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ISSUE BRIEF

Fully Maintain the Prevention and Public Health Fund

Current Status:

The Affordable Care Act (ACA) for the first time in the nation's history creates a dedicated fund for prevention. The Prevention and Public Health Fund is the nation's largest single investment in prevention and takes an innovative approach by supporting cross-sector and public-private partnerships and collaborations to improve outcomes. The Prevention Fund provides more than $12.5 billion in mandatory appropriations over 10 years to improve public health and prevent chronic illnesses, including obesity and related diseases, through increased screenings, counseling and care and community-based prevention programs. Prevention Fund dollars also provide investments to expand and offer additional training for the public health workforce. Since 2010, more than $2 billion has been distributed from the Fund.

The Fund supports services and programs that allow health to be improved in communities, schools, workplaces and homes through encouraging healthier lifestyles and eliminating obstacles to healthy life choices. The Fund:

- Supports community-driven prevention efforts targeted at reducing tobacco use, increasing physical activity, improving nutrition, expanding mental health and injury prevention programs, and improving prevention activities;
- Provides financial support directly to states and communities, and gives them flexibility to address their most pressing health challenges; and
- Invests in programs that are proven, effective prevention efforts. Oversight and evaluation is a key component of every Fund-sponsored program, and strict performance measures ensure accountability before federal dollars are spent.

In 2012, Congress enacted legislation that cut more than $5 billion from the Fund to partially offset the cost of extending certain tax cuts and unemployment insurance, as well as the Medicare "doc fix," which maintains a high reimbursement rate to doctors who accept Medicare patients. Several additional attempts have been made to eliminate the Fund entirely or repurpose its priorities to cover funding shortfalls in other programs.

Why The Prevention Fund Matters:

- The Fund is being used for programs at the local, state and federal level to reduce the rate of obesity and tobacco use by five percent within five years. Obesity and tobacco are two of the leading drivers of chronic diseases and related health care costs. For instance, reducing obesity by lowering the average body mass index (BMI) of Americans by five percent could spare millions of Americans from diseases including type 2 diabetes, heart disease and cancer, and could save $29.8 billion in health care costs in five years, $158.1 billion in 10 years and $611.7 billion in 20 years. Nearly every state that reduced BMIs by five percent could save between 6.5 percent and 7.9 percent in health care costs.[1]

JANUARY 2013

PREVENTING EPIDEMICS.
PROTECTING PEOPLE.

- The Fund enables state and local health officials to respond to emergencies that put citizens' lives and health at stake — including natural disasters, terrorist attacks, infectious disease outbreaks, and unsafe food, air and water.
- The Fund creates job opportunities by providing training and financial assistance for workers, and invests in up-to-date equipment and technology needed to protect communities from disease outbreaks and other health threats.

Recommendations:

▲ **Ensure full funding of the Prevention and Public Health Fund.** Funding for the Prevention and Public Health Fund must be restored to original funding levels. In addition, consistent with the intent of the Fund, it should be used to supplement existing health program funds, rather than supplant them or justify cuts to other health programs.

B. EXPAND COMMUNITY TRANSFORMATION GRANTS TO BENEFIT ALL AMERICANS

Current Status:

Community Transformation Grants (CTGs), a component of the Prevention and Public Health Fund created by the ACA, are targeted at addressing the leading causes of chronic diseases to improve the health of Americans and reduce health care costs over the long term. They are administered and supported by Centers for Disease Control and Prevention (CDC).

Awardees can use the grants to target the causes of chronic diseases — by supporting tobacco-free living, active living and healthy eating, and clinical and community preventive services to prevent and control high blood pressure and high cholesterol; or developing programs that focus on disease prevention and health promotion, including social and emotional wellness and healthy and safe physical environments.

CTGs are required to base their efforts on proven, evidence-based approaches and must meet measurable, achievable outcomes to receive federal dollars. They are developed by community members working together at the local level, not federal policymakers who may not understand the specific community's needs.

CTGs are expected to improve the health of 130 million people — more than four out of 10 Americans. In 2011, $103 million was awarded to 61 communities in 36 states, serving approximately 120 million Americans. In 2012, $70 million was awarded to 40 communities, directly impacting about 9.2 million Americans. Twenty percent of all programs are in rural or frontier areas.[2]

Why CTGs Matter:

- CTGs allow communities to work with partners from a range of sectors to design specific interventions that meet the most pressing needs of their populations.
- CTGs invest in proven, effective community-based interventions, and focus on addressing the leading causes of chronic disease, such as tobacco use, obesity, poor nutrition and health disparities.
- Within five years, CTG grantees are expected to reduce the following by five percent: death and disability due to tobacco use; the rate of obesity (through nutrition and physical activity interventions); and death and disability due to heart disease and stroke.[3]

Recommendations:

▲ **Increase the number of Community Transformation Grants so that all Americans benefit.** Because of limited funding, only 40 percent of Americans benefit from the long-term benefits and cost savings generated in communities that receive these grants. Congress should double the current investment to expand the number of CTGs awarded, so that the program can be scaled up to address communities all across the country.

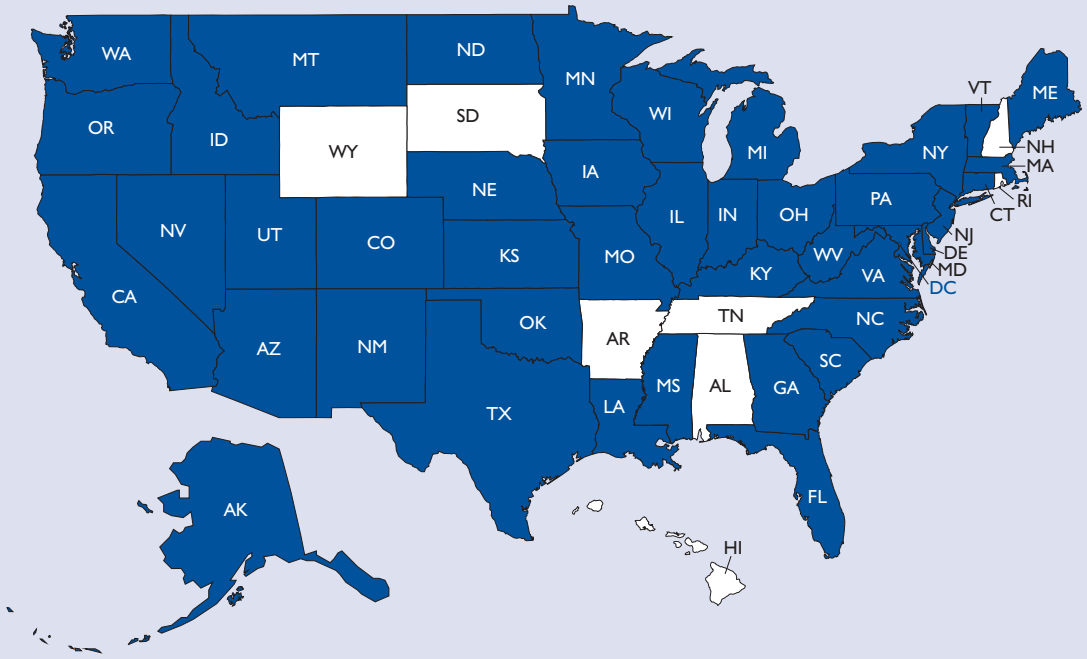
HOW IT'S WORKING:

- **West Virginia utilized CTGs to help local health departments in every county address the top challenges facing their community and develop solutions.** The West Virginia Department of Health used CTG support to help local health departments in every county in the state implement targeted initiatives including: safe places in communities to work and play, Farm-to-School Initiatives to improve nutrition in school settings, Child and Day Care Center Nutrition Programs to educate and empower children to choose healthy lifestyles through physical activity and healthy food choices, and community coordinated care systems that link and build referral networks between the clinical system and community-based lifestyle programs so people can manage their health.

- **Oklahoma is using a CTG to work with a range of sectors to make healthier choices easier in the state.** Nearly 70 percent of Oklahoma County's premature deaths are largely preventable, arising from an unhealthy lifestyle, poor diet or the use of tobacco, alcohol or other substances. In addition, the county spends about $920 million every year to treat chronic disease.[4] In September 2011, Oklahoma City was awarded a $3.5 million CTG. Using a portion of those funds, along with additional outside resources, the Oklahoma City-County Health Department (OCCHD) created the "My Heart, My Health, My Family" program to provide prevention programs and services, specifically focused on cardiovascular disease. The program includes lesson plans on healthy living (e.g. portion control and the benefits of substituting water for sugar sweetened beverages) and participants receive access to free regular clinical checkups four times a year and free medication. The CTG money will also support other obesity-specific initiatives, including a campaign to reduce consumption of sugary beverages, expanded walking and biking trails, a push to help schools offer healthy menu options and a physical education coordinator for city schools.[5]

Community Transformation Grants (CTGs)

In 2011, CDC awarded $103 to 61 state and local government agencies, tribes and territories and nonprofit organization in 36 states and nearly $4 million to 6 national networks of community-based organizations. In 2012, approximately $70 million was awarded to 40 smaller communities (areas with more than 500,000 people in neighborhoods, school districts, villages, towns, cities and counties).



State	Type of Award and Year
Alaska	■ Southeast Alaska Regional Health Consortium (Implementation 2011) ■ Yukon-Kuskokwim Health Corporation (Capacity-Building 2011)
Arizona	■ Tohono O'odham Community Action (Small Community 2012)
California	■ Public Health Institute (Implementation 2011) ■ San Francisco Department of Public Health (Implementation 2011) ■ County of San Diego Health and Human Services Agency (Implementation 2011) ■ Los Angeles County Department of Public Health (Implementation 2011) ■ County of Kern, Public Health Services Department (Capacity-Building 2011) ■ Fresno County Department of Public Health (Capacity-Building 2011) ■ Sierra Health Foundation (Capacity-Building 2011) ■ Stanislaus County Health Services Agency (Capacity-Building 2011) ■ Ventura County Public Health (Capacity-Building 2011) ■ Toiyabe Indian Health Project (Capacity-Building 2011) ■ Community Health Councils, Inc. (Small Community 2012) ■ County of Sonoma (Small Community 2012) ■ St. Helena Hospital Clear Lake (Small Community 2012) ■ County of Santa Clara (Small Community 2012)
Connecticut	■ Connecticut Department of Public Health (Capacity-Building 2011)
Colorado	■ Denver Health and Hospital Authority (Implementation 2011)
Delaware	■ Nemours/Alfred I. duPont Hospital for Children (Small Community 2012)
District of Columbia	■ District of Columbia Department of Health (Small Community 2012)
Florida	■ Broward Regional Health Planning Committee (Implementation 2011) ■ School Board of Miami-Dade County (Small Community 2012)

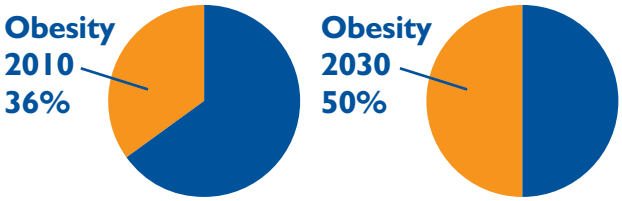
** Map does not reflect funds to national networks and organizations*

Community Transformation Grants (CTGs)	
State	**Type of Award and Year**
Georgia	■ Cobb Public Health (Capacity-Building 2011) ■ Tanner Medical Center, Inc. (Small Community 2012)
Idaho	■ Benewah Medical Center (Small Community 2012)
Illinois	■ Illinois Department of Public Health (Implementation 2011) ■ Chicago Public Schools, District 229 (Small Community 2012) ■ Quality Quest for Health of Illinois, Inc. (Small Community 2012)
Indiana	■ Welborn Baptist Foundation, Inc. (Small Community 2012)
Iowa	■ Iowa Department of Public Health (Implementation 2011)
Kansas	■ YMCA of Wichita (Small Community 2012)
Kentucky	■ Louisville Metro Department of Public Health and Wellness (Implementation 2011) ■ Unlawful Narcotics Investigation Treatment Education, Inc (Unite) (Capacity-Building 2011) ■ Microclinic International (Small Community 2012)
Louisiana	■ Louisiana Department of Health and Human Services (Capacity-Building 2011) ■ Linking the Parish, Inc. (Small Community 2012)
Maine	■ Maine Department of Health and Human Services/Maine CDC (Implementation 2011) ■ MaineGeneral Medical Center (Small Community 2012) ■ Maine Development Foundation (Small Community 2012) ■ MaineHealth (Small Community 2012) ■ Healthy Acadia (Small Community 2012)
Maryland	■ Maryland Department of Health and Mental Hygiene (Implementation 2011) ■ Institute for Public Health Innovation (Small Community 2012) ■ Prince George's County (Small Community 2012)
Massachusetts	■ Massachusetts Department of Public Health (Implementation 2011) ■ Massachusetts Department of Public Health Middlesex County (Implementation 2011) ■ Pioneer Valley Planning Commission (Small Community 2012) ■ YMCA Southcoast (Small Community 2012)
Michigan	■ Sault Ste. Marie Tribe of Chippewa Indians (Implementation 2011) ■ Spectrum Health Hospitals (Capacity-Building 2011) ■ Central Michigan District Health Department (Small Community 2012)
Minnesota	■ Minnesota Department of Health (Implementation 2011) ■ Hennepin County Human Services and Public Health Department (Implementation 2011) ■ Minneapolis Heart Institute Foundation (Small Community 2012)
Mississippi	■ My Brother's Keeper, Inc. (Capacity-Building 2011)
Missouri	■ Mid-America Regional County Community Services Corporation (Implementation 2011) ■ Ozarks Regional YMCA (Small Community 2012)
Montana	■ Montana Department of Public Health and Human Services (Implementation 2011)
Nebraska	■ Douglas County Health Department (Implementation 2011)
Nevada	■ Clark County School District (Small Community 2012)
New Jersey	■ New Jersey Prevention Network (Capacity-Building 2011)
New Mexico	■ New Mexico Department of Health (Implementation 2011) ■ Bernalillo County Office of Environmental Health (Capacity-Building 2011)
New York	■ The Fund for Public Health in New York (Implementation 2011) ■ University of Rochester Medical Center (Implementation 2011) ■ Health Research, Inc./New York State Department of Health (Small Community 2012)
North Carolina	■ North Carolina Division of Public Health (Implementation 2011)
North Dakota	■ North Dakota Department of Health (Capacity-Building 2011)

Community Transformation Grants (CTGs)	
State	**Type of Award and Year**
Ohio	■ Austen BioInnovation Institute (Capacity-Building 2011) ■ Public Health — Dayton and Montgomery County (Capacity-Building 2011) ■ The Lima Family YMCA (Small Community 2012)
Oklahoma	■ Oklahoma City-County Health Department (Implementation 2011) ■ Little Dixie Community Action Agency, Inc. (Small Community 2012) ■ Indian Nation Council of Governments Area Agency on Aging (Small Community 2012) ■ Cherokee Nation (Small Community 2012)
Oregon	■ Northeast Oregon Network (Small Community 2012) ■ City of Beaverton (Small Community 2012)
Pennsylvania	■ Philadelphia Department of Public Health (Implementation 2011) ■ Lancaster General Health (Capacity-Building 2011)
South Carolina	■ South Carolina Department of Health and Environmental Control (Implementation 2011) ■ YMCA of Greenville (Small Community 2012)
Texas	■ Texas Department of State Health Services (Implementation 2011) ■ City of Austin Health and Human Services Department (Implementation 2011) ■ Houston Department of Health and Human Services (Capacity-Building 2011) ■ Project Vida (Small Community 2012)
Utah	■ Utah Department of Health (Capacity-Building 2011)
Vermont	■ Vermont Department of Health (Implementation 2011)
Virginia	■ Fairfax County Department of Neighborhood and Community Services (Capacity-Building 2011)
Washington	■ Washington State Department of Health (Implementation 2011) ■ Tacoma-Pierce County Health Department (Implementation 2011) ■ Confederated Tribes of The Chehalis Reservation (Capacity-Building 2011) ■ Sophie Trettevick Indian Health Center (Capacity-Building 2011) ■ Seattle Children's Hospital (Small Community 2012) ■ Inland Northwest Health Services (Small Community 2012)
West Virginia	■ West Virginia Bureau of Public Health (Implementation 2011) ■ West Virginia University Research Corporation (Small Community 2012)
Wisconsin	■ University of Health Services, University of Wisconsin Madison (Implementation 2011) ■ Great Lakes Inter-Tribal Council, Inc. (Capacity-Building 2011)
Territories	■ Ulkerreuil A Klengar (Capacity-Building 2011)
National Networks	■ American Lung Association (2011) ■ American Public Health Association (2011) ■ Asian Pacific Partners for Empowerment, Advocacy and Leadership (2011) ■ Community Anti-Drug Coalitions of America (2011) ■ National REACH Coalition (2011) ■ YMCA of the USA (2011)

HALF OF AMERICANS COULD BE OBESE BY 2030

An analysis conducted by the National Heart Forum, based on a peer-reviewed model published last year in The Lancet, estimates that that 50 percent of Americans are on track to be obese in the next 20 years.[6] Obesity could even top 60 percent in 13 states. Right now, 36 percent of Americans are obese.



Obesity-Related Diseases, 2012		Rise in Obesity-Related Diseases, 2030	
Type 2 diabetes	25 million Americans	Type 2 diabetes	6 million new cases
Coronary heart disease and Stroke	27.8 million Americans	Coronary heart disease and stroke	5 million new cases
Obesity-Related Cancer	One in three cancer deaths is related to obesity, poor nutrition or physical inactivity — approximately 190,650 per year	Obesity-Related Cancer	400,000 new cases

Obesity-Related Health Care Costs, 2012	Rise in Obesity-Related Health Care Costs, 2030
$147 billion	$147 billion + between $48 billion and $66 billion

Community Transformation Grants: Reducing Obesity by 5 Percent

CTGs are a key investment of the Prevention Fund. A performance measure of CTGs is to reduce the rate of obesity by 5 percent using evidence-based nutrition and physical activity programs that have proven results. CTGs will benefit more than one in three Americans, approximately 145 million people.

Impact of Reducing Obesity

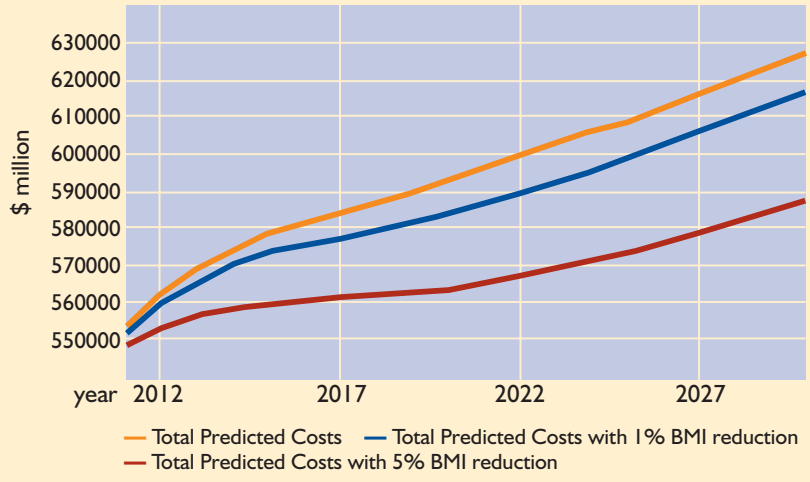
A 2012 analysis by the National Heart Forum found that reducing obesity, specifically by reducing BMI by 5 percent in states by 2030, millions of Americans could be spared from diseases and billions could be saved in health care spending.[7]

If BMIs were lowered by 5 percent by 2030, the number of Americans who could be spared from developing major obesity-related diseases could range from:

- Type 2 diabetes: 14,389 in Alaska to 796,430 in California;
- Coronary heart disease and stroke: 11,889 in Alaska to 656,970 in California;
- Obesity-related cancer: 809 in Alaska to 52,769 in California.

And, nearly every state by could save between 6.5 percent and 7.9 percent in obesity-related health care costs.

Projected Obesity-Related Health Care Costs 2010 to 2030



Local Health Officials: Chief Health Strategists Transforming Communities

By Rahul Gupta, Health Officer and Executive Director, Kanawha-Charleston Health Department

Just like the rest of the country, West Virginia and Kanawha County has been battling the obesity epidemic for decades. Across the state, there have been a myriad of physical activity, nutrition and other initiatives focused on helping people get to and remain at a healthy weight.

However, when these obesity prevention programs came in, there was a huge problem with sustainability so after a few years a program would lose funding and disappear. Quickly, residents saw these programs as fads or simply flashes in the pan. A lot of communities around the state felt kind of used, they were put into a program and researched and when the grant was up, the program was gone and, with it, the support, incentives and staffing. There was nothing built into the infrastructure of the community so there was no capacity left to sustain the process. Clearly, as obesity rates and chronic conditions like diabetes continue to increase, this incremental, start and stop approach has failed.

Realizing this early on, our community created an independent Health Coalition in Kanawha County that included the local hospitals, K-12 education systems, higher education, business and other people who had a stake and roots in our community. While health and wellbeing is a personal responsibility, it is the local, state and national government's job to provide easy outlets for citizens to reach their goals. The founding idea of the coalition was that if there are challenges facing the community, they will be brought to the coalition and they will be solved and resources will be dedicated by partner agencies.

As the coalition's benefits to the community became apparent, it was obvious that the state needed more of these county-level coalitions across West Virginia.

Transforming Communities

When the CTG program was launched in May, 2011, we saw this as an opportunity to obtain the kind of resources and support that could stand up programs and capacity which would then remain in place after grant dollars disappeared.

The CTGs made it even easier to bring stakeholders and institutions to a common table to talk about health. At the outset, we had over 100 organizations interested in being part of transforming the state and local communities.

As we learned our lesson from past grants and programs, we weren't going to let everyone get their piece of the CTG pie and go home in a silo. We wanted to ensure that each community worked with each other as well as across the traditional silos, so efforts were complimentary, not duplicative.

It became evident that the best conduit for the grant money and ideas to flow was through Local Health Departments (LHDs). Our plan was to position the LHDs from all 55 counties as wellness or healthy living hubs for their communities. They would work with the local and state Departments of Education, West Virginia's Universities and the Osteopathic School to ensure plans would work and were research driven and connected to clinical settings.

While it might not seem like a huge shift, this was a culture change in how resources and grants were distributed across the state. Instead of each LHD getting their money and going home, it was clear the funding was to build capacity, i.e., the resources and ability to do things — sort of how it's better to teach a man to fish than simply give him a fish. LHDs were also the natural lead because they were trusted voices in the community and, quite simply, they weren't going anywhere. Every day, in each community across West Virginia (and across the nation, for that matter) local health employees serve to carry out and accomplish the basic public health needs of their jurisdictions. As a result, our communities are safer, healthier and protected from deadly diseases.

Once we had the framework in place, we went back to communities to understand their needs. Every three years, our county coalition conducts a needs assessment, which includes telephone surveys, focus groups, and key informant surveys. A community forum, which is open to the public, is held to prioritize the top three health concerns in the county. Once identified, work groups are formed to address these health concerns over the next three years within the county after which the process recommences with a new needs as-

sessment. Examples of health concerns that our community has asked to address in the past have included high rates of tobacco use including second hand smoke, poor nutritional standard, lack of physical activity and prevalence of substance abuse.

While we haven't been able to create a statewide Comprehensive Clean Indoor Air Regulation (CIAR), that hasn't stopped LHDs like Kanawha-Charleston Health Department (KCHD) from creating their own ordinances and enforcing them — it's great to enact a policy, but the enforcement has to be just as good.

In Kanawha County, our Sanitarians conduct close to 5,000 inspections annually to ensure our CIAR ordinance is enforced and we have a near 100 percent compliance rate. To build support in our community for the ordinance, we took not only a policy approach (discussing the medical benefits of clean air), but also a social/media approach, business approach (showing that it would not hurt bars or restaurants but actually could increase business), and a science and research approach (we demonstrated a 37 percent reduction in heart attack related hospital admission rate in presence of CIAR over eight years — published in CDC's Preventing Chronic Diseases, July 2011 issue). Every facet of our community became advocates for clean air for different reasons — a one-time tobacco-reliant community transformed into one with clean air.

Meanwhile, at a state level, we continue to work toward enacting a statewide comprehensive law. While it has happened incrementally, the capacity and know-how is there across the state. In fact, our local ordinance has been utilized by the state's Division of Personnel to implement a state employee policy against second hand smoke. Consequently, the state government, without legislation, has adopted a comprehensive clean indoor air regulation for all state employees, which reaches and benefits thousands of West Virginians.

In addition, in doing our needs assessment, it became clear that people simply didn't have access to safe places to work out and play. There was a huge barrier on the environmental side in our community: there were no sidewalks and the areas with the largest populations had no options for physical activity. We needed to connect those who wanted to work out with safe places to do so.

In Kanawha County, we built a Physical Activity Sites Google Map (http://www.kchdwv.org/Home/Health-Promotion.aspx). It includes a Google map of all physical activity opportunities in the County as well as tools such as walk score, Everytrail and Gmaps pedometer which can be used on mobile devices. The map empowers people to seek out nearby physical activity outlets. We hope to replicate this model in other counties across the state through CTG.

In addition, we're looking to improve nutrition and physical activity in school and after-school settings, by, most notably:

- Farm-to-School Initiatives: We have developed blueprints and guides for county Food Service Directors and farmers, giving them the capacity and knowledge to stand up their own sustainable programs.
- Child and Day Care Center Nutrition Programs: We implemented the "Be Choosy, Be Healthy" program, which educates and empowers children to choose healthy lifestyles. We have also expanded the "I am Moving, I am Learning" curriculum, which increases physical activity and promotes healthy food choices.

Lastly, our state is supporting the development of community coordinated care systems that link and build referral networks between the clinical system and community-based lifestyle programs that can help people overcome disease and disability and manage their health. We've linked clinicians with programs like Dining with Diabetes, Patient Centered Medical Home pilot initiatives, the National Diabetes Program and Chronic Disease Self-Management Program.

We want programs to be complimentary to clinical practice. If a physician is seeing 30 patients a day that need diabetes/weight loss resources, we need to provide these clinicians with the capacity and information to direct their patients to a referral network outside the doctor's office. This approach is both time and cost effective and has the potential for healthier outcomes for patients.

West Virginia has worked long and hard to reverse the obesity epidemic. We've learned what doesn't work and we're beginning to transform our state, community by community. It's become clear that we need to provide people with the resources to create their own programs and that positioning LHDs as chief health strategists will ensure capacity is maintained and programs continue if grant funding disappears. By ensuring that education, health, commerce and other key stakeholders are responsible for setting and enforcing policy, the entire community truly has a stake in the health and wellbeing of everyone.

Providing a Holistic, Community-based Approach to Substance Abuse

By Karen Kelly, UNITE President/CEO

Prescription drug abuse is inflicting a devastating toll on families and communities across southern and eastern Kentucky, a region of Appalachia already shackled by economic and environmental obstacles.

Our commonwealth ranks as the fourth most medicated state in the nation; Kentuckians are abusing prescription painkillers at an alarming rate of about one in 15 residents. And with addiction comes death — nearly 1,000 lives (82 per month) in 2011, more than from motor vehicle crashes.

The prescription drug problem proliferated largely unchecked until early 2003, when a series of articles was published exposing the addiction and corruption associated with abuse across southern and eastern Kentucky — a problem chiefly associated with the painkiller OxyContin. Reacting to this disturbing news, Kentucky Fifth District Congressman Harold "Hal" Rogers formed Operation UNITE (Unlawful Narcotics Investigations, Treatment and Education) to provide a holistic, community-based approach to address these problems.

UNITE works to rid communities of illegal drug use and misuse of prescription drugs through undercover narcotics investigations, coordinating treatment for substance abusers, providing support to families and friends of substance abusers, and educating the public about the danger of using drugs. Involving broad-based community representation, UNITE's volunteer community coalitions are empowered to educate and activate individuals to no longer accept or tolerate the drug culture.

While grassroots initiatives target the most pressing local needs, UNITE provides regional support through a multi-faceted, synergistic offering of programs. These include: treatment vouchers for low-income residents, creating more than 30 Drug Court programs (an intensive alternative to incarceration for non-violent drug offenders), funding residential treatment beds, offering drug-free workplace and community education trainings, creating nearly 100 in-school anti-drug UNITE Clubs, funding a 30-member AmeriCorps program at three dozen elementary schools, and hosting a week-long summer camp for at-risk middle school youth, among others.

In 2007, UNITE was one of 12 organizations invited to participate in a White House Roundtable with President George W. Bush to discuss the growing prescription drug abuse issue. UNITE's ability to form partnerships and elicit proactive involvement of communities was touted as a model for the nation.

Addressing the Issues

About 59 percent of the Kentucky Cabinet for Health and Family Services' cases of children killed or nearly killed because of abuse or neglect in 2009-10 involved suspected substance abuse by parents or caregivers. Nationally, it is estimated that 75 percent or more of abuse and neglect cases involve substance abuse.

Fueling an addiction becomes the primary focus of parents and caregivers, resulting in diversion of limited resources to drugs instead of food, clothing and other needs of their children. In addition, the impaired state of an addict can lead to harmful decisions.

Anecdotal evidence suggests that 75-80 percent of all crime is related in some way to substance abuse. In addition, Kentucky's medical providers are overwhelmed with drug-related incidents, while the workers' compensation industry loses millions of dollars annually to fraud. This menace hurts the economic climate and sours a community's quality of life.

Just as the disease of addiction impacts more than the addict, prevention involves more than simply stopping the flow of illegal drugs and diversion of prescription and over-the-counter medications. Sure we must incarcerate the criminal element, but transforming society requires generational changes in attitude, providing nurturing environments for those seeking to rebuild their lives, along with instilling opportunity and hope.

UNITE's approach has sought to tackle the underlying contributing causes of substance abuse and tap into the time and talents of concerned community members.

UNITE is currently in the capacity-building phase of a HHS CTG to support public health efforts intended to reduce chronic diseases, promote healthier lifestyles, reduce health disparities, and control health care spending. This program will serve 119 of the state's 120 counties.

This fall, under the leadership of UNITE's Medical Advisory Council with funding from an Appalachian Regional Commission grant, a series of five symposiums are planned to educate doctors and dispensers about the dangers of prescription drug abuse and how to use the state's Kentucky All Schedule Prescription Electronic Reporting (KASPER) system.

In order to tap the time and talent of community volunteers, UNITE has created a series of ready-to-use educational kits that trained individuals can present. Each kit includes promotional materials, a PowerPoint presentation, and step-by-step implementation guide.

Accidental Dealer

A national study conducted by the National Center on Addiction and Substance Abuse at Columbia University™ in 2011 found 46 percent of all high school students currently use addictive substances, and one in three meets the medical criteria for addiction. According to the Substance Abuse and Mental Health Services Administration, an estimated 70 percent of teens obtain these drugs from family members or friends — often without their consent.

This kit educates individuals on the importance of tracking and securing your medications in the home. UNITE recently partnered with Kentucky Employers' Mutual Insurance (KEMI) — the state's largest provider of workers' compensation insurance — to provide medication lockboxes to residents.

One-Step Misery: Kentucky Meth Epidemic

With the number of methamphetamine incidents at record levels across the state, more and more innocent people are being impacted — not only emergency responders and health care workers, but on work sites, in our neighborhoods and in our schools.

The number of meth lab incidents has spiraled out of control, increasing 400 percent from 2007 to 2011, ranking Kentucky fourth in the nation. This campaign — spearheaded by Appalachia HIDTA (High Intensity Drug Trafficking Area), UNITE, the Kentucky State Police and the Kentucky Narcotic Officers' Association — explains the problem and why people should be concerned.

It also focuses on a possible solution: require a prescription for cold and allergy medications containing pseudoephedrine — the only required ingredient of meth for which there is no substitute.

Addicted: A Dose of Reality

This hard-hitting program is designed to give parents and caregivers the truth about the dangers and availability of drugs. The three-part presentation combines parenting techniques, the science of addiction, and the ins and outs of trendy drugs relevant to their community.

Combining video testimonies from recovering addicts and parents of addicts, authentic information about drug addiction is packed into the presentation.

Life With a Record

Currently in production, this kit will detail the consequences of having a drug-related conviction on your record.

National Rx Drug Abuse Summit

Kentucky is not alone in facing the prescription drug problem, now categorized as an "epidemic" by CDC. Prescription drug abuse continues to be a significant and growing problem that cuts across geographical regions, age groups, social class, economic standing, occupation and ethnic background.

Guided by a National Advisory Board, UNITE coordinated the 2012 National Rx Drug Abuse Summit featuring thought-provoking presentations by 100 experts and leaders in five educational tracks: health care, advocacy and prevention, human resources, treatment and law enforcement. More than 700 stakeholders — representing 45 states, the District of Columbia and three other countries — participated in the Summit, which included a forum with members of the Congressional Caucus on Prescription Drug Abuse.

This discussion on prescription drug abuse issues will continue with a second National Rx Drug Abuse Summit, to be held at the Omni Orlando Resort at ChampionsGate in Florida on April 2-4, 2013.

For more information about Operation UNITE visit their website at www.operationunite.org. To learn about the Summit visit www.nationalrxdrugabusesummit.org.

In 2003, Fifth District Congressman Harold "Hal" Rogers (R-Somerset) worked to create Operation UNITE, a regional anti-drug initiative empowering citizens groups and community leaders in 29 southern and eastern Kentucky counties. UNITE, which stands for Unlawful Narcotics Investigations, Treatment & Education, seeks to fight the drug epidemic by expanding drug awareness and education programs to keep people from using drugs; coordinating drug treatment and outreach programs for those who are already addicted; and operating regional undercover law enforcement task forces for interdiction and prosecution of those dealing drugs. For more information contact Karen Kelly toll-free at 1-866-678-6483.

ENDNOTES

1 Trust for America's Health. *F as in Fat: How Obesity Threatens America's Future, 2012.* Washington, D.C.: Trust for America's Health. http://www.tfah.org/report/100/ (accessed October 2012).

2 Community Transformation Grants (CTG) Program Fact Sheet. In *U.S. Centers for Disease Control and Prevention.* http://www.cdc.gov/communitytransformation/funds/index.htm (accessed October 2012)

3 Centers for Disease Control and Prevention. *Funding Opportunity Announcement: Public Prevention Health Fund: Community Transformation Grants.* 2011.

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Trust for America's Health
WWW.HEALTHYAMERICANS.ORG

1730 M Street, NW, Suite 900
Washington, DC 20036
(t) 202-223-9870
(f) 202-223-9871