports and monitors a continuum of contracted prevention and treatment services with private, not-for-profit organizations to meet those responsibilities. DADAPR efforts focus on three primary program and service areas.

- β Impaired Driving Intervention Services
- β Substance Abuse Prevention and Treatment Services
- β The Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention & Treatment

DADAPR is also a substance abuse technical assistance resource for other NH government operations and provides support to other agencies to develop the capacity to identify and respond to substance abuse issues, assists with policy development, helps implement best practices, and provides staff training on substance abuse prevention and treatment.

NH Department of Health & Human Services: On the World Wide Web!

The Department of Health and Human Services is an agency that helps people. We do this in partnerships with families, community groups, private providers, other government agencies and many thousands of foster parents, neighbors and citizens who make New Hampshire a special place to be caring individuals.

DHHS must be accessible to those it serves and the availability of resources through the Internet is one part of better service to NH residents. This website is part of our commitment to providing our customers with excellent service and accurate information. Currently, there are 140 individual programs and services with websites of their own under the overall DHHS website. Please find us at <http://www.dhhs.state.nh.us/DHHS/>

RHODE ISLAND

Adolescent Health: The Office of HIV& AIDS, the Adolescent and Young Adult Health Unit at the Rhode Island Department of Health (HEALTH), and the Office of Integrated Services at the Department of Education, have joined to sponsor an innovative parent education program called "Can We Talk?" After parents are trained, they are offered tips on how they can talk with their children about the sensitive issues discussed during their training. The program is unique in that it highlights the differing cultures, values, and opinions of families, and allows parents to sensitively address these issues in their own way.

Asthma Plan: HEALTH announced a statewide asthma plan. The plan, developed in conjunction with the Rhode Island Asthma Coalition, including the State's three major health plans: United Health Care, Neighborhood Health Plan of Rhode Island, and Blue Cross & Blue Shield of Rhode Island, employs a single, uniform asthma treatment plan for every child and adult with



asthma. Improved treatment planning and coordination are expected to reduce unnecessary hospitalizations, days absent from work (or school), and promote the quality of life.

Breast Cancer: On May 6, 2002, HEALTH and the Rhode Island Cancer Council, Inc. (RICAN) presented the breast care guidelines to key Rhode Island cancer physicians at a symposium in the HEALTH Auditorium. The guidelines provide evidence-based cancer treatment to all Rhode Island women. It puts Rhode Island among only a handful of states to update, disseminate and incorporate comprehensive, state-of-the-art breast cancer care into the State's cancer plan guidelines. An updated segment of the State's cancer plan, the algorithm gives physicians clear guidance on how to manage breast cancer. It brings together into one practice the best thinking of Rhode Island's cancer treatment specialists in internal medicine, radiology and surgery.

Food Protection: HEALTH is working with local community groups to evaluate the effectiveness of its outreach program on the dangers of mercury in fish. The outreach campaign has focused on the fact that fish can be a part of a healthy diet, but that some types of fish can contain too much mercury or other contaminants, especially for pregnant women. Working with Clean Water Action, HEALTH will be evaluating both the current state of awareness about mercury issues, and the effectiveness of the educational materials used to conduct outreach.

HCUP: HEALTH released its 8th report in conjunction with the Health Care Quality Performance Measurement and Reporting Program. This report uses hospital discharge data to measure the quality of hospital care. Rhode Island hospitals performed above the national benchmark in four areas; hospital performance appeared similar to the national benchmarks for three indicators; and in the remaining three areas, hospitals in Rhode Island did not look as good as the national benchmarks. This report represents the first time that hospital discharge data has been used in Rhode Island to measure health care quality.

Health Plan Performance: HEALTH has completed the second annual report of Rhode Island Health Plan Performance. This report is based on Calendar Year 1999 data, and it represents the most comprehensive Health Plan Performance Report done anywhere in the United States. In general, the report reflects good performance on the part of Rhode Island Health Plans, although there is obviously room for improvement as well.

HIV Prevention: The Rhode Island Community Planning Group for HIV Prevention (RICPG) has successfully completed their Year 2002 Comprehensive Plan for HIV Prevention. The RICPG is composed of approximately 24 individuals representing a culturally and racially diverse group of Rhode Islanders. The highest priority for prevention remains infected drug users who engage in unprotected sex or needle sharing. The second prevention priority is women engaging in unprotected sex with men. The third priority areas are men engaging in unprotected sex with men, and youth engaging in unprotected sex and/or alcohol or other drug use.

Hospital Quality: On November 27, 2001, HEALTH released a report on hospital surveys, incidents and events for 1994 through 2000. The study identified problems in areas of hospital performance that strongly influence the rate of medical errors. HEALTH made ten specific recommendations designed to promote quality, improve accountability, and help prevent medical errors in hospitals. As a result of this report, HEALTH issued 29 deficiency notices and required plans of

correction from 12 hospitals. The hospital regulations were changed to clarify incident and event reporting definitions and reporting requirements. Subsequently, incident reports increased from 132 to 1999 to a projected 294 in 2000.

Lead Hazard Mitigation Public Law 2002-187 and Public Law 2002-188: The law establishes a reasonable, affordable, effective standard for lead hazard mitigation based on the HUD standard. Statute requires the compilation, publication, and use for enforcement of data about properties responsible for multiple poisonings. The law defines the responsibility of property owners to inspect and care for their property, especially when there are children under age six, and to provide tenants information about lead hazards. It drops the theory of “innocent owner” and replaces it with principle of “complying owner.” The law eliminates the insurance exclusion for liability for lead poisoning and replaces it effective July 1, 2004, with coverage within the basic liability policy for those who comply with the law, and by buy-back for those who do not comply with the law but do not have a record of lead poisonings.

Lead Poisoning Prevention: HEALTH’s Childhood Lead Poisoning Prevention Program has completed an initial evaluation of its new Case Management system. This new system, devised by the Department of Human Services (DHS) and implemented by our community partners, the Visiting Nurse Association (VNA), and the HELP Lead Safe Center, calls for both the VNA and HELP to conduct home visits and provide education to families with children with moderate poisoning, while families with children with severe lead poisoning receive a more comprehensive suite of social, medical and housing services from HELP alone.

Patient Satisfaction: On November 7, 2001, the Health Care Quality Steering Committee approved the Hospital Patient Satisfaction Public Report. This is a watershed event because this is the first time that hospitals in Rhode Island have ever used the same patient satisfaction vendor and questionnaire, and also the first time that hospital patient satisfaction information has ever been shared with the public in Rhode Island.

Physical Education: Healthy Schools! Healthy Kids!, a partnership of HEALTH and the Rhode Island Department of Education (RIDE), has been awarded \$90,000 to implement physical activity initiatives for pre-teens (9-13 years old) that will support and reinforce the messages of the Centers for Disease Control and Prevention’s (CDC) National Youth Media Campaign. Specially, HEALTH will utilize funds to perform a statewide assessment of physical education (PE) programs in Rhode Island schools, assist community partners in the development and implementation of content standards for PE, conduct professional development training for educators in the application of PE content standards, and coordinate local activities with the CDC’s National Youth Media Campaign.

Rite Care Update: Rite Care, Rhode Island’s Medicaid managed care program, currently enrolls uninsured pregnant women, children and families who meet eligibility criteria. Families who receive Temporary Assistance for Needy Families (TANF) also are covered under Rite Care. As of August 2002, Rite Care enrollment was 116,778. Rite Share, Rhode Island’s Premium Assistance Program, currently has 2,148 enrollees. Both Rite Care and Rite Share members who have income over 150 percent of the federal poverty level are subject to cost sharing. The premiums that families pay (for cost sharing) range from \$61 to \$92 per month.

School Safety: HEALTH met with officials from the Department of Environmental Management, EPA, and the Department of Labor and Training (DLT) to discuss moving forward with the Toxic Free Schools program. These agencies have received chemical inventories from five Rhode Island schools. A review of these inventories by DLT and HEALTH resulted in identification of many chemicals with the potential for unnecessary health and safety risks to children. State agencies are now working cooperatively to find cost effective options for the reuse or disposal of these chemicals, and hope to develop partnerships between private businesses with chemical expertise, and public schools eager to ensure a safe learning environment.

Tobacco Control: On April 1, 2002, HEALTH launched Rhode Island's first statewide 1-800-Try-To-Stop Quit Smoking Program. The program provides free state-of-the-art treatment tailored to meet the needs of different kinds of smokers and those concerned about them. A call to the 1-800-Try-To-Stop phone number (1-800-8 DEJALO for Spanish) will be answered by the Smokers' Information Resource Center, which will help callers choose from a number of services.

Women's Health: The Office of Women's Health has been established in the Division of Disease Prevention and Control. The responsibilities of the Office of Women's Health include: developing plans and policies for the improvement of the health status of women; researching women's health programs, policies, and practices; collecting and analyzing data, and preparing reports for presentation to HEALTH, the Women's Health Advisory Committee, and other agencies; researching funding resources and developing funding requests and proposals; and providing technical assistance to programs serving women's health needs.

Worksite Wellness: HEALTH was pleased to receive the Silver Well Workplace Award from the Wellness Councils of America (WELCOA) at the 8th Annual Worksite Health Awards Conference on May 23, 2002, co-sponsored by the Greater Providence Chamber of Commerce, the Rhode Island Chamber of Business and Industry, and Blue Cross & Blue Shield of Rhode Island. HEALTH is the only State health department in New England to receive this award, and one of only three nationally.

Conference Registrants

David C. Abdo
REG. INTERGOVERNMENTAL
AFFAIRS SPEC
US DHHS, REGION ONE, NE
JFK BLDG, RM 2100
BOSTON MA 02203
(617) 565-1912
DAVID.ABDOO@HHS.GOV

Magda Ahmed
REGIONAL COORDINATOR
MDPH, REFUGEE AND IMMI-
GRANT HEALTH PROG
23 SERVICE CENTER
NORTHAMPTON MA 01160
(413) 586-7525
MAGDA.AHMED@STATE.MA.US

Autumn Allen
PROGRAM COORDINATOR
HSPH, DIV OF PUB HEALTH
PRACTICE
1552 TREMONT ST
BOSTON MA 02120
(617) 495-4000
AALLEN@HSPH.HARVARD.EDU

Claude A. Allen
DEPARTMENT SECRETARY
US DHHS
200 INDEPENDENCE AVE, SW
Washington, DC 20201
(202) 690-6133
richard.parker@hhs.gov

Shelley Allison, MPH
MANAGER OF QUALITY PRO-
GRAMS
HARVARD PILGRIM HEALTHCARE
93 WORCESTER STREET
WELLESLEY MA 02481
(617) 509-4129
shelley_allison@hphc.org

Carlos Alvarez
EXECUTIVE DIRECTOR
ALA OF MA
ONE ABBEY LANE
MIDDLEBORO MA 02346
(508) 947-7204
CALVAREZ@ALA-MA.ORG

Caroline Apovain, MD
DIR, NUT & WEIGHT MGMNT, DIV
OF ENDO & DIAB
BOSTON MEDICAL CENTER
D BLDG
88 EAST NEWTON ST, STE 614D
BOSTON MA 02118
(617) 638-8556
CAROLINE.APOVIAN@BMC.ORG

Robert H. Aseltine, Jr., Ph.D.
DEPT BEHAVIORAL SCIENCES &
COMM HLTH
UNIV OF CT HEALTH CTR, MC3910
263 FARMINGTON AVE
FARMINGTON CT 06030
(860) 679-3282
ASELTINE@UCHC.EDU

Kathleen Atkinson
ASST. COMMISSIONER FOR
POLICY & PLANNING
MA DPH
250 WASHINGTON STREET
2ND FLOOR
BOSTON MA 02108
(617) 624-5270
KATHY.ATKINSON@STATE.MA.US

S. Bryn Austin, Sc.D.
INSTRUCTOR IN PEDIATRICS
DIV OF ADOLESC. MED/
CHILDREN'S HOSPITAL
300 LONGWOOD AVE
BOSTON MA 02115
BRYN.AUSTIN@TCH.HARVARD.EDU

Bobbie D. Bagley
HIV/HLTHY FAMILIES PROG MGR.
NH MINORITY HLTH COALITION
25 LOWELL ST, 3RD FL
MANCHESTER NH 03101
(603) 627-7703
BOBBIEB@X-ACT.COM

Nannette Bailey, EdM
MINORITY HEALTH PROGRAM
COORDINATOR
HSPH, DIV OF PH PRACTICE
1552 TREMONT STREET
BOSTON MA 02120
(617) 495-4000
NBAILEY@HSPH.HARVARD.EDU

Dalila Balfour, BSW
REGIONAL COORDINATOR
MDPH-BFCH-WRHO
23 SERVICE CENTER
NORTHAMPTON MA 01160
(413) 586-7525
DALILA.BALFOUR@STATE.MA.US

Patti Baum
HEALTH PROMOTION MANAGER
NH DHHS
6 HAZEN DRIVE
CONCORD NH 03301
(603) 271-4828
PBAUM@DHHS.STATE.NH.US

Joanne Bean, R.N., M.B.A., B.S.N.
DIR, SPECIAL PROJECTS
AMERICAN DIABETES ASSN.
10 INGRAHAM STREET
MANCHESTER ME 04351
(800) 676-4065 X3713//207-622-8708
JBEAN@DIABETES.ORG

Patricia Beckenhaupt, RN, MS, MPH
DIRECTOR OF HEALTH
NORTHEAST DIST. DOH
136 MAIN ST
DANIELSON CT 06239
(860) 774-7350
PBECKENHAUPT@NDDH.ORG

Loretta Becker, M.Ed., DIRECTOR
URBAN LEAGUE OF RI
246 PRAIRIE AVE
PROVIDENCE RI 02905
(401) 351-5000 X 147
LORETTA@ULRI.ORG

Maria Bettencourt, MPH
DIR., NUT & PHYS ACTIVITY
MA DEPT PUBLIC HEALTH
250 WASHINGTON ST
BOSTON MA 02108
(617) 624-5440
MARIA.BETTENCOURT@STATE.MA.US

Joseph Bevilacqua, Ph.D.
MENTAL HEALTH PROMOTION &
SUBSTANCE ABUSE PREV
P.O. Box 143
Adamsville, RI 02801
(401) 635-2792
BEVILACQUA7@COX.NET

Michelle Biando
VACCINE ACCOUNT MANAGER
GLAXOSMITHKLINE
21 HALL ROAD
WEBSTER MA 01570
(508) 579-1500

David Blackburn
EXECUTIVE DIRECTOR
CNRCT
332 WASHINGTON STREET
WELLESLEY MA 02481
(781) 235-2555
DBLACKBURN@CNRCT.ORG

Ruth Blodgett
SR VP OF SYST PLAN
& PROGRAM DEVELOPMENT
BERKSHIRE MEDICAL CENTER
725 NORTH STREET
PITTSFIELD MA 01201
(413) 447-2144
RBLODGETT@BHS1.ORG

Delmy Bonilla
LATINO PEER EDUCATOR
NH MINORITY HLTH COALITION
25 LOWELL ST, 3RD FL
MANCHESTER NH 03101
(603) 627-7703
DELMY@NHHEALTHEQUITY.ORG

Linda Bouley, RD, LDN
EDUCATIONAL SPECIALIST
MA DEPT OF ED
350 MAIN STREET
MALDEN MA 02148
(781) 338-6456
LBOULEY@DOE.MASS.EDU

Marc M. Boutin
VP, GOV REL & ADVOCACY
AMERICAN CANCER SOCIETY
30 SPEEN ST
FRAMINGHAM MA 01701
(508) 270-4682
MARC.BOUTIN@CANCER.ORG

Hollis Burkhart, MA
CONSULTANT TO NECON
107 HILLSIDE AVENUE
REHOBOTH MA 02769
(508) 252-9489
HVB@ATTBI.COM

Dolores C. Calaf, MA
COMMUN. RELATIONS LIAISON
DIV OF MED ASSISTANCE
600 WASHINGTON ST, 5TH
BOSTON MA 02111
(617) 210-5318
DCALAF@NT.DMA.STATE.MA.US

James P. Campbell
NAT'L CHAIR, NAT'L ASSN HIV
OVER FIFTY
NEAETC
23 MINER STREET
BOSTON MA 02215
(617) 523-2942
CAMPBELLJIM1@AOL.COM

Audrey Chan, MPH
NE COAL FOR HLTH EQUITY
103 HAWTHORNE WAY #212
SOUTH LAWRENCE MA 01843
(978) 258-2027
AUDREY.CHAN@AYA.YALE.EDU

David A. Chatel
SR. VP FOR HEALTH MARKETING
AMERICAN HEART ASSN
20 SPEEN STREET
FRAMINGHAM, MA 01701
(800) 662-1701 x3947
david.chatel@heart.org

Lilian Cheung, D.Sc., RD
DIRECTOR HEALTH PROMOTION
& COMMUNICATIONS
DEPT OF NUTRITION, HSPH
665 HUNTINGTON AVE
BOSTON MA 02115
(617) 432-1086
LCHEUNG@HSPH.HARVARD.EDU

Kerrie Jones Clark
EXECUTIVE DIRECTOR
RI HEALTH CENTER ASSN.
235 PROMENADE ST., SUITE 104
PROVIDENCE RI 02908
(401) 274-1771 X201
KCLARK@RIHCA.ORG

Bruce Cohen, Ph.D.
DIRECTOR, DIV OF RESEARCH
& EPIDEMIOLOGY
MA DPH
BUREAU OF HEALTH STATISTICS
250 WASHINGTON ST, 6TH FLOOR
BOSTON MA 02108
(617) 624-5635
BRUCE.COHEN@STATE.MA.US

Lillian Colavecchio, MSS, LICSW
PROGRAM SPECIALIST
MA DPH
250 WASHINGTON STREET, 4TH FL
BOSTON MA 02108
(617) 624-5407
LILLIAN.COLAVECCHIO@STATE.MA.US

Graham A. Colditz, MD, DrPH
PROFESSOR OF MEDICINE
HARVARD SCHOOL OF PH,
CHANNING LAB
181 Longwood Avenue
Boston, MA 02115
(617) 525-2258
GRAHAM.COLDITZ
@CHANNING.HARVARD.EDU

Avery Colt
EXECUTIVE DIRECTOR
RI PUBLIC HEALTH FOUNDATION
ONE TURKS HEAD PLACE
SUITE 1450
PROVIDENCE RI 02903
(401) 273-2286
RIPHF@GIS.NET

Candace Combe, MS, RD, LDN
PROJECT DIRECTOR
DANA-FARBER CANCER INST
44 BINNEY STREET, SMTH 230
BOSTON MA 02115
(617) 632-5079
CANDACE_COMBE@DFCIHARVARD.EDU

Carol Cone
CEO
CONE, INC.
90 Canal Street, 6th Floor
Boston, MA 02114
(617) 272-8333
mpraz@coneinc.com

Raymond Considine, MSW
PRESIDENT
THE MEDICAL FOUNDATION
95 BERKELEY ST, #201
BOSTON MA 02116
(617) 451-0049 X701
RCONSIDINE@TMFNET.ORG

MaryAnn Cooney, RN, MS
DIRECTOR, CHRONIC DISEASE
PREVENTION
NH DHHS, OFFICE OF COMMU-
NITY AND PUBLIC HEALTH
6 HAZEN DRIVE
Concord, NH 03301
(603) 271-4549
MCOONEY@DHHS.STATE.NH.US

Jennifer Coplon, Ph.D., MSW
DIRECTOR, PROGRAMS AND
CLIENT RELATIONS
TUFTS HEALTH CARE INSTITUTE
136 HARRISON AVE
BOSTON MA 02111
(617) 636-6637
JENNIFER_COPLON@TUFTS-
HEALTH.COM

Mary E. Costanza, MD
PROFESSOR OF MEDICINE
UMASS MEDICAL SCHOOL
53 LAKE AVENUE, NORTH
NEWTON MA 02459
(617) 244-1100
MARY.COSTANZA@UMASSMED.EDU

Joyce Coutu, MAT
HEALTH PLANNER
RI DEPT OF HEALTH
3 CAPITOL HILL
PROVIDENCE RI 02908
(401) 222-5119
JOYCEC@DOH.STATE.RI.US

Suzanne Craig, MD, PhD
COORDINATOR, MA 5 A DAY
MA 5 A DAY, MA DPH
250 WASHINGTON ST - 4TH FL
BOSTON MA 02108
(617) 624-5418
SUZANNE.CRAIG@STATE.MA.US

Brian M. Cresta
REGIONAL DIRECTOR
REGION ONE, US DHHS
2100 JFK Building
Boston, MA 02203
(617) 565-1500

Diana Cullum-Dugan, RD, LD
CLINIC COORD/NUTRITION PROG
BOSTON MED CTR, NUTRITION &
WEIGHT MGMNT CTR
732 HARRISON AVE, PRESTON 2
BOSTON MA 02118
(617) 638-5975
DIANA.CULLUMDUGAN@BMC.ORG

Wayne F. Dailey, Ph.D.
SR. POLICY ADVISOR
CT DMHAS - P.O. BOX 341431
410 CAPITOL AVE, MS 14MCP
Hartford, CT 06134
(860) 418-6899
WAYNE.DAILEY@PO.STATE.CT.US

Deirdre M. Danahar, MSW, MPH, LCSW
ASST. DIRECTOR/ADMIN.
NE AETC
23 MINER STREET
BOSTON MA 02215
(617) 262-5657
DDANAHAR@NEAETC.ORG

Hooky Darack
SECRETARY, NEPHA
1672 BEACON ST
WABAN MA 02468
(617) 332-4629
www.hookyd@gis.net

Nancy Davis, Ed.D.
PUBLIC HEALTH ADVISOR
SAMHSA/CTR FOR MENTAL
HEALTH SVCS
5600 FISHERS LANE, RM 17-C-05
Rockville, MD 20857
(301) 443-2844
NDAVIS1@SAMHSA.GOV

David Day
VP OF ADVOCACY
AMERICAN HEART MARK CTR
401 PARK DRIVE, MS 01-06
BOSTON MA 02215
(617) 246-4319
JANET.EDMUNSON@BCBSMA.COM

Gerald L. Evans, MD
DIRECTOR
HEARTVENTURES
P.O. BOX 761
Framingham, MA 01701
(508) 629-5560
evans@heartventures.com

Jacqueline P. Fields, Ph.D.
VISITING SCHOLAR
CTR. FOR RESEARCH ON WOMEN,
WELLESLEY COLLEGE
71 GREAT HILL ROAD
Sandwich, MA 02563
(508) 420-4143
JACQUEPFIELDS@AOL.COM

Mindy Fitterman, M.Ed., RD
NUTRITION CONSULTANT
NH DHHS
6 HAZEN DRIVE
CONCORD NH 03301
(603) 271-4830
MFITTERMAN@DHHS.STATE.NH.US

Justine Fluck
BU SCHOOL OF PUBLIC HEALTH
18A WOODVIEW DRIVE
FALMOUTH MA 02540
(508) 540-4602
JFLUCK@BU.EDU

Kathy Foell, MS, RD
DIRECTOR, CARDIOVASCULAR
HEALTH INITIATIVE
MA DEPARTMENT OF HEALTH
250 WASHINGTON ST 4TH
Boston, MA 02108
(617) 624-5469
KATHY.FOELL@STATE.MA.US

Sally Fogerty, BSN, MEd
ASST COMMISSIONER, BFCH
MASS DPH
250 WASHINGTON ST, 5TH
BOSTON MA 02108
(617) 624-6090
SALLY.FOERTY@STATE.MA.US

Beth Foley, M.Ed., RN
INTERIM DIRECTOR, LIFETIME
CTR FOR FAM HLTH
FALLON COMMUNITY HEALTH
PLAN
630 A PLANTATION STREET
WORCESTER MA 01605
(508) 852-6110
BETH.FOLEY@FCHP.ORG

Durrell Fox
PROJECT DIRECTOR
NE HIV ED CONSORTIUM
23 MINER STREET
Boston, MA 02215
(617) 566-2283
DFOXNEHEC@AOL.COM

Roberta Friedman, ScM
PROGRAM MANAGER
MA PUBLIC HEALTH ASSN
434 JAMAICA WAY
JAMAICA PLAIN MA 02130
(617) 524-6696 X103
RFRIEDMAN@MPHAWEB.ORG

Ralph Fuccillo, MA
EXECUTIVE DIRECTOR
HARVARD PILGRIM HEALTH
CARE FOUNDATION
93 WORCESTER STREET
WELLESLEY HILLS MA 02481
(617) 509-9421
RALPH_FUCCILLO@HPHC.ORG

John Fulton, Ph.D.
ASSOCIATE DIRECTOR OF
HEALTH
RI DEPARTMENT OF HEALTH
RM 403, THREE CAPITOL HILL
Providence, RI 02908
(401) 222-1394 x115
FULT100W@AOL.COM

Donna Gallagher, RNC, MS, ANP,
FAAN
DIRECTOR
NEW ENGLAND AIDS EDUC &
TRAINING CTR.
23 MINER STREET
Boston, MA 02215
(617) 262-5657
DMGALLAG@aol.com

Joxel Garcia, MD, MBA
COMMISSIONER
STATE OF CT DEPARTMENT OF
PUBLIC HEALTH
P O BOX 340348, MS#13COM
Hartford, CT 06134
(860) 509-7101
JOXEL.GARCIA@PO.STATE.CT.US

Danna Gaynor, RN, BSM, MM
ASST. DIR OF QUALITY MGMNT,
PCC PLAN
MA DIV OF MED ASSISTANCE
600 WASHINGTON ST
BOSTON MA 02111
(617) 210-5416
DGAYNOR@NT.DMA.STATE.MA.US

William Gerrish
DIRECTOR
CT OFFICE OF HEALTH COMMU-
NICATIONS
P O BOX 340308, MS#13 CMN
HARTFORD CT 06134-0308
(860) 509-7270
WILLIAM.GERRISH@PO.STATE.CT.US

Joanne Gersten, RN, MS
DIR OF CANCER CONTROL
COMMUNITY RESOURCE DEVEL
AMERICAN CANCER SOC
360 RT. 101, UNIT 8
BEDFORD, NH 03110
(800) 640-7101 X107
JOANNE.GERSTEN@CANCER.ORG

Brian K. Gibbs, Ph.D.
DIRECTOR, PROG. TO ELIMINATE
HEALTH DISPARITIES
HARVARD SCHOOL OF PH
1552 TREMONT STREET
BOSTON MA 02120
(617) 495-5849
BKGIBBS@HSPH.HARVARD.EDU

Donald B. Giddon, DMD, PhD
CLINICAL PROFESSOR, GROWTH
& DEVELOPMENT
HARVARD MEDICAL SCHOOL
277 LINDEN STREET
WELLESLEY MA 02482
(781) 235-2995
DONALD_GIDDON@HMS.HARVARD.EDU

James R. Giebfried, PT, EDT, MA,
CPH
COMM HLTH INIATIVES COORD
BCBS OF RI
444 WESTMINSTER STREET
PROVIDENCE RI 02903
(401) 459-5239
GIEBFRIED.J@BCBSRI.ORG

Sophie Glidden
DIRECTOR, OFFICE OF RURAL
HEALTH & PRIMARY CARE
MAINE BUREAU OF HEALTH
161 Capitol Street
Augusta, ME 04333
(207) 287-5503
SOPHIE.E.GLIDDEN@STATE.ME.US

Andrea Goldstein, RN
PRIMARY CARE CONSULTANT
AMERICAN CANCER SOCIETY
14 CANTERBURY DRIVE
CANTON MA 02021
(508) 270-4653
ANDREA.GOLDSTEIN@CANCER.ORG

Judith Gorbach, Ed.M, MPH
CONSULTANT, PUBLIC HEALTH
BOARD MEMBER MPHA, NEPHA
31 PERRY LANE
WESTON MA 02493
(781) 647-3634
JAGORBACH@POST.HARVARD.EDU

Jennie Greene, MS
PROJ. MANAGER & MULTIMEDIA
PRODUCER
HARVARD CENTER FOR CANCER
PREVENTION
665 HUNTINGTON AVE, BLDG 2,
RM 121
BOSTON MA 02115
JRGREENE@HSPH.HARVARD.EDU

Terry Greene, MS
ENVIRONMENTAL HLTH ASSOC
JSI CTR. FOR ENVIRONMENTAL
HEALTH STUDIES
44 FARNSWORTH ST
BOSTON MA 02210
(617) 482-9485
TGREENE@JSI.COM

Diana Grigsby
PROGRAM MANAGER, CARDIO-
VASCULAR HEALTH
BOSTON PH COMMISSION
1010 MASS AVE, 2ND FL
BOSTON MA 02118
(617) 534-5359
DIANA_GRIGSBY@BPHC.ORG

Christie L. Hager, JD, MPH
SR. RESEARCH ASSOC.
SCHNEIDER INST. FOR HEALTH
POLICY, BRANDEIS
415 SOUTH STREET, MS 035
WALTHAM MA 02454
(781) 736-3978
HAGER@BRANDEIS.EDU

Cheryl Haller, MS
REGIONAL CANCER CONTROL
DIRECTOR
ACS
150 KENNEDY DRIVE
South Burlington, VT 05403
(802) 658-0626
CHERYL.HALLER@CANCER.ORG

Megan D. Hannan
DIRECTOR OF GOVT. RELATIONS
& ADVOCACY
AMERICAN CANCER SOCIETY
1 MAIN STREET, SUITE 300
TOPSHAM ME 04086
(207) 373-3707
MEGAN.HANNAN@CANCER.ORG

R. Scott Hanson, M.D., M.P.H.
PAST PRESIDENT
RI PUBLIC HEALTH ASSOCIATION
235 BEACON DRIVE
NORTH KINGSTOWN RI 02852
(401) 789-1086
R_HANSON@BROWN.EDU

Dianne Harnad, MSW
DIRECTOR OF PREVENTION
SVCS.
CT DMHAS - MS #14PIT
410 CAPITOL AVE, MS 14 PIT
Hartford, CT 06134
(860) 418-6828
DIANNE.HARNAD@PO.STATE.CT.US

Walter Harper, MA
COORDINATOR, MINORITY
HEALTH & WELLNESS
URBAN LEAGUE OF RI
246 PRAIRIE AVE
PROVIDENCE RI 02905
(401) 351-5168
WALTER_HARPER@BROWN.EDU

Kari Hartwig, DrPH
LECTURER
YALE UNIV SCHOOL OF PUBLIC
HEALTH
P.O. BOX 208034
NEW HAVEN CT 06520
(203) 785-5553
KARI.HARTWIG@YALE.EDU

Frederick A. Hesketh, PE, LS
LEGISLATIVE LIAISON
AMERICAN CANCER SOCIETY
1 ESSEX LANE
BLOOMFIELD CT 06002
(860) 242-2830
FREDHESKETH@SNET.NET

Patricia Hitz McKnight
NAT'L ACCT REP FOR MASS
THE CTRS FOR MEDICARE &
MEDICAID SVCS
RM. 2275, JFK FEDERAL BUILD-
ING
BOSTON MA 02203
(617) 565-1268
PHITZMCKNIGHT@CMS.HHS.GOV

Phuong Hoang
DIR. MONITORING & EVAL
NH MINORITY HLTH COALITION
25 LOWELL ST, 3RD FL
MANCHESTER NH 03101
(603) 627-7703
PHUONG@NHHEALTHTHEQUITY.ORG

Barbara Hodge
CONSULTANT
AON CONSULTING
P O BOX 428
GREENFIELD CTR. NY 12833
(518) 893-2451
BARB@HODGEPODGE.COM

William H. Hollinshead, MD, MPH
MEDICAL DIRECTOR, DIV OF
FAMILY HEALTH
RI DEPT OF HEALTH
3 CAPITOL HILL, ROOM 302
PROVIDENCE RI 02908
(401) 222-4655
BILLH@DOH.STATE.RI.US

Jeanie Holt, MS, ARNP
PROJECT DIRECTOR
REACH 2010 COALITION/NH MIN
HLTH COAL
P O BOX 3992
MANCHESTER NH 03105
(603) 627-7703
JEANIE@NHHEALTHTHEQUITY.ORG

Jane M. Hudson, MA
DIRECTOR
MENTAL HEALTH ADVANCEMENT
RESOURCE CENTER
500 PROSPECT STREET
PAWTUCKET RI 02860
(401) 726-8383
JANEHUDSON@MHARC.ORG

Hutson W. Inness
DIRECTOR OF HIV PREV & CLI-
ENT SVCS
TAPESTRY HEALTH
39 MULBERRY ST, LOWER LEVEL
SPRINGFIELD MA 01105
(413) 747-5144
HINNISS@TAPESTRYHEALTH.ORG

Linda Jorgensen, BSW
DIRECTOR
HEALTH EDUCATION
UMASS BOSTON M/2/412
BOSTON MA 02125
(617) 287-5680
LINDA.JORGENSEN@UMB.EDU

Margaret E. Kane
EXECUTIVE DIRECTOR
AMERICAN LUNG ASSN OF RI
298 WEST EXCHANGE STREET
PROVIDENCE RI 02903
(401) 421-6487
MKANE@LUNGRI.ORG

Charlie Kaniecki
DISTRICT HEALTH OFFICER
MA DPH
23 SERVICE CENTER
NORTHAMPTON MA 01060
(413) 586-7525 x1167
charlie.kaniecki@state.ma.us

Audrey L. Kanik, M.Ed., RD
612 NORTH MAST ROAD
NEW BOSTON NH 03070
(603) 497-8533
ALKANIK@AOL.COM

Joan Davidson Kaplan
REGIONAL MANAGER
ABBOTT LABORATORIES
400 RELLA BLVD, SUITE 205
SUFFERN NY 10901
(845) 357-7994
joan.kaplan@abbott.coM

David L. Katz, MD, MPH, FACPM
DIRECTOR
YALE-GRIFFIN PREV RSRCH CTR
130 DIVISION ST
DERBY CT 06418
(203) 732-1265
KATZDL@POL.NET

Chester R. Kennedy
1ST PRESIDENT, FOUNDER
PUBLIC HEALTH MUSEUM
178 WASHINGTON ST
SHERBORN MA 01770
(508) 653-6511
CHETKENNEDY@ATT.NET

Roderick King, MD, MPH
DIRECTOR
BOSTONE HRSA FIELD OFFICE,
US DHHS
JFK FED BLDG, RM 1826
BOSTON MA 02203
(617) 565-1420
RKING@HRSA.GOV

Thomas Kirk, Jr.
COMMISSIONER
DEPT MENTAL HEALTH
& ADDICTION SVCS
PO BOX 341431, MS14COM
Hartford, CT 06134
(860) 418-6969
THOMAS.KIRK@PO.STATE.CT.US

Fran M. Kochman
STATE PROGRAMS AND ALLY
DEVELOPMENT
GLAXOSMITHKLINE
P O BOX 618
OLD SAYBROOK CT 06475
(860) 388-6977
fran.m.kochman@gsk.com

Christopher F. Koller
CEO
NEIGHBORHOOD HEALTH PLAN
OF RI
50 HOLDEN STREET, STE. 200
PROVIDENCE RI 02908
(401) 459-6000
CKOLLER@NHPRI.ORG

Rep. Peter J. Koutoujian
VICE CHAIR
JOINT COMMITTEE ON HEALTH
CARE, MA STATE LEGISLATURE
RM. 448, STATE HOUSE
Boston, MA 02115
(617) 722-2582
DANIEL.DELANY@HOU.STATE.MA.US

John Lacasse, ENG.D.SC
PRESIDENT
MEDICAL CARE DEVELOPMENT
11 Parkwood Drive
Augusta, ME 04330
(207) 622-7566
JLACASSE@MCD.ORG

Sienna Larson
PROGRAM MANAGER
NH MINORITY HEALTH COALI-
TION
P O BOX 3992
MANCHESTER NH 03105
(603) 627-7703
SIENNA@NHHEALTHTHEQUITY.ORG

Peter Lee, MPH
DIR, MA PARTNERSHIP FOR
HEALTHY COMM & LOCAL PH
THE MEDICAL FOUNDATION
622 WASHINGTON ST, 2ND FL
DORCHESTER MA 02124
(617) 451-0049 X 210
PLEE@TMFNET.ORG

Lisa Letourneau, MD, MPH
DIR, CLINICAL INTEGRATION
MAINEHEALTH
465 CONGRESS ST, STE 600
ATTN:241 OXFORD
PORTLAND ME 04101
(207) 541-7533
LETOUL@MMC.ORG

Ana Cristina Lindsay, DDS, MPH,
DrPH
RESEARCH ASSOC. DEPT OF
NUTRITION
HARVARD SCHOOL OF PH
665 HUNTINGTON AVE
BOSTON MA 02115
(617) 432-0983
ANA_LINDSAY@HARVARD.EDU

Arn Lisnoff, M.S.
ADMIN, MENTAL HEALTH
MHRH/DIV OF BEHAVIORAL
HEALTHCARE SVCS
BARRY HALL, 14 HARRINGTON
ROAD
CRANSTON RI 02920
(401) 462-6037
ALISNOFF@MHRH.STATE.RI.US

Kimberly Lopes
UNE CENTER FOR
TRANSCULTURAL HEALTH
10 HEATH LANE
STEEP FALLS ME 04085
(207) 675-3744
KIMBERLY_LOPES@WRIGHTEXPRESS.COM

William Lowenstein
ASSOC DIRECTOR, PREV DIV
DMHMRSAS
159 STATE HOUSE STATION
AUGUSTA ME 04333
(207) 287-6484
WILLIAM.LOWENSTEIN@STATE.ME.US

Kim MacNeill
COMM & DEVEL DIRECTOR
NH MINORITY HLTH COALITION
25 LOWELL ST, 3RD FL
MANCHESTER NH 03101
(603) 627-7703
KIM@NHHEALTHTHEQUITY.ORG

Arnold D. Malin, MBA
DIRECTOR, PRENATAL & OB/GYN
SVCS
MERCY MEDICAL CENTER
317 MAPLE STREET
HOLYOKE MA 01040
(413) 536-7385
ARNIE.MALIN@SPHS.COM

Marty Mancuso, MA
REGIONAL DIRECTOR
CANCER CONTROL
AMERICAN CANCER SOCIETY
538 PRESTON AVENUE
MERIDEN CT 06450
(203) 379-4830
MMANCUSO@CANCER.ORG

Sharon Marable, M.D., MPH
ASST MEDICAL DIRECTOR
RI DOH, DIV OF DIS PREV &
CONTROL
RM. 408, 3 CAPITOL HILL
PROVIDENCE RI 02908
(401) 222-5353
SHARONM@DOH.STATE.RI.US

Robert J. Marshall, Jr. Ph.D.
ASST DIRECTOR
PUBLIC HEALTH AFFAIRS
RI DOH
RM 401, THREE CAPITOL HILL
PROVIDENCE RI 02908
(401) 222-2231
BOBM@DOH.STATE.RI.US

Jocelyn McCree, MA
HIV/AIDS REGIONAL RES.
COORD.
US DHHS
2126 JFK BUILDING
BOSTON MA 02203
(617) 565-1112
JMCCREE@OSOPHS.DHHS.GOV

Celia Gomes McGillivray, MPH,
CHES, ADN
DIRECTOR CLINICAL AFFAIRS
RI HEALTH CTR ASSN
235 PROMENADE ST, SUITE 104
PROVIDENCE RI 02908
(401) 274-1197 X211
CMCGILLIVRAY@RIHCA.ORG

Janet McGrail Spillane, RN
VP CANCER PREVENTION &
DETECTION
AMERICAN CANCER SOCIETY
30 SPEEN ST
Framingham, MA 01701
(508) 270-4662
JANET.MCGRAIL@CANCER.ORG

Dede McGuire, CHE, MS
VP, WELLNESS & REHAB SVCE
LINE
CARE NE HEALTH SYSTEM
455 TOLL GATE ROAD
WARWICK RI 02886
(401) 736-4670
MCGUIRED@CARENE.ORG

Kathy McManus, RD, MS, LDNMS, RD
DIRECTOR, DEPT OF NUTRITION
BRIGHAM & WOMEN'S HOSPITAL
75 FRANCIS STREET
BOSTON MA 02113
(617) 732-5593
KMCMANUS@PARTNERS.ORG

Kathryn V. McMurry, MS
SR. NUTRITION ADVISOR
HHS/OPHS/ODPHP
200 INDEPENDENCE AVE SW
RM 738-G
WASHINGTON DC 20201
(202) 401-0751
KMCMURRY@OSOPHS.DHHS.GOV

Samia Medina-Rogers, RN
PROFESSIONAL LIAISON
DIABETES EDUCATOR
NH MINORITY HLTH COALITION
37 MAYFLOWER DRIVE
MILFORD NH 03055
(603) 627-7703
SAMIA81472@MSN.COM

Jazmin Miranda-Smith, M.Ed.
EXECUTIVE DIRECTOR
NH MINORITY HLTH COALITION
P O BOX 3992
MANCHESTER NH 03101
(603) 627-7703
JAZMIN@NHHEALTHTHEQUITY.ORG

Barbara A. Moeykens, MS
SOCIAL MARKETING SPECIALIST
VT DEPARTMENT OF HEALTH
P.O. BOX 70
Burlington, VT 05402
(802) 651-1607
BMOEYKE@VDH.STATE.VT.US

Kirk Morgan
SR. MANAGER, STATE GOVT
RELATIONS
AVENTIS PHARMACEUTICALS
58 ALPINE DRIVE
LATHAM NY 12110
(518) 785-4906
KIRK.MORGAN@AVENTIS.COM

Vivien Morris, MPH, MS, RD, LDN
DIRECTOR, MA OVERWEIGHT
PREV & CONTROL INITIATIVE
MA DEPT OF PUBLIC HEALTH
250 WASHINGTON ST, 4TH FL
BOSTON MA 02108
(617) 994-9859
VIVIEN.MORRIS@STATE.MA.US

Donna Morris, MSW
CONNECTIONS COUNSELING CTR
58 COOLIDGE CIRCLE
NORTHBOROUGH MA 01532
(508) 393-9514
DONNAMORRIS58@AOL.COM

Susan Morrison, M.Ed.
HEALTH PROMOTION ADVISOR
NH DHHS OCPH
6 HAZEN DRIVE
CONCORD NH 03301
(603) 271-6887
SMORRISON@DHHS.STATE.NH.US

Carolyn Morwick, DIRECTOR,
OFFICE OF POLICY & RESEARCH
NE BOARD OF HIGHER ED
45 TEMPLE PLACE
BOSTON MA 02111
(617) 357-9620
CMORWICK@NEBHE.ORG

Latoya Moseley, HEALTH ED
URBAN LEAGUE
246 PRAIRIE AVENUE
PROVIDENCE RI 02905
(401) 351-5168
LATOYAMOSELEY@HOTMAIL.COM

Beth Mulvey
DIRECTOR OF DEVELOPMENT &
COMMUNITY RELATIONS
BERKSHIRE HEALTH SYSTEMS
725 NORTH ST
PITTSFIELD MA 01201
(413) 447-2060
BMULVEY@BHSL.ORG

Elizabeth Murphy, DIRECTOR,
CANCER PREV & CONTROL
MDPH
250 WASHINGTON ST, 4TH FL
BOSTON MA 02108
(617) 624-5441
elizabeth.murphy@state.ma.us

Shannon Namislo
DIRECTOR OF HLTH INITIATIVES
AMERICAN HEART ASSOCIATION
1111 Elm Street, Suite 9A
WEST SPRINGFIELD MA 01089
(413) 827-0400
SHANNON.NAMISLO@HEART.ORG

Pamela Nathenson, MPH
COORDINATOR OF PROGRAMS
REACH CHF/NO BERKSHIRE HS
71 HOSPITAL AVE
NORTH ADAMS MA 01247
(413) 664-5626
PNATHENSON@NBHEALTH.ORG

Beth Nelles
SR. MARKETING MANAGER
ABBOTT LABORATORIES, DEPT
KP52, BLDG AP 30
200 ABBOTT PARK RD, D502, AP30
ABBOTT PARK IL 60064
(847) 938-2354

Christina Nordstrom, M.Ed.
COMMUNITY ED DIRECTOR
JORDAN HOSPITAL
275 SANDWICH STREET
PLYMOUTH MA 02360
(508) 830-2252
CNORDSTROM@JORDANHOSPITAL.ORG

Kathy O'Connor
DIRECTOR OF CANCER PREV
AMERICAN CANCER SOCIETY
30 SPEEN STREET
FRAMINGHAM MA 01701
(508) 270-4690
KATHY.O'CONNOR@CANCER.ORG

Catherine O'Connor, MA, DIRECTOR
OFFICE OF HLTHY COMMUNITIES
MA DEPT OF PUBLIC HEALTH
250 WASHINGTON ST, 2ND FL
BOSTON MA 02108
(617) 624-5276
CATHY.O'CONNOR@STATE.MA.US

Jhana O'Donnell
CSHP COORDINATOR
MA DEPT OF EDUCATION
350 MAIN ST
MALDEN MA 02148
(781) 338-6325
JO'DONNELL@DOE.MASS.EDU

Susan O'Hara, RN, MPH
O'HARA HEALTHCARE CONSULT.
735 HEMENWAY STREET
MARLBOROUGH MA 01752
(508) 460-2026
OHARAHEALTHCARECONSULTANTS
@ATTBI.COM

Kara Ohlund, PROJECT DIRECTOR
MCD
11 PARKWOOD DRIVE
AUGUSTA ME 04330
(207) 622-7566 X248
KOHLUND@MCD.ORG

Nicholas A. Oliver
RI DIRECTOR OF ADVOCACY
AHA, NE AFFILIATE
275 WESTMINSTER ST, SUITE 100
PROVIDENCE RI 02903
(888) 863-4052
NICHOLAS.OLIVER@HEART.ORG

Bobbi Orsi, BS, RN, CDE
DIRECTOR OF ACCENT ON
HEALTH
BERKSHIRE MEDICAL CENTER
165 TOR COURT
PITTSFIELD MA 01201
(413) 447-3099
BORSI@BHSL.ORG

Barry Paillet
PROGRAM MANAGER
BC/BS OF MA
401 PARK DRIVE, MS 01/06
BOSTON MA 02215
(617) 246-7814
BARRY.PAILET@BCBSMA.COM

Sonia L. Parra
PROGRAM COORDINATOR
NH MINORITY HLTH COALITION
P.O. BOX 3992
MANCHESTER NH 03105
(603) 627-7703
SONIA@NHHEALTHEQUITY.ORG

Mark C. Pettus, MD
ASSOC. CHAIR, DEPT OF MED
BERKSHIRE MEDICAL CENTER
725 NORTH STREET
Pittsfield, MA 01201
(413) 447-2849
MPETTUS@BHS1.ORG

Thu Pham
PROJECT COORDINATOR/VIET-
NAMESE HEALTH PROJECT
MERCY MEDICAL CENTER
271 CAREW STREET
SPRINGFIELD MA 01102
(413) 748-9065

Judy C.C. Phillips, MS, RD, LDN
SR. RESEARCH NUTRITIONIST
CENTER FOR NUTRITIONAL
RESEARCH
332 WASHINGTON ST., STE 360
WELLESLEY MA 02481
(781) 431-2672
NECH3@MINDSPRING.COM

Christine Pontus, RN
LOSS PREVENTION CONSULTANT
BEACON INSURANCE CO
895 GREENVILLE AVE
GREENVILLE RI 02828
(401) 825-2741
CPONTUS@BEACONMUTUAL.COM

Heather Provino, MS
KENT COUNTY MEM HOSPITAL
455 TOLL GATE ROAD
WARWICK RI 02886
(401) 732-3066

Janet Prvu, MS
HEALTH INITIATIVES DIRECTOR
AMERICAN HEART ASSN., NE AFF
20 SPEEN STREET
FRAMINGHAM MA 01701
(508) 620-1700
JPRVU@HEART.ORG

Claire Purdy
NECON STAFF
ONE MEETING STREET
PROVIDENCE RI 02903
(401) 351-5130

Claudia Raya, RD, LDN
NUTRITION ED SPECIALIST
MA DEPT ED, NUTRITION PROG
350 MAIN ST, 4th fl
MALDEN MA 02148
(781) 338-6481
CRAYA@DOE.MASS.EDU

Pamela Starke Reed
DEPUTY DIRECTOR
NIH/NIDDK/DNRC
6707 Democracy Boulevard, Rm 633
BETHESDA MD 20892
(301) 594-8805
PS39@NIH.GOV

Suzanne Rice, RN
EDUCATION COORDINATOR
DIVISION OF MED ASSISTANCE
600 WASHINGTON STREET
BOSTON MA 02111
(617) 210-5608
SRICE@NT.DMA.STATE.MA.US

Lisa Richards, MS, RD
PROGRAM PLANNER
NH DHHS, BUREAU OF NUTRI-
TION & HEALTH PROMOTION
6 HAZEN DRIVE
CONCORD NH 03301
(603) 271-4538
LRICHARDS@DHHS.STATE.NH.US

Glenda Rickabaugh, MA
HEALTH INITIATIVES DIRECTOR,
AHA SOUTHERN REG
AHA, NE AFFILIATE, RI DIV
275 WESTMINSTER ST
PROVIDENCE RI 02903
(401) 274-4544
GLENDA.RICKABAUGH@HEART.ORG

Patricia Risica, Dr.PH
ASST. PROF
BROWN UNIV, INST
FOR COMM HLTH PROMO
4W CORO, 1 HOPPIN STREET
PROVIDENCE RI 02903
(401) 793-8320
PATRICIA_RISICA@BROWN.EDU

John Roberts, MSN, RNCS, ANP
SR. PROJECT SPECIALIST
NEAETC
23 MINER ST
BOSTON MA 02215
(617) 262-5657
JROBERTS@NEAETC.ORG

Laurie L. Robinson, MTS
REG. WOMEN'S HEALTH COORD
OFFICE ON WOMEN'S HEALTH, US
DHHS, REGION I
2126 JFK BLDG
BOSTON, MA 02203
(617) 565-1071
LRobinson2@osophs.dhhs.gov

Maria E. Rodriguez-Immerman, MSW, JD
DIRECTOR OF PROGRAMS
REACH CHF/NO. BERKSHIRE
HEALTH SYSTEMS
71 HOSPITAL AVENUE
NORTH ADAMS MA 01247
(413) 664-5446
MRODRIGUEZ-
IMMERMAN@NBHEALTH.ORG

Milagros C. Rosal, Ph.D.
ASSISTANT PROFESSOR
UMASS MEDICAL SCHOOL
55 LAKE AVENUE NORTH, S-7-755
WORCESTER MA 01655
(508) 856-3173
MILAGROS.ROSAL@UMASSMED.EDU

Betsy Rosenfeld, JD
ACTING REGIONAL HEALTH
ADMINISTRATOR
US DHHS/OFFICE OF PUBLIC
HEALTH & SCIENCE
2100 JFK BLDG
Boston, MA 02203
(617) 565-1505
BETSY.ROSENFELD@HHS.GOV

Amy Rosenstein, MBA
DIRECTOR, NE PH & MANAGED
CARE COLLABORATIVE
BRANDEIS UNIV
415 SOUTH STREET, MS 035
WALTHAM MA 02454
(781) 736-3954
AROSENSTEIN@BRANDEIS.EDU

Anita Ruff, MPH, CHES
PUBLIC HEALTH ADVISOR
CDC/ME BUREAU OF HEALTH
11 SHS, 286 WATER STREET
AUGUSTA ME 04333
(207) 287-5358
ANITA.RUFF@STATE.ME.US

Pat Ruggles, RN, BSc, CRNO
HARVARD PILGRIM
161 CHURCH STREET
DUXBURY MA 02332
(617) 509-8019
PAT_RUGGLES@HARVARDPILGRIM.ORG

Catherine Russell, Ed.D.
EXECUTIVE DIRECTOR
CT AHEC
35 LAFAYETTE STREET
NORWICH CT 06430
(860) 886-1424 X13
RUSSELL.AHEC@SNET.NET

Andrew Ryan
RESEARCH ANALYST
NH MINORITY HEALTH COALI-
TION
25 LOWELL ST, 3RD FL
MANCHESTER NH 03101
(603) 627-7703
ANDREW@NHHEALTHTHEQUITY.ORG

Cathryn Samples, MD, MPH
CLINICAL DIRECTOR AND PI
BOSTON HAPPENS, CHILDRENS
HOSPITAL
300 LONGWOOD AVE, WB 309
BOSTON MA 02130
(617) 355-5767
CATHRYNSAMPLES@TCHHARVARD.EDU

Michelle Samplin-Salgado, MPH
COMMUNICATIONS MANAGER
HARVARD CTR FOR CANC PREV
665 HUNTINGTON AVE
BLDG 2, #121
BOSTON MA 02114
(617) 432-4303
MSAMPLIN@HSPH.HARVARD.EDU

Stephen Sarno, HEALTH EDUCATOR
URBAN LEAGUE
246 PRAIRIE AVENUE
PROVIDENCE RI 02905
(401) 351-5168

Linda Saunders, JD, DEPT DIRECTOR
NH DIV OF BEHAVIORAL HEALTH
MAIN BLDG, SOPS, 105 PLEASANT ST
CONCORD NH 03301
(603) 271-0563
LSAUNDER@DHHS.STATE.NH.US

Randy Schwartz, MSPH
SR. VP FOR CANCER CONTROL
ACS, NE DIV
ONE MAIN STREET, SUITE 300
TOPSHAM ME 04086
(207) 373-3725
RANDY.SCHWARTZ@CANCER.ORG

Janet L. Scott-Harris
PUBLIC HEALTH ADVISOR
US DHHS/OFFICE OF MINORITY
HEALTH, REGION ONE
RM 2126, JFK FEDERAL BUILDING
Boston, MA 02203
(617) 565-1064
jscott-h@hrsa.gov

Susan H. Servais
EXECUTIVE DIRECTOR
MA HEALTH COUNCIL, INC
4 GARRISON ST
NEWTON MA 02467
617-965-3711
MAHLTH@AOL.COM

Douglas Shenson, MD, MPH
EXECUTIVE DIRECTOR
SPARC
BOX 746
LAKEVILLE CT 06039
(860) 435-2896
DSHENSON@CHANNEL1.COM

Lon Sherman, MD
HARVARD SCHOOL OF PH
400 MAIN STREET
AMESBURY MA 01913
(978) 462-1555
LSHERMAN@HSPH.HARVARD.EDU

Christanne Smith Harrison, MPH, RD
COORD FOR NUTRITION ED,
TRAIN & OUTREACH
MA DEPT ED, NUTRITION PROG
350 MAIN ST
MALDEN MA 02148
(781) 338-6934
CSMITH@DOE.MASS.EDU

Aimee Monroy Smith
DIR, GRASSROOTS ADVOCACY
AMERICAN CANCER SOCIETY
538 PRESTON AVE
MERIDEN CT 06450
(203) 379-4850
AIMEE.SMITH@CANCER.ORG

Ruth B. Smith, Ph.D.
ASSISTANT PROFESSOR
THE SHRIVER CENTER
200 TRAPELO ROAD
WALTHAM MA 02452
(781) 642-0229
RUTH.SMITH@UMASSMED.EDU

Cynthia Stein, MD, MPH
INSTRUCTOR IN MEDICINE
HARVARD SCHOOL OF PH,
CHANNING LAB
181 LONGWOOD AVE
BOSTON MA 02115
(617) 525-2258
CYNTHIASTEIN@CHANNINGHARVARD.EDU

Ronald J. Steingard, MD
VICE CHAIR, CHILD & ADOLES-
CENT PSYCHIATRY
UMASS MED SCHOOL, DEPT. OF
PSYCHIATRY
55 LAKE AVE, NORTH
WORCESTER MA 01655
(508) 856-4094
RONALDSTEINGARD@UMASSMED.EDU

Sylvia Stevens-Edouard, MS
DIRECTOR OF COMMUNITY
RELATIONS
BC/BS OF MA
LANDMARK CTR., 401 PARK
DRIVE
BOSTON MA 02215
(617) 246-4843
SYLVIA.STEVENS-
EDOUARD@BCBSMA.COM

Eliot M. Stone, CEO
MA HEALTH DATA
CONSORTIUM, INC
460 TOTTEN POND, STE 385
WALTHAM MA 02451
(781) 890-6042
ESTONE@MAHEALTHDATA.ORG

John Straus, MD
MEDICAL DIRECTOR
MA BEHAVIORAL HEALTH PART-
NERSHIP
150 FEDERAL STREET
BOSTON MA 02110
(617) 790-4120
JOHN.STRAUS@VALUEOPTIONS.COM

Beauregard Stubblefield-Tave, MBA
PRESIDENT
THE STUBBLEFIELD-TAVE GROUP
27 ADAMS AVE
NEWTON MA 02465
617) 501-6951
BSSTUBBL711@AOL.COM

Grant Emerson Summers
PRESIDENT
INFORMED/MEDUCATION, INC.
38 HAMLET AVENUE
WOONSOCKET RI 02895
(401) 762-0020
GRANT@IDS.NET

Donald Swartz, MD
DIRECTOR, DIV OF HLTH IMPROV
VT DEPT OF HEALTH
P.O. BOX 70
BURLINGTON VT 05402
(802) 863-7270
DSWARTZ@VDH.STATE.VT.US

Rachel Talbot-Ross
DIRECTOR, EEO &
MULTICULTURAL AFFAIRS
CITY OF PORTLAND
389 CONGRESS ST
PORTLAND ME 04101
(207) 874-8669
RTR@CI.PORTLAND.ME.US

Florence Tankevich, RN, MS
58 MERRITT AVENUE
TIVERTON RI 02878
(401) 624-3805
FTANKEVICH@AOL.COM

Barbara Tausey, MD, MHA
REG. MEDICAL CONSULTANT
USDHHS.HRSA
1826 JFK FEDERAL BLDG
BOSTON MA 02203
(617) 565-1433
BTAUSEY@HRSA.GOV

Ann Kelsey Thacher, M.S.
CHIEF, OFFICE OF HLTH PROMO
RI DEPARTMENT OF HEALTH
RM 409, THREE CAPITOL HILL
PROVIDENCE RI 02908
(401) 222-7637
ANNT@DOH.STATE.RI.US

Monique Thompson, DIR, P & D
DPH - OFFICE OF
MULTICULTURAL HEALTH
250 WASHINGTON ST., 4TH FL
BOSTON MA 02108
(617) 624-6080
MONIQUE.THOMPSON@STATE.MA.US

Meredith L. Tipton, Ph.D., MPH
ASSOC. DEAN FOR COMM PROG
UNIV OF NE COLLEGE OF MED
11 HILLS BEACH ROAD
BIDDEFORD ME 04005-0011
(207) 283-0171 X2886
MTIPTON@UNE.EDU

Carl Toney, P.A.
ASST. PROF. COLLEGE OF
HEALTH PROFESSIONS
UNIVERSITY OF NEW ENGLAND
716 STEVENS AVE
Portland, ME 04103
(207) 797-7688 X4266
CTONEY@UNE.EDU

Brunilda Torres, LICSW
DIRECTOR
OFFICE OF MULTICULTURAL
HEALTH, MDPH
250 WASHINGTON ST
BOSTON MA 02108
(617) 624-5272
BRUNILDA.TORRES@STATE.MA.US

Charles C. Tretter
EXECUTIVE DIRECTOR
N E GOVERNORS' CONFERENCE
76 SUMMER STREET, SUITE 200
BOSTON MA 02110
(617) 423-6900
FLA2809466@AOL.COM

F. Randy Vogenberg, R.Ph., Ph.D.
VICE PRESIDENT
AON CONSULTING
70 WALNUT STREET
WELLESLEY MA 02481-2102
(781) 239-8242
RANDY_VOGENBERG@AONCONS.COM

Elizabeth Walker, MS
COMMUNITY RELATIONS MGR
HARVARD PREVENTION RE-
SEARCH CTR
677 HUNTINGTON AVE, 7TH FL
BOSTON MA 02115
(617) 432-6596
EWALKER@HSPH.HARVARD.EDU

Adrienne Walsh
DIRECTOR, CANCER CONTROL
AMERICAN CANCER SOCIETY
222 RICHMOND STREET
Providence, RI 02903
(401) 243-2650
AWALSH@CANCER.ORG

Ed Wang, Psy.D.
DIRECTOR, OFFICE OF
MULTICULTURAL AFFAIRS
MA DEPT OF MENTAL HEALTH
25 STANIFORD STREET
BOSTON MA 02114
(617) 626-8137
ED.WANG@DMH.STATE.MA.US

William Waters, Jr., Ph.D.
DEPUTY DIRECTOR
RI DOH
3 CAPITOL HILL, RM 401
PROVIDENCE RI 02908
(401) 222-2231
BillW@doh.state.ri.us//
VICKIL@DOH.STATE.RI.US

Dr. J. Brooks Watt
GILLETTE MED DEPT. 40TH FL
PRUDENTIAL TOWER
BOSTON MA 02199
(617) 421-7631
dr_j_brooks_watt@gillette.com

David S. Weed, Psy.D.
DIRECTOR OF COMMUNITY
CLINICAL SERVICES
CORRIGAN MHC
49 HILLSIDE ST
FALL RIVER MA 02720
(508) 235-7211
DAVID.WEED@STATE.MA.US

Craig R. Wells, MSL
DEPUTY DIRECTOR
SILENT SPRING INSTITUTE
20 CRAFTS STREET
NEWTON MA 02458
(617) 332-4288
WELLS@SILENTSPRING.ORG

Terrie Wetle, Ph.D.
ASSOC. DEAN OF MED
FOR PH & PUB POL
BROWN UNIVERSITY
BOX G-A 205
PROVIDENCE RI 02912
(401) 863-9858
TERRIE_WETLE@BROWN.EDU

Katherine Wells Wheeler
PRESIDENT ELECT
NH PUBLIC HEALTH ASSN.
27 MILL ROAD
DURHAM NH 03824
(603) 868-9633
KATIEWW@AOL.COM

Cheri White, MS
NUTRITION EDUCATION CON-
SULTANT
NH DEPT OF EDUCATION
101 PLEASANT STREET
CONCORD NH 03301
(603) 271-3865
CWHITE@ED.STATE.NH.US

Kathleen White
PUBLIC AFFAIRS DIRECTOR
RETAILERS ASSN OF MA
18 TREMONT ST, SUITE 1040
BOSTON MA 02108
(617) 523-1900 X15
KWHITE@RETAILERSMA.ORG

Jean Wiecha, Ph.D.
SR RESEARCH SPECIALIST
HARVARD SCHOOL OF PH
677 HUNTINGTON AVE, 7TH FL
BOSTON MA 02115
(617) 432-4255
JWIECHA@HSPH.HARVARD.EDU

Walter C. Willett, MD, Dr. PH
CHAIR, DEPT. OF NUTRITION
HARVARD SCHOOL OF PUBLIC
HEALTH
665 HUNTINGTON AVENUE
Boston, MA 02115
(617) 432-4680
WALTER.WILLETT
@CHANNING.HARVARD.EDU

Martha Crosier Wood, MBA
CONSULTANT
51 GLEASON ROAD
LEXINGTON MA 02420
(781) 862-0645
MARTHACWOOD@RCN.COM

Bertram A. Yaffe
CHAIR
NECON
ONE MEETING STREET
PROVIDENCE RI 02903
(401) 351-5130
BYAFFE@AOL.COM

Cheryl Yaffe Kiser, MSW, MSP
DIRECTOR OF MKTG, CTR FOR
CORP CITIZENSHIP
BOSTON COLLEGE
55 LEE ROAD
CHESTNUT HILL MA 02467
(617) 552-8948
KISERCH@BC.EDU

Michelle Zbell, MS
COORDINATED SCHOOL HEALTH
PROG
MA DPH, SCHOOL HEALTH
250 WASHINGTON ST
BOSTON MA 02108
(617) 624-5537
MICHELLE.ZBELL@STATE.MA.US