A Health Department Perspective on the *Guide to Community Preventive Services*

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The first and second editions of the *Guide to Clinical Preventive Services* (GCPS) have been two of the most influential and widely used texts in the field of preventive medicine over the last decade.[1,2] In health departments, for example, the GCPS has been useful in activities ranging from establishing preventive service protocols in public health clinics to developing public and professional education materials and programs at the state level. The recommendations of the U.S. Preventive Services Task Force (USPSTF) have highlighted effective preventive interventions from the individual perspective and have been a benchmark for evidence-based clinical guidelines, in general. However, while a new USPSTF has already begun work on the third edition of the GCPS, comprehensive, evidence-based recommendations for populations have not been developed. Now, with staff support from the Centers for Disease Control and Prevention, the Task Force on Community Preventive Services (Task Force) has been impaneled. This nonfederal group of experts is developing the *Guide to Community Preventive Services: Systematic Reviews and Evidence-Based Recommendations* (the *Guide*). The *Guide* will provide recommendations regarding population-based interventions for disease prevention and health promotion and will be the counterpart to the GCPS. The background and methods of the *Guide* are described in this supplement.[3] In this commentary, we will discuss some of the public health practice needs that will be met by the *Guide* and also highlight some of the challenges that lie ahead in using the recommendations, as they are completed, to actually improve the health of populations and communities.

The first set of recommendations from the Task Force deals with interventions to improve vaccination coverage across the age spectrum. This is a very appropriate topic from the public health perspective since immunizations are: (1) proven effective at reducing disease incidence; (2) cost-saving; (3) well accepted as appropriate by the public and health professionals; and (4) still underutilized in a variety of settings. Thus, there is a need to incorporate interventions into practice that address suboptimal immunization rates. In addressing this issue, the recommendations of the Task Force are specific and discriminating. For example, the Task Force review included the examination of three strategies (among others) that, on initial examination, all seem reasonably likely to increase immunization rates: (1) client reminder/recall; (2) vaccination requirements for child care, school, and college attendance; and (3) community-wide education only. The Task Force, however, gave these approaches the ratings of: *strongly recommended*, *recommended*, and *insufficient evidence*, respectively. Such guidance that differentiates among three seemingly appropriate strategies is desperately needed in public health practice because it enables the prioritization and selection of interventions based on effectiveness and efficiency.

While the specific guidance on individual topics such as vaccine-preventable disease[4] will be widely used in health departments, the Task Force's approach to developing the recommendations will, in itself, advance public health practice. In particular, the Task Force's development and use of evidence-based methods moves the field a critical step forward. While evidence-based medicine has been researched, discussed, and practiced for many years, the concept of evidence-based public health is still unfamiliar to most practicing public health professionals. Yet, to ensure its credibility and integrity, public health practice must be based on objective findings and standards derived from the best science. Furthermore, to make sound policy decisions, the rapidly expanding information base in public health and biomedicine must be accessed and analyzed in a logical and systematic way. Thus, there is a strong need for an evidence-based approach to practice in both clinical and community settings. Such an approach can rationalize the delivery of public health services and help in bringing consistency to public health practice across the approximately 3000 local health departments and 50 state health departments.

Another important approach of the Task Force and its staff is the systematic review of economic evaluations for the interventions examined in the *Guide*. In public health, as in the medical sector, the pressure to "do more with less" has become relentless. Therefore, the need to be able to assess the value of community intervention and to compare interventions explicitly on cost (as well as effectiveness) is becoming increasingly

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important. Unfortunately, for many community services, there will be insufficient information to provide guidance on economic value. The identification of these information gaps, however, will be useful to both researchers and policy makers. We commend the Task Force and its staff for tackling the difficult area of economic evaluation, in spite of the serious challenge posed by missing information.

While the *Guide* will likely be welcomed as a valuable new tool for public health practice when it is released in mid-2001, we recognize that there are a number of challenges that lie ahead. For instance, there are a multiplicity of guidelines being used now in health departments simply because they are a requirement of individual, categorical funding streams from the federal or state level. In addition, there are many other guidelines and practice recommendations produced by professional associations, voluntary health organizations, and health care systems that relate to population medicine and community health. It will take a concerted effort among leaders from all of these sectors to use the *Guide* to attack the problem of overlapping, and in some cases, conflicting guidelines and practice recommendations. While by no means easy, such agreement has been reached in the past on issues such as immunizations[5] and screening mammography.[6] Achieving consensus on practice recommendations increases the likelihood that the recommendations will be understood, accepted, and put into practice.

Another key issue is how the *Guide* will be disseminated, and more importantly, implemented. Recognizing the challenge of translating even well-accepted clinical guidelines into practice, the federal Office of Disease Prevention and Health Promotion developed a program entitled Put Prevention Into Practice,[7] for implementing the USPSTF recommendations. For the population-based recommendations in the *Guide* to be incorporated into practice, coordination with the national Medicine and Public Health Initiative[8] and related state and local programs will be very valuable. This is a natural linkage since the *Guide* targets defined populations in public health and managed care settings. Furthermore, the topics to be addressed by the *Guide*, such as increasing immunization coverage, have both personal and population health implications. Another important national initiative that could support dissemination and implementation of the *Guide* is the National Public Health Performance Standards Program.[9] This program is a joint effort led by the Centers for Disease Control and Prevention in partnership with the American Public Health Association, the Association of State and Territorial Health Officials, the National Association of County and City Health Officials, the National Association of Local Boards of Public Health, and the Public Health Foundation. The program has developed performance standards for local and state health departments to address the wide variation in practice that occurs across public health delivery systems. Since one of the major aims of the program is to support quality improvement efforts in health departments, the *Guide* should be a useful tool in this endeavor. In addition, the partners involved in this effort represent many of the main targets of the *Guide* and need to be involved throughout its development, dissemination, and implementation phases. To their credit, the Task Force and its staff have looked beyond the development of recommendations and have, in fact, outlined a basic framework for dissemination and implementation of the *Guide*.[10]

In summary, the *Guide* will be useful across public health settings from academia to health departments. It will be the first comprehensive, evidence-based evaluation of community preventive services. In addition, the *Guide*'s addressing of economic evaluation will be extremely valuable to decision makers in both public health and managed care settings in which fixed (or shrinking) budgets have become the norm. As with other guideline efforts, though, no matter how clear and compelling the recommendations, implementation of the *Guide* will be even more challenging than its development—and in this case, development is a mammoth undertaking. Ultimately, the importance of the *Guide* will not be measured by the sophistication of its methods, the number of copies distributed, or the frequency with which it is referenced in the peer-reviewed literature. Instead, the importance of the *Guide* will be determined by its impact on enhancing health and quality of life in communities.

Disclaimer: The opinions expressed in this commentary are those of the authors and do not necessarily represent the views of the California Department of Health Services or the Monterey County Health Department.

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