Journal Citations

Frieden, T. R. 2010. A framework for public health action: The health impact pyramid. American Journal of Public Health 100(4):590-595.

**Abstract:**

A 5-tier pyramid best describes the impact of different types of public health interventions and provides a framework to improve health. At the base of this pyramid, indicating interventions with the greatest potential impact, are efforts to address socioeconomic determinants of health. In ascending order are interventions that change the context to make individuals' default decisions healthy, clinical interventions that require limited contact but confer long-term protection, ongoing direct clinical care, and health education and counseling. Interventions focusing on lower levels of the pyramid tend to be more effective because they reach broader segments of society and require less individual effort. Implementing interventions at each of the levels can achieve the maximum possible sustained public health benefit.

**Free Full Text:**

<http://www.ncbi.nlm.nih.gov/pubmed?term=A+framework+for+public+health+action%3A+The+health+impact+pyramid&TransSchema=title&cmd=detailssearch>

Adashi, E. Y., H. J. Geiger, and M. D. Fine. 2010. Health care reform and primary care—the growing importance of the community health center. New England Journal of Medicine 362(22):2047-2050.

**No Abstract available. Free Full Text:**

<http://www.ncbi.nlm.nih.gov/pubmed?term=Health+care+reform+and+primary+care%E2%80%94the+growing+importance+of+the+community+health+center&TransSchema=title&cmd=detailssearch>

Bell, J., and M. Standish. 2005. Communities and health policy: A pathway for change. Health Affairs 24(2):339-342.

**Abstract:**

Improving the health system can reduce the effects of health disparities, but it can do little to eliminate them. An upsurge in new research is documenting the impact of physical, social, and economic environmental factors: air quality, housing conditions, racism, relationship to community institutions, and neighborhood economic conditions, all of which affect health status over time. A combined focus on community and the policies that affect communities' environments presents opportunities for altering and ameliorating the underlying forces at the heart of the determinants of health. This Perspective presents examples of successful community involvement and policy change.

**Full Text Attached. (Bell\_Health\_Affairs\_2005)**

Bielaszka-DuVernay, C. 2011. Vermont’s blueprint for medical homes, community health teams, and better health at lower cost. Health Affairs 30(3):383-386.

**No Abstract available. Full Text Attached. (Bielaszka-DuVernay\_Health\_Affairs\_2011)**

Blumenthal, D. 2010. Launching HITECH. New England Journal of Medicine 362(5):382-385. California Department of Public Health. 2010.

**No Abstract available. Free Full Text:**

<http://www.ncbi.nlm.nih.gov/pubmed?term=Launching+HITECH&TransSchema=title&cmd=detailssearch>

Campbell, S., D. Reeves, E. Kontopantelis, E. Middleton, B. Sibbald, and M. Roland. 2007. Quality of primary care in England with the introduction of pay for performance. New England Journal of Medicine 357(2):181-190.

**No Abstract available. Free Full Text:**

<http://www.ncbi.nlm.nih.gov/pubmed?term=Quality+of+primary+care+in+England+with+the+introduction+of+pay+for+performance&TransSchema=title&cmd=detailssearch>

Dannenberg, A. L., R. Bhatia, B. L. Cole, S. K. Heaton, J. D. Feldman, and C. D. Rutt. 2008. Use of health impact assessment in the U.S. 27 case studies, 1999–2007. American Journal of Preventive Medicine 34(3):241-256.

**Abstract:**

OBJECTIVES: To document the growing use in the United States of health impact assessment (HIA) methods to help planners and others consider the health consequences of their decisions.

METHODS: Using multiple search strategies, 27 HIAs were identified that were completed in the U.S. during 1999-2007. Key characteristics of each HIA were abstracted from published and unpublished sources.

RESULTS: Topics examined in these HIAs ranged from policies about living wages and after-school programs to projects about power plants and public transit. Most HIAs were funded by local health departments, foundations, or federal agencies. Concerns about health disparities were especially important in HIAs on housing, urban redevelopment, home energy subsidies, and wage policy. The use of quantitative and nonquantitative methods varied among HIAs. Most HIAs presented recommendations for policy or project changes to improve health. Impacts of the HIAs were infrequently documented.

CONCLUSIONS: These completed HIAs are useful for helping conduct future HIAs and for training public health officials and others about HIAs. More work is needed to document the impact of HIAs and thereby increase their value in decision-making processes.

**Full Text Attached.** **(Dannenberg\_Am\_J\_Prev\_Med\_2008)**

Geiger, H. J. 2002. Community-oriented primary care: A path to community development. American Journal of Public Health 92(11):1713-1716

 **Abstract:**

Although community development and social change are not explicit goals of community-oriented primary care (COPC), they are implicit in COPC's emphasis on community organization and local participation with health professionals in the assessment of health problems. These goals are also implicit in the shared understanding of health problems' social, physical, and economic causes and in the design of COPC interventions. In the mid-1960s, a community health center in the Mississippi Delta created programs designed to move beyond narrowly focused disease-specific interventions and address some of the root causes of community morbidity and mortality. Drawing on the skills of the community itself, a selfsustaining process of health-related social change was initiated. A key program involved the provision of educational opportunities.

**Free Full Text:**

<http://www.ncbi.nlm.nih.gov/pubmed?term=Community-oriented+primary+care%3A+A+path+to+community+development&TransSchema=title&cmd=detailssearch>

Geiger, H. J. 2005. The first community health centers: A model of enduring value. Journal of Ambulatory Care Management Community Health Centers’ 40th Anniversary Issue October/December 28(4):313-320.

**Abstract:**

Community health centers in the United States, first launched as a federal initiative in 1965, were rooted in models from South Africa, the American civil rights struggle, and a national commitment to address poverty. The first 2 centers, one serving a rural population in the Mississippi Delta and another a public housing project in Boston, incorporated such core principles as provision of primary care to a defined area or population; public health interventions addressing social determinants of health; emphasis on community participation; community empowerment leading to control of the new institutions; epidemiologic methods to identify problems and guide decisions; new combinations of clinical and public health personnel; and reduction of disparities in health and healthcare of the poor and minorities. The continuing relevance of these principles in today's greatly expanded health center network is reviewed.

**Full Text Attached. (Geiger\_J\_Amb\_Care\_Man\_2005)**

Grumbach, K., and J. W. Mold. 2009. A health care cooperative extension service. Journal of the American Medical Association 301(24):2589-2591.

**No Abstract. Full Text Attached. (Grumbach\_JAMA\_2009)**

Gulliford, M. C., M. Ashworth, D. Robotham, and A. Mohiddin. 2007. Achievement of metabolic targets for diabetes by English primary care practices under a new system of incentives. Diabetic Medicine 24(5):505-511.

### Abstract:

#### OBJECTIVE: To analyse achievement of metabolic targets by English general practices following the introduction of a new system of incentives.

#### METHODS: Clinical data were abstracted from the records of 2099 patients at 26 general practices in South London. Cross-sectional data for 2005 were obtained for all general practices in England, including characteristics of registered populations, practice organizational characteristics and 'Quality and Outcomes Framework' (QOF) metabolic targets.

#### RESULTS: Among 26 practices in South London, the median practice-specific proportion of patients achieving HbA(1c) < or = 7.4% each year increased: 2000, 22%; 2001, 32%; 2002, 37%; 2003, 38% and in 2005 from QOF, 57%. In 8484 general practices in England in 2005, the median proportion of diabetic patients with HbA(1c) < or = 7.4% was 59.0%; the highest and lowest centiles ranged from 27.7 to 89.8% among general practices, from 46.9 to 71.0% among 303 primary care trusts and from 49.9 to 67.1.% among 28 health authorities. Comparing the highest and lowest tertiles of deprivation, the per cent achieving HbA(1c) < or = 7.4% was 2.96% (95% confidence interval 2.23-3.69%) lower in the most deprived areas. In areas with the highest proportion of ethnic minorities, the per cent achieving HbA(1c) < or = 7.4% was 2.73% (1.85-3.61%) lower than where there were few ethnic minorities. Practices with the highest total QOF organization scores had more patients achieving the HbA(1c) target (difference 5.03%, 4.43-5.64%).

#### CONCLUSIONS: Intermediate outcomes are improving but deprived areas with less organized services achieve worse glycaemic control. Financial incentives may contribute to improved services and better clinical outcomes.

**Free Full Text:**

<http://onlinelibrary.wiley.com/doi/10.1111/j.1464-5491.2007.02090.x/pdf>

Jordan, J., J. Wright, J. Wilkinson, and R. Williams. 1998. Assessing local health needs in primary care: Understanding and experience in three English districts. Quality Health Care 7(10180795):83-89.

### Abstract:

#### BACKGROUND: Assessing the health needs of a local population has been promoted as a key component in effective targeting of healthcare services and quality improvement. The understanding and experience of assessing health needs in general practice were investigated in three English districts.

#### AIM: To identify the issues surrounding the potential for assessing health needs in primary care.

#### METHOD: Postal survey of 347 general practices in three health authorities. Telephone interviews with a random stratified sample of 35 general practitioners.

#### RESULTS: Although most practices identified assessing health needs as important, it is clear that this identification was typically based on an understanding of assessing needs as primarily focused on individual patient care, based on clinical priorities and involving practice held data. Most practices had not undertaken local consultation, whatever their understanding of assessing health needs. The few practices which had completed population oriented, proactive assessment of needs considered it to have led to tangible improvements in clinical or practice management. Overall, there was apparent confusion over the nature and purpose of assessing needs, although the principled aims and objectives of a population oriented, proactive component to primary care were generally upheld. The need for additional resources and support was identified. In four out of the five cases where specifically population based assessment of health needs had been undertaken, the local public health department had been involved.

#### CONCLUSION: The value of the concept of assessing health needs in primary care holds considerable uncertainty and ambivalence. The findings from this study show that any attempts to promote assessing needs into primary care which focus either primarily or exclusively on the provision of "education" are unduly simplistic. More fundamental questions about the perceived relevance and opportunities for assessing health needs should be considered if primary care groups are to meet future commissioning challenges.

#### Free Full Text:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2483591/?tool=pubmed>

Ku, L., E. Jones, P. Shin, F. R. Byrne, and S. K. Long. 2011. Safety-net providers after health care reform: Lessons from Massachusetts. Archives of Internal Medicine 171(15):1379-1384.

### Abstract:

#### BACKGROUND: National health reform is designed to reduce the number of uninsured adults. Currently, many uninsured individuals receive care at safety-net health care providers such as community health centers (CHCs) or safety-net hospitals. This project examined data from Massachusetts to assess how the demand for ambulatory and inpatient care and use changed for safety-net providers after the state's health care reform law was enacted in 2006, which dramatically reduced the number of individuals without health insurance coverage.

#### METHODS: Multiple methods were used, including analyses of administrative data reported by CHCs and hospitals, case study interviews, and analyses of data from the 2009 Massachusetts Health Reform Survey, a state-representative telephone survey of adults.

#### RESULTS: Between calendar years 2005 and 2009, the number of patients receiving care at Massachusetts CHCs increased by 31.0%, and the share of CHC patients who were uninsured fell from 35.5% to 19.9%. Nonemergency ambulatory care visits to clinics of safety-net hospitals grew twice as fast as visits to non-safety-net hospitals from 2006 to 2009. The number of inpatient admissions was comparable for safety-net and non-safety-net hospitals. Most safety-net patients reported that they used these facilities because they were convenient (79.3%) and affordable (73.8%); only 25.2% reported having had problems getting appointments elsewhere.

#### CONCLUSIONS: Despite the significant reduction in uninsurance levels in Massachusetts that occurred with health care reform, the demand for care at safety-net facilities continues to rise. Most safety-net patients do not view these facilities as providers of last resort; rather, they prefer the types of care that are offered there. It will continue to be important to support safety-net providers, even after health care reform programs are established.

**Full Text Attached. (Ku\_Arch\_Int\_Med\_2011)**

Morris, C. G., and F. M. Chen. 2009. Training residents in community health centers: Facilitators and barriers. Annals of Family Medicine 7(6):488-494.

### Abstract:

#### PURPOSE: Training family medicine residents in underserved settings, such as community health centers (CHCs), may provide a solution to the primary care workforce shortage. We sought to describe the facilitators and barriers to creating partnerships between CHCs and family medicine residencies (FMRs).

#### METHODS: We conducted 19 key informant interviews and 3 focus groups to identify the key factors in the CHC-FMR relationship. Audiotapes and transcripts were analyzed to identify major themes. Key informant results were validated and expanded in the focus group discussions.

#### RESULTS: Four major themes describe the CHC-FMR training partnership: mission, money, quality, and administrative/governance complexity. The CHC-FMR training affiliation is a complex relationship drawn together by a shared mission of service to the underserved, enhanced financial stability, workforce improvement, and greater educational and clinical quality. The relationship is hindered by competing primary missions, chronic underfunding, complex governing institutional regulations, and administrative challenges. In addition, the focus groups offered several policy solutions to address the barriers to CHC-FMR affiliation.

#### CONCLUSIONS: A successful CHC-FMR training partnership relies upon the development of a shared mission of education and service, as well as innovation and flexibility by the organizations that govern them.

**Free Full Text:** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2775610/?tool=pubmed>

Phillips, R. L., S. Bronnikov, S. Petterson, M. Cifuentes, B. Teevan, M. Dodoo, W. D. Pace, and D. R. West. 2011. Case study of a primary care-based accountable care system approach to medical home transformation. The Journal of Ambulatory Care Management 34(1):67-77.

### Abstract:

We report a case study of a mature primary care-based accountable care organization that is both a health plan and a network of medical homes. Over 20 years, WellMed Inc (San Antonio, Texas) implemented many patient-centered services, experimenting to find which belong within clinics and which operate best as system functions. The adjusted mortality rate is half that of the state for people older than 65 years. Hospitalization and readmission rates and emergency department visits have not changed over time, but preventive services have improved. Phased implementation across the network makes it difficult to link improvements to specific processes but they seem to have improved outcomes collectively.

**No Full Text available.**

Poundstone, K. E., S. A. Strathdee, and D. D. Celentano. 2004. The social epidemiology of human immunodeficiency virus/acquired immunodeficiency syndrome. Epidemiologic Reviews 26(1):22-35.

**No Abstract. Free Full text:** <http://epirev.oxfordjournals.org/content/26/1/22.long>

Reynolds, P. P. 2008. A legislative history of federal assistance for health professions training in primary care medicine and dentistry in the United States, 1963-2008. Academic Medicine 83(11):1004-1014.

### Abstract:

This article reviews the legislative history of Title VII of the United States Public Health Service Act. It describes three periods of federal support for health professions training in medicine and dentistry. During the first era, 1963 to 1975, federal support led to an increase in the overall production of physicians and dentists, primarily through grants for construction, renovation, and expansion of schools. The second period, 1976 to 1991, witnessed a shift in federal support to train physicians, dentists, and physician assistants in the fields of primary care defined as family medicine, general internal medicine, and general pediatrics. During this era, divisions of general internal medicine and general pediatrics, and departments of family medicine, were established in nearly every medical and osteopathic medical school. All three disciplines conducted primary care residencies, medical student clerkships, and faculty development programs. The third period, 1992 to present, emphasized the policy goals of caring for vulnerable populations, greater diversity in the health professions, and curricula innovations to prepare trainees for the future practice of medicine and dentistry. Again, Title VII grantees met these policy goals by designing curricula and creating clinical experiences to teach care of the homeless, persons with HIV, the elderly, and other vulnerable populations. Many grantees recruited underrepresented minorities into their programs as trainees and as faculty, and all of them designed and implemented new curricula to address emerging health priorities. This article is part of a theme issue of Academic Medicine on the Title VII health professions training programs.

**Free Full text:** [**h**ttp://journals.lww.com/academicmedicine/Fulltext/2008/11000/A\_Legislative\_History\_of\_Federal\_Assistance\_for.9.aspx](http://journals.lww.com/academicmedicine/Fulltext/2008/11000/A_Legislative_History_of_Federal_Assistance_for.9.aspx)

Roland, M. 2004. Linking physicians' pay to the quality of care—A major experiment in the United Kingdom. New England Journal of Medicine 351(14):1448-1454.

**No Abstract. Free Full Text:** <http://www.nejm.org/doi/pdf/10.1056/NEJMhpr041294>

Steele, G. D., J. A. Haynes, D. E. Davis, J. Tomcavage, W. F. Stewart, T. R. Graf, R. A. Paulus, K. Weikel, and J. Shikles. 2010. How Geisinger’s advanced medical home model argues the case for rapid-cycle innovation. Health Affairs 29(11):2047-2053.

### Abstract:

The Patient Protection and Affordable Care Act of 2010 provides for a number of major payment and delivery system initiatives. These potential changes need to be tested, scaled, and adapted with an urgency not evident in previous demonstration projects of the Centers for Medicare and Medicaid Services. We discuss lessons learned from our iterative tests of care reengineering at Geisinger--specifically, through our advanced medical home model, ProvenHealth Navigator, and the way we continuously modified the model to improve quality and value. We hypothesize that the most important ingredient in our model has been the embedding of nurse case managers into our community practices and the real-time feedback of data on the use of health services by the most complex patients.

**Full Text Attached. (Steele\_Health\_Affairs\_2010)**

Steinbrook, R. 2009. Health care and the American Recovery and Reinvestment Act. New England Journal of Medicine 360(11):1057-1060.

**No Abstract. Free Full Text:** <http://www.nejm.org/doi/full/10.1056/NEJMp0900665>

Vastag, B. 2004. Donald M. Berwick, MD, MPP advocate for evidence-based health system reform. Journal of the American Medical Association 291(16):1945-1947.

**No Abstract. Full Text Attached. (Vastag\_JAMA\_2004)**

Wagner, E. H. 2000. The role of patient care teams in chronic disease management. British Medical Journal 320(7234):569-572.

**No Abstract. Free Full Text:** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117605/?tool=pubmed>

AAP (American Academy of Pediatrics). 2009. The role of preschool home-visiting programs in improving children’s developmental and health outcomes. Pediatrics 123(2):598-603.

### Abstract:

Child health and developmental outcomes depend to a large extent on the capabilities of families to provide a nurturing, safe environment for their infants and young children. Unfortunately, many families have insufficient knowledge about parenting skills and an inadequate support system of friends, extended family, or professionals to help with or advise them regarding child rearing. Home-visiting programs offer a mechanism for ensuring that at-risk families have social support, linkage with public and private community services, and ongoing health, developmental, and safety education. When these services are part of a system of high-quality well-child care linked or integrated with the pediatric medical home, they have the potential to mitigate health and developmental outcome disparities. This statement reviews the history of home visiting in the United States and reaffirms the support of the American Academy of Pediatrics for home-based parenting education and support.

**Free Full Text:** <http://pediatrics.aappublications.org/content/123/2/598.long>

Chapman, J., E. Siegel, and A. Cross. 1990. Home visitors and child health: Analysis of selected programs. Pediatrics 85(6):1059-1068.

### Abstract:

The relationships between selected child health outcomes and programmatic interventions using home visitors are analyzed. The following features of seven programs are systematically reported: program characteristics; description of the home visitors; program objectives, sample size, and research design; outcome measures and reported data. A number of issues such as funding and long-term viability, use of professional or paraprofessional visitors, visitor selection and supervision, and evaluation of home visitor programs require clarification and are discussed. It is concluded that home visitor programs can contribute to child health outcomes such as increased birth weight, improved prenatal care, improved maternal-infant interaction, and improved use of community resources. Pediatricians can be supportive of such programs at many levels: becoming aware of the existence and range of services of home visitor programs in their area that serve families with children and referring families to those programs; being available to advise programs that are in the planning stages; providing advocacy at the local, state, and national level for the funding and development of such programs; and taking the initiative to join multidisciplinary efforts to develop new programs.

**Full Text Attached. (Chapman\_Pediatrics\_1990)**

Duggan, A., A. Windham, E. McFarlane, L. Fuddy, L. MPH, C. Rohde, S. Buchbinder, and C. Sia. 2000. Hawaii’s healthy start program of home visiting for at-risk families: Evaluation of family identification, family engagement, and service delivery. Pediatrics 105(Suppl. 2):250-259.

### Abstract:

#### OBJECTIVE: To describe family identification, family engagement, and service delivery in a statewide home visiting program for at-risk families of newborns.

#### SETTING: Six target communities of Hawaii's Healthy Start Program (HSP), which incorporates 1) early identification of at-risk families of newborns via population-based screening and assessment, and 2) paraprofessional home visiting to improve family functioning, promote child health and development, and prevent child maltreatment.

#### DESIGN: Cross-sectional study: describes early identification process and family characteristics associated with initial enrollment. Longitudinal study: describes home visiting process and characteristics associated with continued participation.

#### SUBJECTS: Cross-sectional study: civilian births in 6 communities (n = 6553). Longitudinal study: at-risk families in the intervention group of a randomized trial of the HSP (n = 373).

#### MEASURES: Process: completeness and timeliness of early identification and home visiting activities; family characteristics: sociodemographics, child abuse risk factors, infant biologic risk.

#### RESULTS: Early identification staff determined risk status for 84% of target families. Families with higher risk scores, young mothers with limited schooling, and families with infants at biologic risk were more likely to enroll in home visiting. Half of those who enrolled were active at 1 year with an average of 22 visits. Families where the father had multiple risk factors and where the mother was substance abusing were more likely to have >/=12 visits; mothers who were unilaterally violent toward the father were less likely. Most families were linked with a medical home; linkage rates for other community resources varied widely by type of service. Half of families overall, but >/=80% of those active at 1 year, received core home visiting services. Performance varied by program site.

#### CONCLUSIONS: It is challenging to engage and retain at-risk families in home visiting. Service monitoring must be an integral part of operations.

**Free Full Text:** <http://pediatrics.aappublications.org/content/105/Supplement_2/250.full>

Frieden, T. R., and D. M. Berwick. 2011. The “million hearts” initiative—preventing heart attacks and strokes. New England Journal of Medicine 365(13):e27.

**No Abstract. Free Full Text:** <http://www.nejm.org/doi/full/10.1056/NEJMp1110421>

Heaman, M. I., C. V. Newburn-Cook, C. G. Green, L. J. Elliott, and M. E. Helewa. 2008. Inadequate prenatal care and its association with adverse pregnancy outcomes: A comparison of indices. BMC Pregnancy and Childbirth 8(1):15.

### Abstract:

#### BACKGROUND: The objectives of this study were to determine rates of prenatal care utilization in Winnipeg, Manitoba, Canada from 1991 to 2000; to compare two indices of prenatal care utilization in identifying the proportion of the population receiving inadequate prenatal care; to determine the association between inadequate prenatal care and adverse pregnancy outcomes (preterm birth, low birth weight [LBW], and small-for-gestational age [SGA]), using each of the indices; and, to assess whether or not, and to what extent, gestational age modifies this association.

#### METHODS: We conducted a population-based study of women having a hospital-based singleton live birth from 1991 to 2000 (N = 80,989). Data sources consisted of a linked mother-baby database and a physician claims file maintained by Manitoba Health. Rates of inadequate prenatal care were calculated using two indices, the R-GINDEX and the APNCU. Logistic regression analysis was used to determine the association between inadequate prenatal care and adverse pregnancy outcomes. Stratified analysis was then used to determine whether the association between inadequate prenatal care and LBW or SGA differed by gestational age.

#### RESULTS: Rates of inadequate/no prenatal care ranged from 8.3% using APNCU to 8.9% using R-GINDEX. The association between inadequate prenatal care and preterm birth and LBW varied depending on the index used, with adjusted odds ratios (AOR) ranging from 1.0 to 1.3. In contrast, both indices revealed the same strength of association of inadequate prenatal care with SGA (AOR 1.4). Both indices demonstrated heterogeneity (non-uniformity) across gestational age strata, indicating the presence of effect modification by gestational age.

#### CONCLUSION: Selection of a prenatal care utilization index requires careful consideration of its methodological underpinnings and limitations. The two indices compared in this study revealed different patterns of utilization of prenatal care, and should not be used interchangeably. Use of these indices to study the association between utilization of prenatal care and pregnancy outcomes affected by the duration of pregnancy should be approached cautiously.

**Free Full Text:**  <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2386440/?tool=pubmed>

Jandorf, L., Y. Gutierrez, J. Lopez, J. Christie, and S. H. Itzkowitz. 2005. Use of a patient navigator to increase colorectal cancer screening in an urban neighborhood health clinic. Journal of Urban Health: Bulletin of the New York Academy of Medicine 82(2):216-224.

### Abstract:

Colorectal cancer (CRC) is the second leading cause of cancer-related deaths in the United States. Racial disparities in CRC incidence and mortality have been well documented. In addition, lower rates of CRC screening among ethnic minorities have been reported. Therefore, we tested the effectiveness of a patient navigator (PN) in increasing compliance with CRC screening in a minority community health setting. Men and women aged 50 or older attending a primary care practice were enrolled if they had not had a fecal occult blood test within the past year, a sigmoidoscopy or barium enema within the past 3-5 years, or a colonoscopy within the past 10 years. Participants were randomly assigned either to receive navigator services (PN+) or not to receive navigator services (PN-). There were no demographic differences between the two groups. Within 6 months of physician recommendation, 15.8% in the PN+group had complied with an endoscopic examination, compared with only 5% in the PN - group (P=.019). The PN+group also demonstrated higher rates of fecal occult blood test completion (42.1% vs. 25%, P=.086). Thus, a PN system successfully increases CRC screening rates among a predominantly minority population of low socioeconomic status.

**Free Full Text:** <http://www.springerlink.com/content/m6h4635852004x26/fulltext.pdf>

Olds, D. L., J. Eckenrode, C. R. Henderson, H. Kitzman, J. Powers, R. Cole, K. Sidora, P. Morris, L. M. Pettitt, and D. Luckey. 1997. Long-term effects of home visitation on maternal life course and child abuse and neglect—fifteen-year follow-up of a randomized trial. Journal of the American Medical Association 278(8):637-643.

### Abstract:

#### CONTEXT: Home-visitation services have been promoted as a means of improving maternal and child health and functioning. However, long-term effects have not been examined.

#### OBJECTIVE: To examine the long-term effects of a program of prenatal and early childhood home visitation by nurses on women's life course and child abuse and neglect.

#### DESIGN: Randomized trial.

#### SETTING: Semirural community in New York.

#### PARTICIPANTS: Of 400 consecutive pregnant women with no previous live births enrolled, 324 participated in a follow-up study when their children were 15 years old.

#### INTERVENTION: Families received a mean of 9 home visits during pregnancy and 23 home visits from the child's birth through the second birthday. DATA SOURCES AND MEASURES: Women's use of welfare and number of subsequent children were based on self-report; their arrests and convictions were based on self-report and archived data from New York State. Verified reports of child abuse and neglect were abstracted from state records.

#### MAIN RESULTS: During the 15-year period after the birth of their first child, in contrast to women in the comparison group, women who were visited by nurses during pregnancy and infancy were identified as perpetrators of child abuse and neglect in 0.29 vs 0.54 verified reports (P<.001). Among women who were unmarried and from households of low socioeconomic status at initial enrollment, in contrast to those in the comparison group, nurse-visited women had 1.3 vs 1.6 subsequent births (P=.02), 65 vs 37 months between the birth of the first and a second child (P=.001), 60 vs 90 months' receiving Aid to Families With Dependent Children (P=.005), 0.41 vs 0.73 behavioral impairments due to use of alcohol and other drugs (P=.03), 0.18 vs 0.58 arrests by self-report (P<.001), and 0.16 vs 0.90 arrests disclosed by New York State records (P<.001).

#### CONCLUSIONS: This program of prenatal and early childhood home visitation by nurses can reduce the number of subsequent pregnancies, the use of welfare, child abuse and neglect, and criminal behavior on the part of low-income, unmarried mothers for up to 15 years after the birth of the first child.

**Full Text Attached. (Olds\_JAMA\_1997)**

Olds, D. L., H. Kitzman, R. Cole, J. Robinson, K. Sidora, D. W. Luckey, C. R. Henderson, C. Hanks, J. Bondy, and J. Holmberg. 2004. Effects of nurse home-visiting on maternal life course and child development: Age 6 follow-up results of a randomized trial. Pediatrics 114(6):1550-1559.

### Abstract:

#### OBJECTIVE: To test, with an urban, primarily black sample, the effects of prenatal and infancy home visits by nurses on mothers' fertility and economic self-sufficiency and the academic and behavioral adjustment of their children as the children finished kindergarten, near their sixth birthday.

#### METHODS: We conducted a randomized, controlled trial of a program of prenatal and infancy home-visiting in a public system of obstetric and pediatric care in Memphis, Tennessee. A total of 743 primarily black women at <29 weeks of gestation, with no previous live births and with > or =2 sociodemographic risk characteristics (unmarried, <12 years of education, or unemployed), were randomly assigned to receive nurse home visits or comparison services. Outcomes consisted of women's number and timing of subsequent pregnancies, months of employment, use of welfare, food stamps, and Medicaid, educational achievement, behavioral problems attributable to the use of substances, rates of marriage and cohabitation, and duration of relationships with partners and their children's behavior problems, responses to story stems, intellectual functioning, receptive language, and academic achievement.

#### RESULTS: In contrast to counterparts assigned to the comparison group, women visited by nurses had fewer subsequent pregnancies and births (1.16 vs 1.38 pregnancies and 1.08 vs 1.28 births, respectively), longer intervals between births of the first and second children (34.28 vs 30.23 months), longer relationships with current partners (54.36 vs 45.00 months), and, since the previous follow-up evaluation at 4.5 years, fewer months of using welfare (7.21 vs 8.96 months) and food stamps (9.67 vs 11.50 months). Nurse-visited children were more likely to have been enrolled in formal out-of-home care between 2 and 4.5 years of age (82.0% vs 74.9%). Children visited by nurses demonstrated higher intellectual functioning and receptive vocabulary scores (scores of 92.34 vs 90.24 and 84.32 vs 82.13, respectively) and fewer behavior problems in the borderline or clinical range (1.8% vs 5.4%). Nurse-visited children born to mothers with low levels of psychologic resources had higher arithmetic achievement test scores (score of 88.61 vs 85.42) and expressed less aggression (score of 98.58 vs 101.10) and incoherence (score of 20.90 vs 29.84) in response to story stems. There were no statistically significant program effects on women's education, duration of employment, rates of marriage, being in a partnered relationship, living with the father of the child, or domestic violence, current partner's educational level, or behavioral problems attributable to the use of alcohol or drugs.

#### CONCLUSION: This program of prenatal and infancy home-visiting by nurses continued to improve the lives of women and children at child age 6 years, 4 years after the program ended.

**Free Full Text:** <http://pediatrics.aappublications.org/content/114/6/1550.full>

Paskett, E. D., J. P. Harrop, and K. J. Wells. 2011. Patient navigation: An update on the state of the science. CA: A Cancer Journal for Clinicians 61(4):237-249.

### Abstract:

Although patient navigation was introduced 2 decades ago, there remains a lack of consensus regarding its definition, the necessary qualifications of patient navigators, and its impact on the continuum of cancer care. This review provides an update to the 2008 review by Wells et al on patient navigation. Since then, there has been a significant increase in the number of published studies dealing with cancer patient navigation. The authors of the current review conducted a search by using the keywords "navigation" or "navigator" and "cancer." Thirty-three articles published from November 2007 through July 2010 met the search criteria. Consistent with the prior review, there is building evidence of some degree of efficacy of patient navigation in terms of increasing cancer screening rates. However, there is less recent evidence concerning the benefit of patient navigation with regard to diagnostic follow-up and in the treatment setting, and a paucity of research focusing on patient navigation in cancer survivorship remains. Methodological limitations were noted in many studies, including small sample sizes and a lack of control groups. As patient navigation programs continue to develop across North America and beyond, further research will be required to determine the efficacy of cancer patient navigation across all aspects of the cancer care continuum.

**Free Full Text:** <http://onlinelibrary.wiley.com/doi/10.3322/caac.20111/full>

Percac-Lima, S., R. W. Grant, A. R. Green, J. M. Ashburner, G. Gamba, S. Oo, J. M. Richter, and S. J. Atlas. 2008. A culturally tailored navigator program for colorectal cancer screening in a community health center: A randomized, controlled trial. Journal of General Internal Medicine 24(2):211-217.

### Abstract:

#### BACKGROUND: Minority racial/ethnic groups have low colorectal cancer (CRC) screening rates.

#### OBJECTIVE: To evaluate a culturally tailored intervention to increase CRC screening, primarily using colonoscopy, among low income and non-English speaking patients.

#### DESIGN: Randomized controlled trial conducted from January to October of 2007.

#### SETTING: Single, urban community health center serving a low-income, ethnically diverse population.

#### PATIENTS: A total of 1,223 patients 52-79 years of age overdue for CRC screening, randomized to intervention (n = 409) vs. usual care control (n = 814) groups.

#### INTERVENTION: Intervention patients received an introductory letter with educational material followed by phone or in-person contact by a language-concordant "navigator." Navigators (n = 5) were community health workers trained to identify and address patient-reported barriers to CRC screening. Individually tailored interventions included patient education, procedure scheduling, translation and explanation of bowel preparation, and help with transportation and insurance coverage. Rates of colorectal cancer screening were assessed for intervention and usual care control patients.

#### RESULTS: Over a 9-month period, intervention patients were more likely to undergo CRC screening than control patients (27% vs. 12% for any CRC screening, p < 0.001; 21% vs. 10% for colonoscopy completion, p < 0.001). The higher screening rate resulted in the identification of 10.5 polyps per 100 patients in the intervention group vs. 6.8 in the control group (p = 0.04).

#### LIMITATIONS: Patients were from one health center. Some patients may have obtained CRC screening outside our system.

#### CONCLUSIONS: A culturally tailored, language-concordant navigator program designed to identify and overcome barriers to colorectal cancer screening can significantly improve colonoscopy rates for low income, ethnically and linguistically diverse patients. ClinicalTrials.gov registration number: NCT00476970.

**Free Full Text:**  <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628981/?tool=pubmed>

Roger, V. L., A. S. Go, D. M. Lloyd-Jones, R. J. Adams, J. D. Berry, T. M. Brown, M. R. Camethon, S. Dai, G. de Simone, E. S. Ford, C. S. Fox, H. J. Fullerton, C. Gillespie, K. J. Greenlund, S. M. Hailpem, J. A. Heit, P. M. Ho, V. J. Howard, B. M. Kissela, S. J. Kittner, D. T. Lackland, J. H. Lichtman, L. D. Lisabeth, D. M. Makuc, G. M. Marcus, A. Marelli, D. B. Matchar, M. M. McDermott, J. B. Meigs, C. S. Moy, D. Mozaffarian, M. E. Mussolino, G. Nichol, N. P. Paynter, W. D. Rosamond, P. D. Sorlie, R. S. Stafford, T. N. Turan, M. B. Turner, N. D. Wong, and J. Wylie- Rosett. 2011. Heart disease and stroke statistics—2011 update a report from the American Heart Association. Circulation 123(4):E18-E209.

**No Abstract. Free Full Text:**  <http://circ.ahajournals.org/content/123/4/e18.long>

U.S. Preventive Services Task Force. 2008. Screening for colorectal cancer: U.S. Preventive Services Task Force recommendation statement. Annals of Internal Medicine 149(9):627-637.

### Abstract:

#### DESCRIPTION: Update of the 2002 U.S. Preventive Services Task Force (USPSTF) recommendation statement on screening for colorectal cancer.

#### METHODS: To update its recommendation, the USPSTF commissioned 2 studies: 1) a targeted systematic evidence review on 4 selected questions relating to test characteristics and benefits and harms of screening technologies, and 2) a decision analytic modeling analysis using population modeling techniques to compare the expected health outcomes and resource requirements of available screening modalities when used in a programmatic way over time.

#### RECOMMENDATIONS: The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary. (A recommendation). The USPSTF recommends against routine screening for colorectal cancer in adults 76 to 85 years of age. There may be considerations that support colorectal cancer screening in an individual patient. (C recommendation). The USPSTF recommends against screening for colorectal cancer in adults older than age 85 years. (D recommendation). The USPSTF concludes that the evidence is insufficient to assess the benefits and harms of computed tomographic colonography and fecal DNA testing as screening modalities for colorectal cancer. (I statement).

**Free Full Text:** <http://www.annals.org/content/149/9/627.long>

Valery, L., O. Anke, K. K. Inge, and B. Johannes. 2008. Effectiveness of smoking cessation interventions among adults: A systematic review of reviews. European Journal of Cancer Prevention 17(6):535- 544.

### Abstract:

The objective of this study was to identify the most effective intervention strategies and policies for smoking cessation among adults. The Medline and Cochrane Library databases were searched, limited to publications since January 2000. A 'review of reviews' approach was followed. Systematic reviews and meta-analyses were included. Reviews aimed at adolescents or specific subgroups were excluded. Two reviewers independently assessed titles and abstracts. For every intervention strategy, only the most recent publication was included. Twenty-three studies met the inclusion criteria. The included intervention strategies and policies were ranked according to their effect size, taking into account the number of original studies, the proportion of studies with a positive effect and the presence of a long-term effect. Evidence of effectiveness for the following strategies was found: group behavioural therapy [odds ratio (OR) 2.17, confidence interval (CI) 1.37-3.45], bupropion (OR 2.06, CI: 1.77-2.40), intensive physician advice (OR 2.04, Cl: 1.71-2.43), nicotine replacement therapy (OR 1.77, CI: 1.66-1.88), individual counselling (OR 1.56, CI: 1.32-1.84), telephone counselling (OR 1.56, CI: 1.38-1.77), nursing interventions (OR 1.47, CI: 1.29-1.67) and tailored self-help interventions (OR 1.42, CI: 1.26-1.61). A 10% increase in price increased cessation rates by 3-5%. Comprehensive clean indoor laws increased quit rates by 12-38%. These results show and confirm that a wide array of effective smoking cessation intervention approaches and policies can have a large impact on smoking cessation rates.

**No Full Text Access.**

Andrulis, D. P. 1998. Access to care is the centerpiece in the elimination of socioeconomic disparities in health. Annals of Internal Medicine 129(5):412-416.

### Abstract:

Many health care professionals have sustained an almost single-minded conviction that disparities in access to health care across socioeconomic groups are the key reason for the major discrepancies in health status between wealthy persons and poor persons. Others, however, have argued that a host of factors work to create major impediments and that reducing or eliminating financial barriers to health care in particular will do little to reduce discrepancies in health status. This paper, while acknowledging the spectrum of contributing factors, argues that the elimination of financially based differences in access is central to any effort to create equity in outcomes across socioeconomic groups. Through selected review of the many studies on health insurance, access, outcomes, and socioeconomic status, it establishes that a core links affected populations, their difficulty in financing health care, and the threat to their well-being. In so doing, it cites findings that strongly associate lack of insurance (especially for persons who live in poverty), inability to obtain services, and adverse health outcomes. It also uses the example of Medicaid and other coverage for HIV-infected persons in particular as an important positive instance in which leveling the discrepancies in health care across socioeconomic groups can move toward creating quality in access and outcomes. The competitive pressures in today's health care environment threaten to drive socioeconomic groups further apart, especially insured and uninsured persons. However, the recent enactment of state actions, especially the State Child Health Insurance Program, represent powerful examples of health insurance expansion that have lessons for policymakers at all levels for the monitoring and reduction of socioeconomic disparities.

**Full Text Attached. (Andrulis\_Ann\_Int\_Med\_1998)**

Baker, E. L., M. A. Potter, D. L. Jones, S. L. Mercer, J. P. Cioffi, L. W. Green, P. K. Halverson, M. Y.

Lichtveld, and D. W. Fleming. 2005. The public health infrastructure and our nation’s health. Annual Review of Public Health 26(1):303-318.

### Abstract:

Threats to Americans' health-including chronic disease, emerging infectious disease, and bioterrorism-are present and growing, and the public health system is responsible for addressing these challenges. Public health systems in the United States are built on an infrastructure of workforce, information systems, and organizational capacity; in each of these areas, however, serious deficits have been well documented. Here we draw on two 2003 Institute of Medicine reports and present evidence for current threats and the weakness of our public health infrastructure. We describe major initiatives to systematically assess, invest in, rebuild, and evaluate workforce competency, information systems, and organizational capacity through public policy making, practical initiatives, and practice-oriented research. These initiatives are based on applied science and a shared federal-state approach to public accountability. We conclude that a newly strengthened public health infrastructure must be sustained in the future through a balancing of the values inherent in the federal system.

**Full Text Attached. (Baker\_annurev.publhealth.26.021304)**

Bazzoli, G. J. 1997. Public-private collaboration in health and human service delivery: Evidence from community partnerships. Milbank Quarterly 75(4):533-561.

 **No Abstract. Free Full Text**: <http://onlinelibrary.wiley.com/doi/10.1111/1468-0009.00068/pdf>

Beitsch, L. M., R. G. Brooks, J. H. Glasser, and Y. D. Coble. 2005. The medicine and public health initiative: Ten years later. American Journal of Preventive Medicine 29(2):149-153.

### Abstract:

The Medicine and Public Health Initiative (MPHI) was created jointly 10 years ago by the American Medical Association and the American Public Health Association to bridge the nearly century-wide gulf between the respective disciplines. We review the history of MPHI and its growing significance in light of recent terrorism events. We report on current MPHI activities by examining three bellwether states-California, Florida, and Texas-as well as international sites. Upon its inception, MPHI was rapidly embraced and nationally disseminated. Sustainability 10 years later in the post-911 world requires renewed commitment by all collaborators. In order to meet the numerous health challenges facing our nation, from terrorism to chronic disease, and for MPHI to be successful, medicine and public health must work in tandem.

**Full Text Attached. (Beitsch\_Am\_J\_Prev\_Med\_2005)**

Bodenheimer, T., E. H. Wagner, and K. Grumbach. 2002. Improving primary care for patients with chronic illness. Journal of the American Medical Association 288(14):1775-1779.

### Abstract:

The chronic care model is a guide to higher-quality chronic illness management within primary care. The model predicts that improvement in its 6 interrelated components-self-management support, clinical information systems, delivery system redesign, decision support, health care organization, and community resources-can produce system reform in which informed, activated patients interact with prepared, proactive practice teams. Case studies are provided describing how components of the chronic care model have been implemented in the primary care practices of 4 health care organizations.

**Full Text Attached. (Bodenheimer\_JAMA\_2002)**

Bodenheimer, T., K. Grumbach, and R. Berenson. 2009. Health care 2009 A lifeline for primary care. The New England Journal of Medicine 36(26):2693-2696.

 **No Abstract. Free Full Text:**  <http://www.nejm.org/doi/full/10.1056/NEJMp0902909>

Brandt, A. M., and M. Gardner. 2000. Antagonism and accommodation: Interpreting the relationship between public health and medicine in the United States during the 20th century. American Journal of Public Health 90(5):707-715.

### Abstract:

Throughout the course of the 20th century, many observers have noted important tensions and antipathies between public health and medicine. At the same time, reformers have often called for better engagement and collaboration between the 2 fields. This article examines the history of the relationship between medicine and public health to examine how they developed as separate and often conflicting professions. The historical character of this relationship can be understood only in the context of institutional developments in professional education, the rise of the biomedical model of disease, and the epidemiologic transition from infectious disease to the predominance of systemic chronic diseases. Many problems in the contemporary burden of disease pose opportunities for effective collaborations between population-based and clinical interventions. A stronger alliance between public health and medicine through accommodation to a reductionist biomedicine, however, threatens to subvert public health's historical commitment to understanding and addressing the social roots of disease.

**Free Full Text:** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446218/?tool=pubmed>

CDC (Centers for Disease Control and Prevention). 1992. Effectiveness in disease and injury prevention estimated national spending on prevention—United States, 1988. Morbidity and Mortality Weekly Reports 41(29):529-531.

**No Abstract. Free Full Text:** <http://www.cdc.gov/mmwr/preview/mmwrhtml/00017286.htm>

Coleman, K., B. T. Austin, C. Brach, and E. H. Wagner. 2009. Evidence on the chronic care model in the new millennium. Health Affairs 28(1):75-85.

### Abstract:

Developed more than a decade ago, the Chronic Care Model (CCM) is a widely adopted approach to improving ambulatory care that has guided clinical quality initiatives in the United States and around the world. We examine the evidence of the CCM's effectiveness by reviewing articles published since 2000 that used one of five key CCM papers as a reference. Accumulated evidence appears to support the CCM as an integrated framework to guide practice redesign. Although work remains to be done in areas such as cost-effectiveness, these studies suggest that redesigning care using the CCM leads to improved patient care and better health outcomes.

**Full Text Attached. (Coleman\_Health\_Affairs\_2009)**

Duffy, J. 1979. The American medical profession and public health: From support to ambivalence. Bulletin of the History of Medicine 53(Spring):1-22.

**No Abstract. Full Text Attached. (Duffy\_Bull\_Hist\_Med\_1979)**

Epstein, L., J. Gofin, R. Gofin, and Y. Neumark. 2002. The Jerusalem experience: Three decades of service, research, and training in community-oriented primary care. American Journal of Public Health 92(11):1717-1721.

### Abstract:

Community-oriented primary care (COPC) developed and was tested over nearly 3 decades in the Hadassah Community Health Center in Jerusalem, Israel. Integration of public health responsibility with individual-based clinical management of patients formed the cornerstone of the COPC approach. A family medicine practice and a mother and child preventive service provided the frameworks for this development. The health needs of the community were assessed, priorities determined, and intervention programs developed and implemented on the basis of detailed analysis of the factors responsible for defined health states. Ongoing health surveillance facilitated evaluation, and the effectiveness of interventions in different population groups was illustrated. The center's international COPC involvement has had effects on primary health care policy worldwide.

**Free Full Text:** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447316/?tool=pubmed>

Fineberg, H. V. 2011. Public health and medicine. American Journal of Preventive Medicine 41(4):S149- S151.

**No Abstract. No Full Text Access.**

Flottemesch, T. J., P. Fontaine, S. E. Asche, and L. I. Solberg. 2011. Relationship of clinic medical home scores to health care costs. The Journal of Ambulatory Care Management 34(1):78-89.

### Abstract:

Multilevel, multivariate models examined the relationship between Primary Care Medical Home (PCMH) practice systems as measured by the Physician Practice Connections®-Readiness Survey™ (PPC®-RS™) and costs (total, outpatient, and inpatient) using 2008 patient data from 21 primary care clinics. Overall, PPC-RS scores were associated with insignificant changes in total (-$75/person, 1.1%) outpatient (-$67/person, 1.2%), and inpatient ($68/person, 0.5%) costs. However, improved PPC-RS scores were associated with significant decreases in total ($2378, 4.4%) and outpatient ($1282/person, 3.5%) costs among patients with 11 or more prescriptions suggesting higher functioning PCMHs may lead to reduced costs among the most complex and costly patients.

**No Full Text Access.**

French, S. A., M. Sory, J. A. Fulkerson, and P. Hannan. 2004. An environmental intervention to promote lower-fat food choices in secondary schools: Outcomes of the tacos study. American Journal of Public Health 94(9):1507-1512.

### Abstract:

#### OBJECTIVES: We evaluated an environmental intervention intended to increase sales of lower-fat foods in secondary school cafeterias.

#### METHODS: Twenty secondary schools were randomly assigned to either an environmental intervention or a control group for a 2-year period. The intervention increased the availability of lower-fat foods and implemented student-based promotions.

#### RESULTS: A steeper rate of increase in sales of lower-fat foods in year 1 (10% intervention vs -2.8% control, P =.002) and a higher percentage of sales of lower-fat foods in year 2 (33.6% intervention vs 22.1% control, P =.04) were observed. There were no significant changes in student self-reported food choices.

#### CONCLUSIONS: School-based environmental interventions to increase availability and promotion of lower-fat foods can increase purchase of these foods among adolescents.

**Free Full Text:** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448482/?tool=pubmed>

Gostin, L. O., P. D. Jacobson, K. L. Record, and L. E. Hardcastle. 2011. Restoring health to public reform: Integrating medicine and public health to advance the population’s wellbeing. Pennsylvania Law Review 159:1777-1823.

**No Abstract. No Full Text Access.**

Green, L. A., G. E. Fryer, B. P. Yawn, D. Lanier, and S. M. Dovey. 2001. The ecology of medical care revisited. New England Journal of Medicine 344(26):2021-2025.

**No Abstract. Full Text Attached. (Green\_NEJM200106283442611)**

Halverson, P. K., G. P. Mays, and A. D. Kaluzny. 2000. Working together? Organizational and market determinants of collaboration between public health and medical care providers. American Journal of Public Health 90(12):1913-1916.

### Abstract:

#### OBJECTIVES: This study examines organizational characteristics and market conditions likely to influence collaborative relationships between public health agencies and community medical care providers.

#### METHODS: Public health directors in 60 US counties were surveyed by telephone concerning their relationships with area community hospitals (n = 263) and community health centers (n = 85). Multivariate models were used to estimate the effects of organizational and market characteristics on collaboration.

#### RESULTS: Collaboration was reported among 55% of the hospitals and 64% of the health centers. Certain forms of collaboration were more likely in markets characterized by higher HMO penetration and lower HMO competition.

#### CONCLUSIONS: Targeted efforts to facilitate collaboration may be required in settings where institutional and market incentives are lacking.

#### Free Full Text: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446432/?tool=pubmed>

Jones, P. E. 2007. Physician assistant education in the United States. Academic Medicine 82(9):882-887.

### Abstract:

As physician assistant (PA) programs developed in the 1960s, curriculum models emerged around the central themes of physician-dependent practice and competency-based education. By 2007, there were 136 accredited programs in the United States, with 108 (79%) offering a master-degree curriculum. PA program preclinical and clinical curricula are typically evenly divided in length, and the typical U.S. PA program has a full-time attendance curriculum of 26.5 continuous months. In academic year 2005-2006, the typical PA student was a 27-year-old white woman with a 3.4 overall grade point average and 29 months of prior health care experience who matriculated with a baccalaureate degree into a master-degree PA program. In the 2005 application cycle, the number of applicants per available seat was 2.25 for both allopathic medical schools and PA programs. The transition to a predominately master-degree curriculum resulted in new challenges for PA faculty development, and the number of PA educators with terminal academic degrees continues to lag behind the educational needs of training programs. The topic of PA specialty training and recognition remains controversial. Although the PA profession has prospered since inception, concerns exist regarding workforce issues such as the appropriate balance of autonomy and supervision, role delineation, and the continuing trend toward specialization. The omission or inaccurate classification of PAs within U.S. health care access and workforce literature projects an incomplete picture, and it is important to consider the contributions PAs have made and will continue to make in addressing the nation's health care needs.

**Free Full Text:** <http://journals.lww.com/academicmedicine/Fulltext/2007/09000/Physician_Assistant_Education_in_the_United_States.14.aspx>

Kindig, D., and G. Stoddart. 2003. What is population health? American Journal of Public Health 93(3):380-383.

### Abstract:

Population health is a relatively new term that has not yet been precisely defined. Is it a concept of health or a field of study of health determinants? We propose that the definition be "the health outcomes of a group of individuals, including the distribution of such outcomes within the group," and we argue that the field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link these two. We present a rationale for this definition and note its differentiation from public health, health promotion, and social epidemiology. We invite critiques and discussion that may lead to some consensus on this emerging concept.

**Free Full Text:** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447747/?tool=pubmed>

llife, S., and P. Lenihan. 2003. Integrating primary care and public health: Learning from the community oriented primary care model. International Journal of Health Services 33(1):85-98.

### Abstract:

Community-oriented primary care (COPC), a 50-year-old widely applied innovative approach to primary care development, seems to be the same combination of public health and general practice perspectives currently sought in the formation of primary care trusts in Britain's NHS. The article reviews the experience of implementing COPC methods, the outcomes, and the applicability to and implications for primary care policy, taking the current British reforms as an example. The COPC model has been developed mainly in underserved populations to integrate public health objectives and primary care through interdisciplinary approaches, with active involvement of the target population. COPC methods are time consuming, can create problems with professional boundaries, and are vulnerable to socioeconomic changes. They can also deliver complex packages of care for target populations, particularly in poor areas underserved by traditional medical services. British primary care reforms may be seen as an unplanned, uncontrolled, nationwide experiment in applying COPC methods. They differ from COPC as applied elsewhere because change has been introduced from above rather than below, into a well-developed primary care system rather than underserved communities. International experience suggests the need for attention to factors promoting and impeding success and to reliable outcome measures. If this experiment succeeds, COPC methodology may facilitate similar changes in other health care systems.

**Full Text Attached. (Iliffe\_Int\_J\_Health\_Serv\_2003)**

McGinnis, J. M., and W. H. Foege. 1993. Actual causes of death in the United States. Journal of the American Medical Association 270(18):2207-2212.

### Abstract:

#### OBJECTIVE: To identify and quantify the major external (nongenetic) factors that contribute to death in the United States.

#### DATA SOURCES: Articles published between 1977 and 1993 were identified through MEDLINE searches, reference citations, and expert consultation. Government reports and complications of vital statistics and surveillance data were also obtained.

#### STUDY SELECTION: Sources selected were those that were often cited and those that indicated a quantitative assessment of the relative contributions of various factors to mortality and morbidity.

#### DATA EXTRACTION: Data used were those for which specific methodological assumptions were stated. A table quantifying the contributions of leading factors was constructed using actual counts, generally accepted estimates, and calculated estimates that were developed by summing various individual estimates and correcting to avoid double counting. For the factors of greatest complexity and uncertainty (diet and activity patterns and toxic agents), a conservative approach was taken by choosing the lower boundaries of the various estimates.

#### DATA SYNTHESIS: The most prominent contributors to mortality in the United States in 1990 were tobacco (an estimated 400,000 deaths), diet and activity patterns (300,000), alcohol (100,000), microbial agents (90,000), toxic agents (60,000), firearms (35,000), sexual behavior (30,000), motor vehicles (25,000), and illicit use of drugs (20,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.

#### CONCLUSIONS: Approximately half of all deaths that occurred in 1990 could be attributed to the factors identified. Although no attempt was made to further quantify the impact of these factors on morbidity and quality of life, the public health burden they impose is considerable and offers guidance for shaping health policy priorities.

**Full Text Attached. (McGinnis\_JAMA\_1993)**

McMichael, A. J. 1999. Prisoners of the proximate: Loosening the constraints on epidemiology in an age of change. American Journal of Epidemiology 149(10):887-897.

### Abstract:

"Modern epidemiology" has a primary orientation to the study of multiple risk factors for chronic noncommunicable diseases. If epidemiologists are to understand the determinants of population health in terms that extend beyond proximate, individual-level risk factors (and their biological mediators), they must learn to apply a social-ecologic systems perspective. The mind-set and methods of modern epidemiology entail the following four main constraints that limit engagement in issues of wider context: 1) a preoccupation with proximate risk factors; 2) a focus on individual-level versus population-level influences on health; 3) a typically modular (time-windowed) view of how individuals undergo changes in risk status (i.e., a life-stage vs. a life-course model of risk acquisition); and 4) the, as yet, unfamiliar challenge of scenario-based forecasting of health consequences of future, large-scale social and environmental changes. The evolution of the content and methods of epidemiology continues. Epidemiologists are gaining insights into the complex social and environmental systems that are the context for health and disease; thinking about population health in increasingly ecologic terms; developing dynamic, interactive, life-course models of disease risk acquisition; and extending their spatial-temporal frame of reference as they perceive the health risks posed by escalating human pressures on the wider environment. The constraints of "the proximate" upon epidemiology are thus loosening as the end of the century approaches.

**Free Full Text:** <http://aje.oxfordjournals.org/content/149/10/887.long>

Merzel, C., and J. D’Afflitti. 2003. Reconsidering community-based health promotion: Promise, performance, and potential. American Journal of Public Health 93(4):557-574.

### Abstract:

Contemporary public health emphasizes a community-based approach to health promotion and disease prevention. The evidence from the past 20 years indicates, however, that many community-based programs have had only modest impact, with the notable exception of a number of HIV prevention programs. To better understand the reasons for these outcomes, we conducted a systematic literature review of 32 community-based prevention programs. Reasons for poor performance include methodological challenges to study design and evaluation, concurrent secular trends, smaller-than-expected effect sizes, limitations of the interventions, and limitations of theories used. The effectiveness of HIV programs appears to be related in part to extensive formative research and an emphasis on changing social norms.

**Free Full Text:** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447790/?tool=pubmed>

Phillips, R. L., S. C. Petterson, and A. W. Bazemore. 2011. Primary care physician workforce and outcomes. Journal of the American Medical Association 306(11):1201-1202.

**No Abstract. Full Text Attached. (Phillips\_JAMA\_2011)**

Pickens, S., P. Boumbulian, R. J. Anderson, S. Ross, and S. Phillips. 2002. Community-oriented primary care in action: A Dallas story. American Journal of Public Health 92(11):1728-1732.

### Abstract:

Dallas County, Texas, is the site of the largest urban application of the community-oriented primary care (COPC) model in the United States. We summarize the development and implementation of Dallas's Parkland Health & Hospital System COPC program. The complexities of implementing and managing this comprehensive community-based program are delineated in terms of Dallas County's political environment and the components of COPC (assessment, prioritization, community collaboration, health care system, evaluation, and financing). Steps to be taken to ensure the future growth and development of the Dallas program are also considered. The COPC model, as implemented by Parkland, is replicable in other urban areas.

**Free Full Text:** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447319/?tool=pubmed>

Rosenthal, T. C. 2008. The medical home: Growing evidence to support a new approach to primary care. The Journal of the American Board of Family Medicine 21(5):427-440.

### Abstract:

#### INTRODUCTION: A medical home is a patient-centered, multifaceted source of personal primary health care. It is based on a relationship between the patient and physician, formed to improve the patient's health across a continuum of referrals and services. Primary care organizations, including the American Board of Family Medicine, have promoted the concept as an answer to government agencies seeking political solutions that make quality health care affordable and accessible to all Americans.

#### METHODS: Standard literature databases, including PubMed, and Internet sites of numerous professional associations, government agencies, business groups, and private health organizations identified over 200 references, reports, and books evaluating the medical home and patient-centered primary care.

#### FINDINGS: Evaluations of several patient-centered medical home models corroborate earlier findings of improved outcomes and satisfaction. The peer-reviewed literature documents improved quality, reduced errors, and increased satisfaction when patients identify with a primary care medical home. Patient autonomy and choice also contributes to satisfaction. Although industry has funded case management models demonstrating value superior to traditional fee-for-service reimbursement adoption of the medical home as a basis for medical care in the United States, delivery will require effort on the part of providers and incentives to support activities outside of the traditional face-to-face office visit.

#### CONCLUSIONS: Evidence from multiple settings and several countries supports the ability of medical homes to advance societal health. A combination of fee-for-service, case management fees, and quality outcome incentives effectively drive higher standards in patient experience and outcomes. Community/provider boards may be required to safeguard the public interest.

**Free Full Text:** <http://www.jabfm.org/content/21/5/427.long>

Salsberg, E., P. H. Rockey, K. L. Rivers, S. E. Brotherton, and G. R. Jackson. 2008. US residency training before and after the 1997 balanced budget act. Journal of the American Medical Association 300(10):1174-1180.

### Abstract:

#### CONTEXT: Graduate medical education (GME) determines the size and characteristics of the future workforce. The 1997 Balanced Budget Act (BBA) limited Medicare funding for additional trainees in GME. There has been concern that because Medicare is the primary source of GME funding, the BBA would discourage growth in GME.

#### OBJECTIVE: To examine the number of residents in training before and after the BBA, as well as more recent changes in GME by specialty, sex, and type and location of education.

#### DESIGN: Descriptive study using the American Medical Association/Association of American Medical Colleges National GME Census on physicians in Accreditation Council for Graduate Medical Education (ACGME)-accredited programs to examine changes in the number and characteristics of residents before and after the BBA.

#### MAIN OUTCOME MEASURES: Differences in the number of physicians in ACGME-accredited training programs overall, by specialty, and by location and type of education.

#### RESULTS: The number of residents and fellows changed little between academic year (AY) 1997 (n = 98,143) and AY 2002 (n = 98,258) but increased to 106,012 in AY 2007, a net increase of 7869 (8.0%) over the decade. The annual number of new entrants into GME increased by 7.6%, primarily because of increasing international medical graduates (IMGs). United States medical school graduates (MDs) comprised 44.0% of the overall growth from 2002 to 2007, followed by IMGs (39.2%) and osteopathic school graduates (18.8%). United States MD growth largely resulted from selection of specialties with longer training periods. From 2002 to 2007, US MDs training in primary care specialties decreased by 2641, while IMGs increased by 3286. However, increasing subspecialization rates led to fewer physicians entering generalist careers.

#### CONCLUSION: After the 1997 BBA, there appears to have been a temporary halt in the growth of physicians training in ACGME programs; however, the number increased from 2002 to 2007.

**Full Text Attached. (Salsberg\_JAMA\_2008)**

Starfield, B., and J. Horder. 2007. Interpersonal continuity: Old and new perspectives. British Journal of General Practice 57(540):527-529.

**No Abstract. Free Full Text:** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2099634/?tool=pubmed>

Starfield, B., L. Shi, and J. Macinko. 2005. Contribution of primary care to health systems and health. Milbank Quarterly 83(3):457-502.

### Abstract:

Evidence of the health-promoting influence of primary care has been accumulating ever since researchers have been able to distinguish primary care from other aspects of the health services delivery system. This evidence shows that primary care helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians, a relationship with a source of primary care, or the receipt of important features of primary care. The evidence also shows that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies. The means by which primary care improves health have been identified, thus suggesting ways to improve overall health and reduce differences in health across major population subgroups.

**Full Text Attached. (Starfield\_Milbank\_2005)**

Steinbrook, R. 2009. Health care and the American recovery and reinvestment act. New England Journal of Medicine 360(11):1057-1060.

**No Abstract. Free Full Text:** <http://www.nejm.org/doi/full/10.1056/NEJMp0900665>

Thomas, G. 2008. A systematic review of COPC: Evidence for effectiveness. Journal of Health Care for the Poor and Underserved 19(3):963-980.

### Abstract:

#### PURPOSE: This systematic review was conducted to assess the evidence for effectiveness of the community oriented primary care (COPC) model and discuss alternative approaches to community medicine practice and education.

#### METHODS: A literature search for all articles referring to COPC was conducted. Articles were categorized by type, and the extent of the use of elements of the COPC model, and the level of community involvement.

#### RESULTS: The majority of articles on COPC (60% of those reviewed) describe the general theory or educational use of the methodology. Many published studies are project descriptions not utilizing the complete model as initially described. Few of project descriptions include all elements of COPC or document community participation. Evidence for or against the effectiveness of the COPC model in improving community health outcomes (using the Strength of Recommendation Taxonomy (SORT) classification system as evidence) was found to be limited.

#### CONCLUSIONS: Most publications related to COPC do not use the complete COPC model as originally described and evidence for its effectiveness is lacking. Further research with evaluation of community health outcomes and community participation is needed. Diverse models of community health intervention can be considered for training and collaborative practice with underserved populations.

**No Full Text Access.**

Wagner, E., B. Austin, C. Davis, M. Hindmarsh, J. Schaefer, and A. Bonomi. 2001. Improving chronic illness care: Translating evidence into action. Health Affairs 20(6):64-78.

### Abstract:

The growing number of persons suffering from major chronic illnesses face many obstacles in coping with their condition, not least of which is medical care that often does not meet their needs for effective clinical management, psychological support, and information. The primary reason for this may be the mismatch between their needs and care delivery systems largely designed for acute illness. Evidence of effective system changes that improve chronic care is mounting. We have tried to summarize this evidence in the Chronic Care Model (CCM) to guide quality improvement. In this paper we describe the CCM, its use in intensive quality improvement activities with more than 100 health care organizations, and insights gained in the process.

**Free Full Text:** <http://content.healthaffairs.org/content/20/6/64.long>

Welton, W. E., T. A. Kantner, and S. M. Katz. 1997. Developing tomorrow’s integrated community health systems: A leadership challenge for public health and primary care. Milbank Quarterly 75(9184684):261-288.

### Abstract:

As the nation's health system moves away from earlier models to one grounded in population health and market-based systems of care, new challenges arise for public health professionals, primary care practitioners, health plan and institutional managers, and community leaders. Among the challenges are the need to develop creative concepts of organization and accountability and to assure that dynamic, system-oriented structures support the new kind of leadership that is required. Developing tomorrow's integrated community health systems will challenge the leadership skills and integrative abilities of public health professionals, primary care practitioners, and managers. These leaders and their new organizations must, in turn, assume increased accountability for improving community health.

**Free Full Text.** <http://onlinelibrary.wiley.com/doi/10.1111/1468-0009.00054/pdf>

White, K. L. 2000. Fundamental research at primary care level. The Lancet 355(9218):1904-1906.

**No Abstract. Free Full Text:** <http://www.sciencedirect.com/science/article/pii/S0140673600023047>

White, K. L., T. F. Williams, and B. G. Greenberg. 1961. Ecology of medical care. New England Journal of Medicine 265(18):885-892.

**No Abstract. Full Text Attached. (White\_NEJM\_1961)**

Zhang, X., R. L. Phillips Jr, A. W. Bazemore, M. S. Dodoo, S. M. Petterson, X. I., and L. A. Green. 2008. Physician distribution and access: Workforce priorities. American Family Physician 15(77):1378.

### Abstract:

Most Primary Health Professional Shortage Areas (HPSAs) exceed federal population-to-physician designation criteria, yet struggle to maintain access to primary care physicians. Policy options for recruiting and retaining primary care physicians to HPSAs, and new HPSA criteria that support access to primary care practices, should be considered.

**Free Full Text:** <http://www.aafp.org/afp/2008/0515/p1378.html>

Kindig DA. “Understanding Population Health.” *The Milbank Quarterly*, Vol 85, No.1, 2007, pp. 139-161

### Abstract:

Population health is a relatively new term, with no agreement about whether it refers to a concept of health or a field of study of health determinants. There is debate, sometimes heated, about whether population health and public health are identical or different. Discussions of population health involve many terms, such as outcomes, disparities, determinants, and risk factors, which may be used imprecisely, particularly across different disciplines, such as medicine, epidemiology, economics, and sociology. Nonetheless, thinking and communicating clearly about population health concepts are essential for public and private policymakers to improve the population's health and reduce disparities. This article defines and discusses many of the terms and concepts characterizing this emerging field.

**Full Text Attached. (Kindig\_Milbank\_2007)**

Donabedian A, et al. Quality, Cost, and Health: An Integrative Model. *Medical Care.* Vol. 20, N0. 10 (Oct 1982), pp. 975-992

### Abstract:

This article presents an integrative model of the relations among health status, quality of care, and resource expenditure. It defines medical care quality in terms of outcomes, measured as the expected improvements in health status attributable to care. The consideration of how quality so defined is affected by the unconstrained, efficient use of resources for care leads to the specification of the absolutist definition of quality. Consideration of the incidence of individual and external costs and benefits of care provides the basis for distinguishing further between the individualized definition of quality, which depends upon individual preferences and ability to pay, and the social definition of quality, which includes consideration of external benefits, full social definition of quality, which includes consideration of external benefits, full social costs, and preferences for the distribution of welfare. An additional distinction is made between clinical efficiency and production efficiency. This article examines in detail the implications, for the selection of optimal strategies of care, of the three definitions of quality (absolutist, individualized, and social) and the two types of efficiency (clinical and production).

**Full Text Attached. (Donabedian\_Medical\_Care\_1982)**

Gunzenhauser, et al. The Quality Improvement Experience in a High-Performing Local Health Department: Los Angeles County. J Public Health Management and Practice. Jan/Feb 2010, Vol. 16, No.1, pp. 39-48.

### Abstract:

Quality improvement in public health is a key element in the movement toward accreditation. Multiple national, state, and local initiatives are under way to define quality in a public health context and to develop tools and promising practices to support quality-improvement efforts in local health departments. Until recently, efforts to improve quality at the local level have largely focused on performance measurement to assess the relationship between inputs, outputs, and outcomes. The Los Angeles County Department of Public Health has developed its own unique approach to quality improvement. This approach includes focusing on three overlapping areas (professional practice, performance improvement, and public health science) that align closely with essential public health services 8 (competent worker), 9 (evaluation), and 10 (research). Broadening the focus of quality-improvement efforts to include these three areas (rather than performance improvement alone) provides additional opportunities to address key infrastructure issues that may affect the quality of services that are provided to the public and, thus, health outcomes. While the experience in Los Angeles County parallels other efforts, it includes unique elements that will be of use to public health professionals in other agencies. **No Full Text Access.**

Lurie N and Fremont A. “Building Bridges Between Medical Care and Public Health.” *JAMA*. 2009, Vol. 302, No.1, pp. 84-6

**No Abstract. Full Text Attached. (Lurie\_JAMA\_2009)**

Kahn LH. “A Prescription for Change: The Need for Qualified Physician Leadership in Public Health.” *Health Affairs*. July/August 2003, Vol.22, No.4, pp. 241-48.

### Abstract:

A key element missing in the federal bioterrorism preparedness plan is qualified physician leadership at the local level. Physicians now lead fewer than one-fourth of local health departments. When appointed leaders are not physicians, leadership falls on elected officials or non-medical administrators who become managers of outbreaks. As illustrated in recent case examples, these leaders may find themselves in medical emergencies that they are not qualified to handle. In serious disease outbreaks, unprepared leadership could contribute to unnecessary illness and death. Here I propose strategies to increase qualified physician leadership in state and local public health infrastructures.

**Full Text Attached. (Kahn\_Health\_Affairs\_2003)**

Fielding JE and Teutsch SM. “An Opportunity Map for Societal Investment in Health.” *JAMA.* May 25, 2011. Vol. 305, No. 20, pp. 2110-11

**No Abstract. Full Text Attached. (Fielding\_JAMA\_2011)**

Fielding JE and Teutsch SM. “Integrating Clinical Care and Community Health: Delivering Health.” *JAMA*. July 15, 2009. Vol. 302, No. 3, pp. 317-19

**No Abstract. Full Text Attached. (Fielding\_JAMA\_2009)**

Maciosek MV, et al. “Priorities among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis.” *AJPM*. 2006; Vol. 31, No.1, pp. 52-61

### Abstract:

#### BACKGROUND: Decision makers at multiple levels need information about which clinical preventive services matter the most so that they can prioritize their actions. This study was designed to produce comparable estimates of relative health impact and cost effectiveness for services considered effective by the U.S. Preventive Services Task Force and Advisory Committee on Immunization Practices.

#### METHODS: The National Commission on Prevention Priorities (NCPP) guided this update to a 2001 ranking of clinical preventive services. The NCPP used new preventive service recommendations up to December 2004, improved methods, and more complete and recent data and evidence. Each service received 1 to 5 points on each of two measures--clinically preventable burden and cost effectiveness--for a total score ranging from 2 to 10. Priorities for improving delivery rates were established by comparing the ranking with what is known of current delivery rates nationally.

#### RESULTS: The three highest-ranking services each with a total score of 10 are discussing aspirin use with high-risk adults, immunizing children, and tobacco-use screening and brief intervention. High-ranking services (scores of 6 and above) with data indicating low current utilization rates (around 50% or lower) include: tobacco-use screening and brief intervention, screening adults aged 50 and older for colorectal cancer, immunizing adults aged 65 and older against pneumococcal disease, and screening young women for Chlamydia.

#### CONCLUSION: This study identifies the most valuable clinical preventive services that can be offered in medical practice and should help decision-makers select which services to emphasize.

#### Free Full Text: <http://www.sciencedirect.com.ezproxy.nyam.org:2048/science/article/pii/S0749379706001243>

Milstein B, et al. “Why Behavioral and Environmental Interventions are Needed to Improve Health at Lower Cost”. *Health Affairs*. May 2001. Vol. 30:5 pp.823-32.

### Abstract:

We used a dynamic simulation model of the US health system to test three proposed strategies to reduce deaths and improve the cost-effectiveness of interventions: expanding health insurance coverage, delivering better preventive and chronic care, and protecting health by enabling healthier behavior and improving environmental conditions. We found that each alone could save lives and provide good economic value, but they are likely to be more effective in combination. Although coverage and care save lives quickly, they tend to increase costs. The impact of protection grows more gradually, but it is a critical ingredient over time for lowering both the number of deaths and reducing costs. Only protection slows the growth in the prevalence of disease and injury and thereby alleviates rather than exacerbates demand on limited primary care capacity. When added to a simulated scenario with coverage and care, protection could save 90 percent more lives and reduce costs by 30 percent in year 10; by year 25, that same investment in protection could save about 140 percent more lives and reduce costs by 62 percent.

**Full Text Attached. (Milstein\_Health\_Affairs\_2011)**

Book and Website Citations

CDC (Centers for Disease Control and Prevention). 2010. About CDC: Vision, mission, core values, and pledge. <http://www.cdc.gov/about/organization/mission.htm> (accessed November 1, 2011).

CDC. 2011a. Chronic disease prevention and health promotion: Organizational chart. <http://www.cdc.gov/chronicdisease/about/org_chart.htm> (accessed November 1, 2011).

 CDC. 2011b. Department of Health and Human Services Centers for Disease Control and Prevention (CDC). <http://www.cdc.gov/maso/pdf/CDC_Chart_wNames.pdf> (accessed November 1, 2011).

Federal Funds Information for States. 2011 (unpublished). Inventory of federal funding streams: A detailed review of HRSA and CDC funds. Washington, DC: Institute of Medicine.

HHS (Department of Health and Human Services). 2011. Advancing the health, safety, and well-being of our people: FY 2012 president’s budget for HHS. Washington, DC: HHS.

<http://www.hhs.gov/about/FY2012budget/fy2012bib.pdf>

HRSA (Health Resources and Services Administration). 2010. Public Health Steering Committee recommendations (draft). Washington, DC: HRSA. HRSA. 2011a. About HRSA. <http://www.hrsa.gov/about/index.html> (accessed November 1, 2011).

HRSA. 2011b. Bureau of primary health care. <http://www.hrsa.gov/about/organization/bureaus/bphc/index.html> (accessed November 1, 2011).

HRSA. 2011c. Bureaus and offices. <http://www.hrsa.gov/about/organization/bureaus/index.html>

(accessed November 1, 2011).

HRSA. 2011d. Maternal & child health bureau. <http://www.hrsa.gov/about/organization/bureaus/mchb/index.html> (accessed November 1, 2011).

American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. 2007. Joint principles of the patient-centered medical home. <http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home> (accessed December 15, 2011).

IOM (Institute of Medicine). 2010. The future of nursing: Leading change, advancing health. Washington, DC: The National Academies Press. <http://www.nap.edu/catalog.php?record_id=12956>

IOM. 2011. For the public’s health: The role of measurement in action and accountability. Washington, DC: The National Academies Press. <http://www.iom.edu/Reports/2010/For-the-Publics-Health-The-Role-of-Measurement-in-Action-and-Accountability/Report-Brief.aspx>

AHRQ (Agency for Healthcare Research and Quality). 2010. Impact infrastructure for maintaining primary care transformation. <http://www.ahrq.gov/research/impactaw.htm> (accessed January 31, 2012).

ASTHO (Association of State and Territorial Health Officials). 2011. ASTHO profile of state public health. Arlington, VA: ASTHO. <http://www.astho.org/Display/AssetDisplay.aspx?id=2882>

Black infant health program. <http://www.cdph.ca.gov/programs/BIH/Pages/default.aspx> (accessed February 15, 2012).

Carrier, E., T. Yee, and R. L. Garfield. 2011. The uninsured and their health care needs: How have they changed since the recession? The Henry J. Kaiser Family Foundation: Kaiser Commission on Medicaid and the Uninsured. <http://www.kff.org/uninsured/8246.cfm>

CDC (Centers for Disease Control and Prevention). 2011. Community transformation grants. <http://www.cdc.gov/communitytransformation/index.htm> (accessed November 21, 2011).

CDC. 2012. Epidemic Intelligence Service (EIS). <http://www.cdc.gov/EIS/index.html> (accessed February 10, 2012).

Center for Medicare and Medicaid Innovation. 2011. Health care innovation challenge. <http://innovations.cms.gov/About/index.html> (accessed December 15, 2011).

CMS (Centers for Medicaid & Medicare Services). 2011. Regulations, guidance & standards. <https://www.cms.gov/home/regsguidance.asp> (accessed December 15, 2011).

Congressional Budget Office. 2006. Nonprofit hospitals and the provision of community benefits. Washington, DC: U.S. Congress Congressional Budget Office. <http://www.cbo.gov/publication/18256>

Congressional Budget Office. 2011. CBO’s analysis of the major health care legislation enacted in March 2010: Before the subcommittee on health committee on energy and commerce. Washington, DC: U.S. Congress Congressional Budget Office. <http://www.cbo.gov/publication/22077>

European Centre for Health Policy. 1999. Health impact assessment: Main concepts and suggested approach. Brussels: WHO. <http://www.apho.org.uk/resource/view.aspx?RID=44163>

The Henry J. Kaiser Family Foundation. 2011. Focus on health reform: Summary of new health reform law. Menlo Park, CA: The Henry J. Kasier Foundation. <http://www.kff.org/healthreform/8061.cfm>

HHS (Department of Health and Human Services). 2010. News release: “HHS awards $320 million to expand primary care workforce.” <http://www.hhs.gov/news/press/2010pres/09/20100927e.html> (accessed December 15, 2011).

HHS. 2011. Prevention and public health fund: Community transformation grants to reduce chronic disease. <http://www.healthcare.gov/news/factsheets/2011/05/grants05132011a.html> (accessed February 10, 2012).

HHS Administration for Children and Families. 2011. Fact sheet. <http://www.acf.hhs.gov/programs/ocs/csbg/aboutus/factsheets.htm> (accessed January 16, 2012).

HRSA (Health Resources and Services Administration). 2009. Accreditation initiative update: Program assistance letter 2009-12. <http://bphc.hrsa.gov/policiesregulations/policies/pal200912.html> (accessed December 21, 2011).

HRSA. 2011. HHS announces new teaching health centers graduate medical education program. <http://www.hrsa.gov/about/news/pressreleases/110125teachinghealthcenters.html> (accessed December 15, 2011).

IOM (Institute of Medicine). 2010. The healthcare imperative: Lowering costs and improving outcomes: Workshop series summary. Washington, DC: The National Academies Press. <http://www.nap.edu/catalog.php?record_id=12750>

IOM. 2011a. For the public’s health: The role of measurement in action and accountability. Washington, DC: The National Academies Press. <http://www.nap.edu/catalog.php?record_id=13005>

 IOM. 2011b. For the public’s health: Revitalizing law and policy to meet new challenges. Washington, DC: The National Academies Press. <http://www.nap.edu/catalog.php?record_id=13093>

IRS (Internal Revenue Service). 2011. Notice 2011-52, notice and request for comments regarding the community health needs assessment requirements for tax-exempt hospitals, edited by IRS. <http://www.irs.gov/pub/irs-drop/n-11-52.pdf> (accessed November 17, 2011)

Kaiser Family Foundation. 2010. Distribution of revenue by source for federally-funded federally qualified health centers, 2009. <http://www.statehealthfacts.org/comparemaptable.jsp?ind=428&cat=8> (accessed October 24, 2011).

MedPAC (Medicare Payment Advisory Commission). 2009. Accountable care organizations. Washington, DC: MedPAC. <http://www.medpac.gov/chapters/Jun09_Ch02.pdf>

NACCHO (National Association of County and City Health Officials). 2011. 2010 national profile of local health departments. Washington, DC: NACCHO. <http://www.naccho.org/topics/infrastructure/profile/resources/2010report/>

National Prevention, Health Promotion and Public Health Council. 2011. National prevention strategy: America’s plan for better health and wellness. Rockville, MD: National Prevention, Health Promotion and Public Health Council. <http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf>

NIH (National Institutes of Health). 2011. Estimates of funding for various research, condition, and disease categories (RCDC). <http://report.nih.gov/rcdc/categories/> (accessed November 11, 2011).

NRC (National Research Council). 2011. Improving health in the United States: The role of health impact assessment. Washington, DC: The National Academies Press. <http://www.nap.edu/catalog.php?record_id=13229>

Robert Wood Johnson Foundation, Network for Regional Health Care Improvement, and Pittsburgh Regional Health Initiative. 2009. From volume to value: Recommendations of the 2008 NRHI healthcare payment reform summit. Pittsburgh, PA: Network for Regional Healthcare Improvement.

<http://www.nrhi.org/downloads/NRHI2008PaymentReformRecommendations.pdf>

Rosenbaum, S., and R. Margulies. 2010. New requirements for tax-exempt charitable hospitals. Health Reform GPS, [http://www.healthreformgps.org/resources/new-requirements-for-tax-exempt- charitable-hospitals/](http://www.healthreformgps.org/resources/new-requirements-for-tax-exempt-%20charitable-hospitals/) (accessed November 16, 2011).

Trust for America’s Health. 2011. Investing in America’s health: A state-by-state look at public health funding and key health facts. Washington, DC: Trust for America’s Health. <http://healthyamericans.org/assets/files/Investing%20in%20America%27s%20Health.pdf>

U.S. House of Representatives Committee on Ways and Means. 2000. Section 10. Title XX social services block grant program. In 2000 green book background material and data on programs within the jurisdiction of the Committee on Ways and Means. Washington, DC: U.S. Congress. <http://www.gpo.gov/fdsys/pkg/GPO-CPRT-108WPRT108-6/html/GPO-CPRT-108WPRT108-6-2-10.htm>

U.S. National Archives and Records Administration. 2011. Medicare program; Medicare shared savings program: Accountable care organizations. Federal Register 76(212):67802. <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>

The White House. 2009. Memorandum for the heads of executive departments and agencies. <http://www.whitehouse.gov/the_press_office/Memorandum-for-the-Heads-of-Executive-Departments-and-Agencies-Subject-Government> (accessed November 11, 2011).

WHO (World Health Organization). 2010. Adelaide statement on health in all policies: Moving towards a shared governance for health and well-being. Geneva, Switzerland: WHO. <http://www.who.int/social_determinants/hiap_statement_who_sa_final.pdf>

National Partnership for Women & Families. 2012. National Partnership for Women & Families. 2012. <http://www.nationalpartnership.org/site/PageServer> (accessed February 14, 2012).

U.S. Government. 2012. Health data community. <http://www.data.gov/health> (accessed February 14, 2012).

ASTHO (Association of State and Territorial Health Officials). 2011a. ASTHO profile of state public health. Arlington, VA: ASTHO. <http://www.astho.org/Display/AssetDisplay.aspx?id=2882>

ASTHO. 2011b. Budget cuts continue to affect the health of Americans: Update May 2011. Arlington, VA: ASTHO. <http://www.astho.org/Display/AssetDisplay.aspx?id=6024>

CMS Rural Health Center. 2011. Medicare certified rural health clinics as of 7/12/2011. <https://www.cms.gov/MLNProducts/downloads/rhclistbyprovidername.pdf> (accessed October 24, 2011).

HRSA (Health Resources and Services Administration). 2006. Comparison of the rural health clinic and federally qualified health center programs. Rockville, MD: HRSA. <http://www.ask.hrsa.gov/detail_materials.cfm?ProdID=3774>

HRSA. No date (a). About the Ryan White HIV/AIDS Program. <http://hab.hrsa.gov/abouthab/aboutprogram.html> (accessed November 15, 2011).

HRSA. No date (b). Authorizing legislation: Section 330 of the Public Health Service Act (42 USC section 254b) authorizing legislation of the health center program. <http://bphc.hrsa.gov/policiesregulations/legislation/index.html> (accessed January 4, 2012).

HRSA. No date (c). Health center program terminology tip sheet. [http://bphc.hrsa.gov/technicalassistance /health\_center\_terminology\_sheet.pdf](http://bphc.hrsa.gov/technicalassistance%20/health_center_terminology_sheet.pdf) (accessed January 19, 2012).

HRSA. No date (d). HIV/AIDS program funding. <http://hab.hrsa.gov/data/reports/funding.html> (accessed October 25, 2011).

HRSA. No date (e). HIV/AIDS programs part A—grants to emerging metropolitan & transitional grant areas. <http://hab.hrsa.gov/abouthab/parta.html> (accessed November 15, 2011).

HRSA. No date (f). HIV/AIDS programs part B—grants to states & territories. <http://hab.hrsa.gov/abouthab/partbstates.html> (accessed November 15, 2011).

HRSA. No date (g). HIV/AIDS programs part C. <http://hab.hrsa.gov/abouthab/partc.html> (accessed November 15, 2011).

HRSA. No date (h). HIV/AIDS programs part D—services for women, infants, children, youth & their families. <http://hab.hrsa.gov/abouthab/partd.html> (accessed November 15, 2011).

HRSA. No date (i) HIV/AIDS programs SPNS—special projects of national significance (part F). <http://hab.hrsa.gov/abouthab/partfspns.html> (accessed November 15, 2011).

HRSA. No date (j). Uniform Data System 2010 national data. <http://bphc.hrsa.gov/uds/view.aspx?year=2010> (accessed November 17, 2011)

HRSA. No Date (k). What is a health center? <http://bphc.hrsa.gov/about/index.html> (accessed October 24, 2011).

NACCHO (National Association of County and City Health Officials). 2005. Operational definition of a functional local health department. Washington, DC: NACCHO. <http://www.naccho.org/topics/infrastructure/accreditation/OpDef.cfm>

NACCHO. 2010. The status of local health department informatics. Washington, DC: NACHHO. <https://eweb.naccho.org/eweb/DynamicPage.aspx?WebCode=ProdDetailAdd&ivd_prc_prd_key=ed288e2c-b36b-422b-a211-b531db34c28b&ivd_qty=1&Action=Add&site=naccho&ObjectKeyFrom=1A83491A-9853-4C87-86A4-F7D95601C2E2&DoNotSave=yes&ParentObject=CentralizedOrderEntry&ParentDataObject=Invoice%20Detail>

NACCHO. 2011a. 2010 national profile of local health departments. Washington, DC: NACCHO. <http://www.naccho.org/topics/infrastructure/profile/resources/2010report/>

NACCHO. 2011b. Changes in size of local health department workforce. Washington, DC: NACCHO. <http://www.naccho.org/topics/infrastructure/profile/resources/upload/researchbrief_July2011_proof2-final-2.pdf>

National Association of Community Health Centers. 2011. Key health center data by state, 2010: National Association of Community Health Centers. <http://www.nachc.com/client/state_X_key_facts_2010.pdf>

National Center for Farmworker Health. 2011a. About community and migrant health centers. <http://www.ncfh.org/?sid=37> (accessed October 24, 2011).

National Center for Farmworker Health. 2011b. Migrant health voucher programs. <http://www.ncfh.org/index.php?pid=65> (accessed October 24, 2011).

Novick, L. F., and G. P. Mays. 2005. Public health administration: Principles for population-based management. Sudbury, MA: Jones and Bartlett, Inc.

American Cancer Society. 2011. Colorectal cancer facts and figures 2011-2013. Atlanta, GA: American Cancer Society. <http://www.cancer.org/Research/CancerFactsFigures/ColorectalCancerFactsFigures/colorectal-cancer-facts-figures-2011-2013-page>

American Cancer Society. 2012. Cancer facts & figures 2012. Atlanta, GA: American Cancer Society. [http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-031941.pdf](http://www.cancer.org/acs/groups/content/%40epidemiologysurveilance/documents/document/acspc-031941.pdf)

CDC (Centers for Disease Control and Prevention). 2010. Strategies for states to address the “ABCs” of heart disease and stroke prevention. Atlanta, GA: CDC. <http://www.cdc.gov/DHDSP/programs/nhdsp_program/docs/ABCs_Guide.pdf>

CDC. 2011a. Colorectal cancer screening—United States, 2002, 2004, 2006, and 2008. Morbidity and Mortality Weekly Reports 60(01):42-46. <http://www.cdc.gov/mmwr/preview/mmwrhtml/su6001a8.htm>

CDC. 2011b. Division for heart disease and stroke prevention: Data trends & maps. <http://apps.nccd.cdc.gov/NCVDSS_DTM/> (accessed December 15, 2011).

CDC. 2011c. Vital signs: Colorectal cancer screening, incidence, and mortality—United States, 2002— 2010. Morbidity and Mortality Weekly Reports 60(26):884-889. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6026a4.htm>

HHS (Department of Health and Human Services). 2010. Ending the tobacco epidemic: A tobacco control strategic action plan for the U.S. Department of Health and Human Services. Washington, DC: Office of the Assistant Secretary for Health. <http://www.hhs.gov/ash/initiatives/tobacco/index.html>

HRSA (Health Resources and Services Administration). 2010. Public Health Steering Committee recommendations: Reinvigorating HRSA’s public health agenda. Washington, DC: HRSA.

HRSA. 2012. Proposed uniform data system changes for 2012 program assistance letter 2012-01. <http://bphc.hrsa.gov/policiesregulations/policies/pal201201.html> (accessed January 15, 2012).

HRSA and National Initiative for Children’s Health Care Quality. 2011. Collaborate for healthy weight. <http://www.collaborateforhealthyweight.org/About.aspx> (accessed December 15, 2011).

IOM (Institute of Medicine). 2010. A population-based policy and systems change approach to prevent and control hypertension. Washington, DC: The National Academies Press. <http://www.nap.edu/openbook.php?record_id=12819&page=1>

Peplinski, K., C. McLeod, and D. Stark. 2011. Use of patient navigators as a strategy to increase access to care for health disparities populations. Paper read at APHA 139th Annual Meeting and Exposition, Washington, DC.

 Rohweder, C., M. Wolf, A. Schenck, V. Prasad, and S. Diehl. 2011. Options for increasing colorectal cancer screening rates in North Carolina community health centers. Chapel Hill, NC: UNC Lineberger Comprehensive Cancer Center. <http://www.ncspeed.org/sites/default/files/CRC_Toolkit.pdf>

Yowell, A. 2011. Affordable care act maternal, infant, and early childhood home visiting program. Presentation to the committee on integrating primary care and public health. Washington, DC.

AHRQ (Agency for Healthcare Research and Quality). 2011. 2010 national healthcare quality report. Rockville, MD: AHRQ. <http://www.ahrq.gov/qual/nhqr10/nhqr10.pdf>

ASTHO (Association of State and Territorial Health Officials). 2011. Budget cuts continue to affect the health of Americans: Update May 2011. Arlington, VA: ASTHO. <http://www.astho.org/Display/AssetDisplay.aspx?id=6024>

Canadian Labour and Business Centre. 2003. Physician workforce in Canada: Literature review and gap analysis. Ottawa, ON: A Physician Human Resource Strategy for Canada: Task Force Two. <http://www.physicianhr.ca/reports/literatureReviewGapAnalysis-e.pdf>

CDC. 2011. Obesity: Halting the epidemic by making health easier. Atlanta, GA: CDC. <http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2011/Obesity_AAG_WEB_508.pdf>

COGME (Council on Graduate Medical Education). 2010. Council on Graduate Medical Education 20th report: Advancing primary care. Hyattsville, MD: COGME. <http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf>

Commission on Social Determinants of Health. 2008. Closing the gap in a generation: Health equity through action on the social determinants of health. Geneva, Switzerland: WHO. <http://www.who.int/social_determinants/thecommission/finalreport/en/index.html>

Cooperative Actions for Health Program. 2001. Lessons learned in medicine and public health collaboration. Chicago, IL: American Medical Association and Washington DC: American Public Health Association.

European Observatory on Health Systems and Policies. 2006. The health care workforce in Europe learning from experience. Trowbridge, Wilts: European Observatory on Health Systems and Policies. <http://www.euro.who.int/__data/assets/pdf_file/0008/91475/E89156.pdf>

GAO (General Accounting Office). 2003. Physician workforce: Physician supply increased in metropolitan and nonmetropolitan areas but geographic disparities persisted. Washington, DC: GAO. <http://www.gao.gov/new.items/d04124.pdf>

Grumbach, K., and P. Grundy. 2010. Outcomes of implementing patient centered medical home interventions: A review of the evidence from prospective evaluation studies in the United States. Washington, DC: Patient Centered Primary Care Collaborative. <http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf>

HHS (Department of Health and Human Services). 2011a. The community as a learning system for health: Using local data to improve local health. Hyattsville, MD: HHS. <http://cctsi.ucdenver.edu/CO-PACT/Resources/Using%20Local%20Data%20to%20Improve%20Community%20Health.pdf>

HHS. 2011b. Health data initiative. <http://www.hhs.gov/open/initiatives/hdi/index.html> (accessed September 22, 2011).

HRSA (Health Resources and Services Administration). 2010. The registered nurse population: Findings from the 2008 national sample survey of registered nurses. Hyattsville, MD: HHS. <http://bhpr.hrsa.gov/healthworkforce/rnsurveys/rnsurveyfinal.pdf>

HRSA. 2011. Uniform Data System 2010 National Data. Hyattsville, MD: HHS. <http://bphc.hrsa.gov/healthcenterdatastatistics/index.html>

IOM (Institute of Medicine). 1984. Community oriented primary care: A practical assessment. Vol. 1. Washington, DC: National Academy Press. <http://www.nap.edu/openbook.php?record_id=671&page=1>

IOM. 1988. The future of public health. Washington, DC: National Academy Press. <http://www.nap.edu/openbook.php?record_id=1091&page=1>

IOM. 1996. Primary care: America’s health in a new era. Washington, DC: National Academy Press. <http://www.nap.edu/openbook.php?isbn=0309053994>

IOM. 2002. The future of the public’s health in the 21st century. Washington, DC: The National Academies Press. <http://www.nap.edu/openbook.php?record_id=10548&page=1>

IOM. 2003. Who will keep the public healthy? Educating public health professionals for the 21st century. Washington, DC: The National Academies Press. <http://www.nap.edu/openbook.php?isbn=030908542X>

IOM. 2010. The healthcare imperative: Lowering costs and improving outcomes: Workshop series summary. Washington, DC: The National Academies Press. <http://www.nap.edu/openbook.php?record_id=12750>

IOM. 2011a. For the public’s health: Revitalizing law and policy to meet new challenges. Washington, DC: The National Academies Press. <http://www.nap.edu/openbook.php?record_id=13093&page=1>

IOM. 2011b. For the public’s health: The role of measurement in action and accountability. Washington, DC: The National Academies Press. <http://www.nap.edu/openbook.php?record_id=13005&page=1>

Lasker, R. D., and the Committee on Medicine and Public Health. 1997. Medicine and public health: The power of collaboration. New York: The New York Academy of Medicine. <http://www.cacsh.org/pdf/MPH.pdf>

Marmot, M. G., and R. G. Wilkinson. 2006. Social determinants of health. New York: Oxford University Press.

Martin-Misenser, R., R. Valaitis, and The Strengthening Public Health Care Through Primary Care and Public Health Collaboration Research Team. 2009. A scoping literature review of collaboration between primary care and public health: A report to the Canadian Health Services Research Foundation. Hamilton, ON: StrengthenPHC. <http://www.swchc.on.ca/documents/MartinMisener-Valaitis-Review.pdf>

Miller, G., C. Roehrig, P. Hughes-Cromwick, and A. Turner. 2012. What is currently spent on prevention as compared to treatment? In Prevention vs. Treatment: What’s the right balance?, edited by H. S. Faust, and P. T. Menzel. New York: Oxford University Press. Pp. 37-55.

NACCHO (National Association of County and City Health Officials). 2011. Local health department job losses and program cuts: Findings from the July 2011 survey. Washington, DC: NACHHO. <http://www.naccho.org/topics/infrastructure/lhdbudget/upload/JobLossRepor122011FINALUpdated.pdf>

National Association of Community Health Centers. 2009. Primary care access: An essential building block of health reform. Bethesda, MD: National Association of Community Health Centers. <http://www.nachc.com/client/documents/pressreleases/PrimaryCareAccessRPT.pdf>

National Business Group on Health. 2010. The health care delivery system should focus on primary care. Washington, DC: National Business Group on Health. <http://www.businessgrouphealth.org/pdfs/National%20Business%20Group%20on%20Health%27s%20Position%20Statement%20on%20Primary%20Care.pdf>

National Commission on Community Health Services. 1966. Health is a community affair: Report. Cambridge, MA: Harvard University Press.

The New York Academy of Medicine. 2009. A compendium of proven community-based prevention programs. New York: The New York Academy of Medicine. <http://healthyamericans.org/assets/files/NYAM_Compendium.pdf>

New Zealand Ministry of Health. 2000. The New Zealand health strategy. Wellington, New Zealand: Ministry of Health. <http://www.health.govt.nz/publication/new-zealand-health-strategy>

The NHS Confederation. 2004. Making a difference: How primary care trusts are transforming the NHS. London: NHS Confederation. <http://www.nhsconfed.org/Publications/Documents/Making%20a%20difference.pdf>

Noncommunicable Diseases and Mental Health Evidence and Information for Policy World Health Organization. 2003. Primary health care: A framework for future strategic directions. Geneva, Switzerland: WHO. <http://library.cph.chula.ac.th/Ebooks/HSR/Primary%20health%20care_a%20framework%20for%20future%20strategies%20directions.pdf>

Public Health Functions Steering Committee. 1994. Public Health in America: Vision, Mission, and Essential Services. Washington, DC: Office of Disease Prevention and Health Promotion.

Rachlis, M. 2009. Public health and primary health care collaboration: A paper prepared for the public health agency of Canada. <http://www.michaelrachlis.com/publications.php>.

Rosen, G. 1993. A history of public health: Expanded edition. Baltimore, MD: The Johns Hopkins University Press.

Sloane, P. D., J. Bates, M. Gadon, C. Irmiter, and K. Donahue. 2009. Effective clinical partnerships between primary care medical practices and public health agencies. Chicago,IL: American Medical Association. <http://www.ama-assn.org/ama1/pub/upload/mm/433/clinical-partnerships.pdf>

StrenthenPHC. 2011. Strengthening primary health care through primary care and public health collaboration: About the project. <http://strengthenphc.mcmaster.ca/> (accessed January 4, 2012).

Towers Watson and National Business Group on Health. 2010. Raising the Bar on Health Care: Moving Beyond Incremental Change. New York: Towers Watson. <http://www.towerswatson.com/assets/pdf/1345/TW_15565_NBGH.pdf>

Trust for America’s Health. 2011. Investing in America’s health: A state-by-state look at public health funding and key health facts. Washington, DC: Trust for America’s Health. <http://healthyamericans.org/report/83/>

United Health Foundation. 2011. America’s health rankings: A call to action for individuals and their communities. St. Paul, MN: United Health Foundation. <http://www.americashealthrankings.org/SiteFiles/Reports/AHR%202011edition.pdf>

White, K. L. 1991. Healing the schism: Epidemiology, medicine, and the public’s health/Kerr L. White; with foreword by Halfdan Mahler, Frontiers of primary care. New York: Spinger-Verlag.

WHO (World Health Organization). 1978. Declaration of alma-ata: International conference on primary health care, alma-ata, USSR, 6-12 September 1978. Paper presented at The International Conference on Primary Health Care.

WHO. 2003. Social determinants of health: The solid facts. Copenhagen, Denmark: WHO. <http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf>

IOM (Institute of Medicine). 2011. *For the Public’s Health: The Role of Measurement in Action and Accountability.* Washington, D.C.: The National Academies Press. <http://www.nap.edu/openbook.php?record_id=13005&page=1>

Healthy People 2020. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Accessed 2/28/12 at: <http://www.healthypeople.gov/2020>

National Prevention Council, *National Prevention Strategy*, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011. Accessed 2/28/12 at: <http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf>

IOM (Institute of Medicine). 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C.: The National Academies Press <http://www.nap.edu/openbook.php?isbn=0309072808>

Honore PA and Scott W. (2010). *Priority Areas for Improvement of Quality in Public Health.* Washington, DC: Department of Health and Human Services

<http://www.hhs.gov/ash/initiatives/quality/quality/improvequality2010.pdf>

Report to Congress. *National Strategy for Quality Improvement in Public Health.* (2011). Washington, DC: Department of Health and Human Services <http://www.healthcare.gov/law/resources/reports/quality03212011a.html>

Porta, Miquel. “A Dictionary of Epidemiology.” 5th Edition, Oxford University Press, USA, 2008.

Cockerham WC and Ritchey FJ. “Dictionary of Medical Sociology.” Greenwood Press, Westport, Connecticut, 1997.

Culyer, Anthony. “The Dictionary of Health Economics.” Edward Elger Publishing, Northampton, Massachusetts. 2005.

Hyde, Lee. “Essential Dictionary of Health Care: a Practical Reference for Health Managers.” McGraw-Hill, 1988.

Rognehaugh, Richard. “The Managed Care Health Care Dictionary,” 2nd Edition, Aspen Publishers, Inc. Gaithersburg, Maryland. 1998

Last, John. “A Dictionary of Public Health.” 1st Edition, Oxford University Press, USA, 2006.

Swanson DS, Siegel JS, and Shryock HS. “The Methods and Materials of Demography.” Emerald Group Publishing, 2004

Scutchfield FD and Keck CW. Principles of Public Health Practice. 3rd Edition, Delmar Cengage Learning, USA, 2009.

Health Accreditation Board (PHAB). 2011. Acronyms and Glossary of Terms. Version 1.0 Accessed 2/28/12 at: <http://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.0.pdf>

The Community Guide to Preventive Services. Glossary. Accessed 2/28/12 at: <http://www.thecommunityguide.org/about/glossary.html>

The Institute for Healthcare Improvement Triple Aim. Accessed 2/28/12 at:

<http://www.ihi.org>

Center for Medicare and Medicaid Innovation. Mission (modified Triple Aim). Accessed 2/28/12 at: <http://innovations.cms.gov/>

HEDIS (Healthcare Effectiveness Data and Information Set) 2012. National Committee for Quality Assurance. Washington, DC. Accessed 2/28/12 at: <http://www.ncqa.org>

Community Guide to Preventive Services. Accessed 2/28/12 at: <http://www.thecommunityguide.org>

U.S. Preventive Services Task Force. Guide to Clinical Preventive Services. Accessed 2/28/12 at: <http://www.uspreventiveservicestaskforce.org/uspstopics.htm>

County Health Rankings, University of Wisconsin, Population Health Institute. Accessed 2/29/12 at: <http://www.countyhealthrankings.org/>

Community Health Status Indicators. U.S. Department of Health and Human Services, Health Resources and ServicesAdministration. Accessed 2/29/12 at: <http://www.communityhealth.hhs.gov/homepage.aspx?j=1>

IOM (Institute of Medicine). 2009. *State of the USA Indicators: Letter Report.* Washington, DC: The National Academies Press. <http://www.nap.edu/openbook.php?record_id=12534&page=1>

United Health Foundation. 2011America’s Health Rankings. Accessed 2/29/12 at: <http://www.unitedhealthfoundation.org/Grants/GrantsRankings.aspx>

Prevention Quality Indicators. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Accessed 2/29/12 at:

<http://www.qualityindicators.ahrq.gov/Modules/pqi_overview.aspx>

Prevention Endorsement Measures. National Quality Forum. Accessed 2/29/12 at: <http://www.qualityforum.org/Projects/nr/Population_Health_Prevention/Population_Health__Prevention_Endorsement_Maintenance.aspx>

Lomas J, Culyer T, McCutcheon C, McAuley L. *Conceptualizing and Combining Evidence for Health System Guidance.* Accessed 2/29/12 at:

<http://www.chsrf.ca/migrated/pdf/insightAction/evidence_e.pdf>

3FOUR50.com. Oxford Health Alliance. Accessed 2-29-12 at: <http://archive.oxha.org/initiatives/3FOUR50.com>

Essential Health Benefits Categories (2012). U.S. Department of Health and Human Services. Accessed 2/29/12 at: <http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>

National Agenda for PHSSR. The RWJF National Coordinating Center for PHSSR, University of Kentucky College of Public Health. Accessed 2/29/12 at: <http://www.publichealthsystems.org/cphssr/Research/PHSSR_Research_Agenda>

National Network for State and Local Health Surveys. UCLA Center for Health Policy Research. Accessed 2/29/12 at: <http://healthpolicy.ucla.edu/NewsReleaseDetails.aspx?id=89>

National Indicators Warehouse. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Accessed 2/29/12 at: <http://www.healthindicators.gov/>

Handy, Susan. “Critical Assessment of the Literature on the Relationships Among Transportation, Land Use, and Physical Activity.” TRB Special Report 282, prepared for the Transportation Research Board and the Institute of Medicine Committee on Physical Activity, Health, Transportation, and Land Use. <http://onlinepubs.trb.org/onlinepubs/archive/downloads/sr282papers/sr282Handy.pdf>

Bartuska TJ. “The Built Environment: Definition and Scope.” Part One, Chapter One, from “The Built Environment: A Collaborative Inquiry into Design, and Planning,” 2nd Edition, Wiley Publishing, 2007