REPORT OF THE
JOINT SUBCOMMITTEE ON

Studying Means of Reducing Preventable Death and Disability in the Commonwealth and Examining the Feasibility of Implementing a Comprehensive Prevention Plan in Virginia

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 58

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EXECUTIVE SUMMARY

AUTHORITY AND STUDY OBJECTIVES

Adopted by the 1990 Session of the General Assembly, House Joint Resolution No. 179 established a joint subcommittee to study means of reducing preventable death and disability and to examine the feasibility of implementing a comprehensive prevention plan in the Commonwealth. The Committee was directed to consider a number of specific issues regarding social and economic costs to the Commonwealth arising from preventable and premature deaths, disability, and lost productivity due to health risk behaviors. The Committee's work focused on specific state and national data reflecting the impact of certain lifestyle behaviors on health and longevity. In addition, the Committee explored the need for a comprehensive prevention plan as well as the roles of those state agencies charged with the development of a statewide prevention plan. The research and recommendations of state and federal agencies, the health care community, and the Virginia Council on Coordinating Prevention, as well as prevention alternatives implemented by sister states, also merited the Committee's attention.

A RENEWED COMMITMENT TO HEALTH PROMOTION AND DISEASE PREVENTION

Background

The development of health promotion and disease prevention initiatives has increased the average American life expectancy and has spawned a dramatic shift in the pattern of deadly and disabling diseases. Deaths due to acute infectious diseases have dropped sharply, while deaths from chronic diseases, such as heart disease, cancer, and stroke, increased more than 250 percent between 1900 and 1970. Emerging in the medical community is the realization that premature deaths and disabilities from these diseases may be effectively reduced through health promotion and disease prevention.

Reinforced by changes in the overall health care environment, a renewed commitment to prevention seeks to address preventable loss in productivity, spiralling medical costs and insurance rates, and family tragedy. In the Commonwealth, it is estimated that at least 40 percent of lives lost to cardiovascular disease, cancer, liver disease, and automobile accidents in 1988 were directly attributable to unhealthy behaviors such as smoking, alcohol abuse, and lack of exercise. Addressing these lifestyles behaviors through prevention initiatives makes economic and "human" sense.

Federal Efforts and National Objectives

Federal health promotion and disease prevention efforts have become more prominent in recent years, arguably beginning with the Surgeon General's 1964 report on smoking and health. A 1979 report on health promotion and disease prevention more clearly articulated the government's approach to prevention efforts and identified major behavioral risk factors contributing to premature mortality and morbidity. In 1980, an unprecedented 10-year health initiative was adopted by the U.S. Public Health Service as a framework for prevention programs. This initiative did not constitute a federal plan, but challenged both the public and private sectors to develop prevention efforts. The federal government has retained its commitment to developing viable health goals for the nation, having released in late 1990 its objectives for the year 2000. These new national objectives address health promotion, health protection, and preventive services, as well as health disparities among various population groups.

The Commonwealth's Prevention Efforts

The Commonwealth's initial response to the challenges contained in the 1990 national health objectives was characterized by increased efforts to study and explore the unique health needs of Virginians. Prevention issues have been the focus of numerous studies in the last decade, covering nutrition, injury prevention, AIDS, emergency medical services, and the needs of head and spinal cord injured persons. Leading Virginia's health promotion and disease prevention efforts, however, was the 1987 Governor's Task Force on Coordinating Preventive Health, Education and Social Programs, whose recommendations ultimately led to the establishment of the Virginia Council on Coordinating Prevention. Although possessing no regulatory or enforcement authority, the Council is statutorily empowered to make recommendations to the Governor regarding policies, regulations, and funding that will further prevention initiatives.

Central to the Commonwealth's disease prevention and health promotion efforts is the Comprehensive Prevention Plan. Jointly developed biennially by a number of state agencies, the Plan is designed to coordinate state and private efforts to provide a broad prevention agenda for Virginia. The 1990-92 Plan includes nine positive "goal statements" for use by state agencies and the administration as a guide for budget and program planning. Although a seemingly ideal blend of agency cooperation, public and private sector collaboration, and legislative oversight, the Plan and the Council still need a clear mechanism for the implementation and funding of effective prevention measures in the Commonwealth.

CONCLUSIONS AND RECOMMENDATIONS

The Commonwealth's commitment to health promotion and disease prevention is evident in the plethora of programs offered at the state and local levels. Repeatedly the target of governmental study, prevention has been recognized by statute as a valuable tool in reducing unnecessary human suffering and avoiding needless expense. While progress has been made through a number of initiatives, such as school health education, independent living programs for youth and the elderly, community health coalitions, and worksite wellness programs, stable funding and program evaluation are necessary to ensure the continuation of the most effective initiatives. Increased focus on prevention and health promotion in the training of medical professionals, enhancement of data collection to reflect racial and ethnic subgroups, and exploration of insurance packages that incorporate health risk ratings have also been cited as measures warranting examination. The cost-effectiveness and proven success of current initiatives support the continued development, implementation, and evaluation of additional measures that will reduce premature and preventable death and disability.

The Committee makes the following recommendations:

RECOMMENDATION 1:

That patient and community health education be identified as a "core program" within the Department of Health.

RECOMMENDATION 2:

That the Department of Health give greater visibility and support to health promotion and chronic disease and injury prevention initiatives.

RECOMMENDATION 3:

That the Department of Health facilitate an in-depth evaluation of current health education demonstration projects to identify elements for successful implementation of health education and health promotion programs in those agencies receiving funding through the Office of Health Education and Information and that the Department seek additional funding for such evaluation through federal block grants.

RECOMMENDATION 4:

That the Department of Health develop a statewide health promotion initiative to target a major behavioral risk factor and that this proposed initiative be presented to the Council on Coordinating Prevention and the 1992 General Assembly.

RECOMMENDATION 5:

That local health districts be encouraged to form local health services advisory boards with broad representation to assist health districts in the development and implementation of community-based public health objectives and strategies.

RECOMMENDATION 6:

That community health education specialist positions be funded as full-time state employees within each local health district's budget and that these employees serve as a members of local district management teams under the supervision of the local health director.

RECOMMENDATION 7:

That the Commission on Health Care for All Virginians include in its study an examination of health promotion efforts, particularly those at the worksite, and their overall effectiveness and utility as cost containment measures.

RECOMMENDATION 8:

That the Commonwealth establish a $900,000 small grants program, to be administered by the Department of Health, for application in every health district for the implementation of quality worksite health promotion programs.

RECOMMENDATION 9:

That the Department of Health establish a task force to develop a plan for the delivery of worksite health promotion information and services to small and large employers.

RECOMMENDATION 10:

That the Department of Personnel and Training undertake a demonstration project that evaluates the feasibility and potential cost benefits of providing risk-rated health insurance for all state employees and retirees.

RECOMMENDATION 11:

That the Department of Health (Bureau of Vital Statistics) coordinate with sister states to explore the efficacy of modifying current death certificate forms to require information on behavioral risk factor history.

RECOMMENDATION 12:

That the Department of Health study the feasibility of refining its analysis and collection of vital statistics data to include the more specific presentation of racial and ethnic data.

RECOMMENDATION 13:

That the Department of Health develop methods of securing and utilizing existing data sources, such as hospital, public care and emergency care discharge data, and other sources of health information as part of a pilot project morbidity index sampling system.

RECOMMENDATION 14:

That the Minority Health Advisory Committee develop long-range minority initiatives in state health and human services and that the Department of Health continue its efforts to provide necessary staff support to assist the Advisory Committee.

RECOMMENDATION 15:

That the Department of Education study current school health education programs, including present curricula requirements and instructor qualifications and training, and the efficacy and appropriateness of adopting a comprehensive approach to school health education.

RECOMMENDATION 16:

That incentives be developed to encourage the Commonwealth's medical schools to increase emphasis on primary care, health promotion, and disease prevention in the curriculum and training requirements for health care professionals.

RECOMMENDATION 17:

That additional funding be provided to ensure the ongoing focus and coordination of injury prevention within the Department of Health.

RECOMMENDATION 18:

That the Code of Virginia be revised to make seat belt non-use a violation reportable to the Division of Motor Vehicles for the assignment of demerit points and that the traffic violation form be amended to require information on seat belt use.

RECOMMENDATION 19:

That the Department of Public Safety increase its public education efforts regarding injury and accident prevention, including seat belt and child safety seat use.

RECOMMENDATION 20:

That the Board of Housing and Community Development review current injury prevention initiatives in the Uniform Statewide Building Code and consider specific revisions to incorporate anti-scald requirements for new construction and renovation, stricter safety standards for steps, stairs, curbs, railings, and flooring, and requirements for fencing around residential pools.

RECOMMENDATION 21:

That data collection for the compilation of injury statistics and the description of injury events reflect the preventability of these occurrences and that "injuries" include accidental as well intentional injuries.

RECOMMENDATION 22:

That the joint subcommittee be continued for one additional year to continue its examination of health promotion and disease prevention and to incorporate in its study emphasis on the Comprehensive Prevention Plan and initiatives addressing social services, independent living, and other related concerns.

REPORT OF THE JOINT SUBCOMMITTEE STUDYING MEANS OF REDUCING PREVENTABLE DEATH AND DISABILITY IN THE COMMONWEALTH AND EXAMINING THE FEASIBILITY OF IMPLEMENTING A COMPREHENSIVE PREVENTION PLAN IN VIRGINIA

I. AUTHORITY FOR STUDY

Adopted by the 1990 Session of the General Assembly, House Joint Resolution No. 179 (HJR 179) established a joint subcommittee to study means of reducing preventable death and disability and to examine the feasibility of implementing a comprehensive prevention plan in the Commonwealth. The Committee was comprised of nine members, including four members of the House Committee on Health, Welfare, and Institutions and one member of the House Committee on Appropriations, to be appointed by the Speaker of the House of Delegates, as well as two members of the Senate Committee on Education and Health, one member of the Senate Committee on Finance, and one member of the Senate Committee on Rehabilitation and Social Services, all to be appointed by the Senate Committee on Privileges and Elections.

II. OBJECTIVES AND STUDY DESIGN

Citing the number of preventable premature deaths occurring in the Commonwealth annually, HJR 179 states that many of these deaths can be attributed to "health risk behaviors" which may "increase the risk of heart attack, stroke, and cancer." Because nearly half of the health care claims in Virginia arise from "lifestyle related problems," educating citizens about these health risk behaviors may curb the number of preventable deaths. The increasing burden that support for indigent health care places on the Commonwealth's general fund, together with the millions of dollars of tax revenues lost due to premature deaths, necessitates the examination of "the economic and social ramifications of preventable deaths and injuries." Although several agencies are charged with the responsibility of developing a comprehensive plan for health promotion and disease prevention, the implementation of this plan is not statutorily mandated.

The resolution directed the Committee not only to study means of reducing preventable death and disability and the feasibility of implementing a comprehensive prevention plan, but also to consider a number of specific issues regarding the social and economic costs to the Commonwealth arising from preventable and premature death, disability, and lost productivity due to health risk behaviors. The Committee's study included consideration of the need for a comprehensive prevention plan and an examination of specific national and state data reflecting the relationship between preventable and premature death, disability, lost productivity, and health risk behaviors. Also reviewed were the roles of those state agencies charged with the development of a statewide prevention plan. In addition, the research and recommendations of state and federal agencies, the health care and medical communities, and the Virginia Council on Coordinating Prevention, as well as prevention initiatives in other states, warranted the Committee's consideration.

III. A RENEWED COMMITMENT TO HEALTH PROMOTION AND DISEASE PREVENTION

Although improving public health through disease prevention and health promotion measures is often perceived as a "modern" ideal, the concept may actually be traced to ancient times.[1] Sanitation was a concern for the ancient Romans, who are credited with developing water works and sewers. The quarantine of disease-carrying ships enforced during the Crusades and

1. L. Breslow, "A Health Promotion Primer for the 1990's," Health Affairs 6 at 7 (Summer 1990) [hereinafter referred to as Breslow].

was later embraced within English statutory and common laws. In America, preservation of public health was initially within the states' police power under the Constitution.[2]

Historically, public health measures have been driven by the need to control communicable diseases. Turn-of-the-century strategies to combat infectious diseases such as tuberculosis, diphtheria, or influenza included sanitation efforts, vaccines, and mass immunizations. The increased life expectancy Americans may enjoy today is the result not only of medical breakthroughs but also preventive measures in better nutrition, improved sanitation, and the pasteurization of milk.[3] Advances in medical cures and preventive efforts have spawned a dramatic shift in the pattern of deadly and disabling diseases. While the number of deaths attributable to acute infectious disease dropped sharply, deaths due to major chronic diseases--heart disease, cancer, stroke--increased more than 250 percent between 1900 and 1970.[4] Health experts agree that attention must now focus on "epidemic diseases generated by twentieth-century patterns of living: coronary heart disease, lung cancer, and other noncommunicable diseases."[5] Emerging in the medical community is the realization that deaths and disabilities from these diseases may be effectively reduced through health promotion and disease prevention.

This renewed commitment to disease prevention and health promotion has arguably been reinforced by changes in the overall health care environment. Spiralling health care costs and rising insurance premiums have strained budgets in the public and private sectors. By the year 2000, health care costs are expected to comprise 15 percent of the Gross National Product.[6] Hoping to reduce employee absenteeism, increase productivity, and stabilize insurance rates, the business community has urged greater emphasis on prevention.[7] Escalating expenditures for indigent care have challenged federal and state governments to develop cost-effective alternatives which focus on disease prevention and health promotion. In Virginia, the Medicaid budget now exceeds $1 billion a year; in the last five years, general fund appropriations for Medicaid have increased 103 percent.[8]

Accompanying the emphasis on health promotion and disease prevention is "the discovery that major diseases in industrialized society . . . emerge largely from the conditions of life and the

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2. E. Richards, "The Jurisprudence of Prevention: The Right of Societal Self-Defense Against Dangerous Individuals," 16 Hastings Const. L.Q. 329 at 332, 334 (Spring 1989).

3. U.S. Department of Health, Education, and Welfare, Public Health Service, Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention 1979 at *vii* (July 1979) (hereinafter referred to as Healthy People). In 1987, the average life expectancy at birth was 75 years. According to the National Center for Health statistics, this figure represents "the average number of years that a group of infants would live if they were to experience throughout life the age-specific death rates prevailing in 1987." The average life expectancies for men and women were 71.5 and 78.4, respectively, while the black population life expectancy was 69.4 years. U.S. Department of Health and Human Services, Centers for Disease Control, "Advance Report of Final Mortality Statistics 1987," Monthly Vital Statistics Report at 3, 4 (September 26, 1989) [hereinafter referred to as Mortality Statistics 1987].

4. Healthy People, supra note 3, at *vii*.

5. Breslow, supra note 1, at 7.

6. Interim Report of the Joint Subcommittee on Health Care for All Virginians, Senate Document No. 35 at 13 (1990) [hereinafter referred to as Senate Document No. 35].

7. Breslow, supra note 1, at 9. See also, Macro Systems, Inc., Obtaining Sources for Prevention: A Michigan Case Study at 2 (January 1990) (hereinafter referred to as Michigan Case Study).

8. Senate Document No. 35, supra note 6, at 35. About half of Virginia's Medicaid budget is funded by the federal government; however, the federal matching share has decreased from 57% to 50% in the last decade.

ways people cope with those conditions."[9] Scholars have characterized the availability of excess calories, alcohol, tobacco, and physical ease as "common conditions" of life in twentieth-century America; the link between these "conditions" or lifestyles choices and health and mortality may well be evidenced in the leading causes of death and disability in the United States and in Virginia.[10] Cardiovascular disease, cancer, and injuries are often linked to health risk behaviors which are preventable and controllable.[11] In the Commonwealth, it is estimated that at least 40 percent of lives lost to cardiovascular disease, cancer, liver disease, and automobile accidents in 1988 were "directly attributable" to unhealthy behaviors such as smoking, alcohol abuse, and lack of exercise.[12]

Preventable premature deaths and disabilities have a tragic and profound impact on families and communities, resulting in lost wages and productivity, reduced tax revenues, and overuse of health care benefits.[13] Reducing these preventable deaths and disabilities requires recognition that "current patterns of illness and death cannot be altered by biomedical science alone."[14] Effective health promotion and disease prevention measures, health experts contend, may combine community and personal efforts by "focusing on the process of enabling individuals, through social action, to 'take control' of their own health."[15] A renewed commitment to developing and implementing effective health promotion and disease prevention initiatives "make[s] both human and economic sense . . . to enhance national vitality and significantly reduce preventable suffering and costs."[16] In meeting the charge of HJR 179, the Committee reviewed the social and economic costs of health risk behaviors and preventable death and disability and examined federal and state initiatives focusing on health promotion and disease prevention.

IV. FEDERAL EFFORTS: DEVELOPING NATIONAL OBJECTIVES

Although federal health promotion and disease prevention initiatives have become more prominent in recent years, periodic assessments of American health occurred as early as the late eighteenth and mid-nineteenth centuries.[17] Renewed national efforts, however, arguably began in 1964, with the issuance of the Surgeon General's Report on Smoking and Health. This seminal report documented the "critical link" between smoking and a number of fatal or disabling diseases. The federal government's new approach to prevention was clearly articulated 15 years later in the 1979 Surgeon General's Report on Health Promotion and Disease Prevention. Entitled Healthy People, this report called for "individual discipline and political will" to address preventable death

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9. Breslow, supra note 1, at 10.

10. Id.

11. Mortality Statistics 1987, supra note 3, at 1; see also, Health Promotion and Education Council of Virginia, Virginia Prospers: 1990 General Assembly Fact Sheet [hereinafter referred to as Virginia Prospers]. Cardiovascular disease typically includes heart disease and stroke.

12. Virginia Department of Health, Virginia's Health Risks--1990 [hereinafter referred to at Virginia's Health Risks].

13. Id.

14. J. Mason, "A Prevention Policy Framework for the Nation," Health Affairs 22 at 23 (Summer 1990) [hereinafter referred to as Mason].

15. Breslow, supra note 1, at 11.

16. Mason, supra note 14, at 27.

17. U.S. Department of Health and Human Services, Public Health Service, Office of Disease Prevention and Health Promotion, The 1990 Health Objectives for the Nation: A Midcourse Review at 1 (November 1986) [hereinafter referred to as Midcourse Review].

and disability and touted prevention as "an idea whose time has come."[18] The report identified smoking, alcohol and drug use, occupational risks, and injuries as "major risk factors responsible for most of the premature morbidity and mortality in this country" and specified priorities and measurable goals "to enhance both individual and national perspectives on prevention."[19]

A 1980 companion report, Promoting Health/Preventing Disease: Objectives for the Nation, offered an unprecedented 10-year health initiative and contained 226 measurable targets for health improvement in 15 "priority areas." This document addressed issues as diverse as nutrition, fitness, smoking, substance abuse, family planning, and injury prevention. Significantly, the U.S. Public Health Services adopted these goals as "the principal preventive health framework and as a management tool to direct programs."[20] Although not constituting a federal plan, the 1990 objectives were intended to be national in scope, challenging the public and private sectors and sparking a "surge of innovation" at the state and local levels.[21]

Although a final assessment of the success of the 1990 national preventive health objectives is not yet available,[22] the federal government has continued its 10-year objectives pattern, having issued a conference report on health goals for the year 2000. The report establishes three broad goals: to increase the span of healthy life, to reduce "health disparities" among population groups, and to provide access to preventive services for all Americans. Within these goals, 22 priority areas have been established to address health promotion, health protection, and preventive services. Reflecting the importance of data evaluation and monitoring, a priority area has also been established for surveillance systems. Specific priorities have been established for various age groups. Designed to provide quantifiable targets that are linked to the 1990 objectives, the Year 2000 Objectives were intended to reach a broad audience and to be compatible with current goals adopted by federal agencies and health organizations.[23]

Providing guidance for "what is to be achieved at a national level,"[24] the Year 2000 Objectives were expected to be finalized and released in late 1990. The success of these objectives, however, rests largely with the states. This shared obligation for public health may well reflect

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18. Healthy People, supra note 3, at 9, *vii*, 7; see also, Michigan Study, supra note 7, at 2.

19. Healthy People, supra note 3, at 9, 11.

20. Mason, supra note 14, at 23-25. The fifteen priority areas included preventive services such as high blood pressure control, family planning, pregnancy and infant health, immunization, and sexually transmitted diseases. Health protection targets included occupational safety and health, dental health, accident and injury prevention, and toxic agent and radiation control. Promotion priorities focused on smoking, nutrition, stress, and substance abuse. Midcourse Review, supra note 17, at 2.

21. Midcourse Review, supra note 17, at 1, 4. A midcourse review, published in 1986, showed that only 60 of the original 226 objectives appeared unlikely to be reached by 1990, and that only eight were moving in a negative direction.

22. Mason, supra note 14, at 24. Final data reflecting progress made under the 1990 objectives are expected in 1991-1992.

23. Division of Legislative Services, Staff Memorandum, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (October 29, 1990). A draft version, Promoting Health/Preventing Disease: Year 2000 Objectives of the Nation, had been released in September 1989 for review and comment.

24. U.S. Department of Health and Human Services, Public Health Service, Office of Disease Prevention and Health Promotion, ODPHP Director's Report (January 1990), and U.S. Department of Health and Human services, Public Health Service, Healthy People 2000 Fact Sheet (August 9, 1990) [hereinafter referred to as 2000 Fact Sheet].

"the strong foundation of federalism that undergirds the American public health system by involving both private and public sectors at all levels."[25] Aided by federal guidelines and resources, the states and communities must develop their own priorities and implementation plans to meet unique local needs.[26]

V. MEETING THE FEDERAL CHALLENGE TO THE STATES: THE COMMONWEALTH'S RESPONSE

Early Efforts

The Commonwealth's response to the federal challenges established in the 1990 health objectives was initially characterized by increased efforts to review and explore the unique health needs of Virginians. Over the last 10 years, prevention issues have been the focus of numerous legislative and executive agency studies. The value of nutrition in enhancing health and reducing medical and dental costs was recognized in the Program on Food and Nutrition; although the Program faltered in 1986, nutrition counseling surfaced in other prevention efforts.[27] In 1987, the Report by the Secretary of Human Resources on the Health Needs of School-Age Children urged increased emphasis on disease and injury prevention and health promotion programs. Among the prevention measures cited by the report were nutrition education, physical fitness, family life education, dental care, and psychological counseling. Alcohol and drug abuse and teen pregnancy have also been specifically targeted for their role in the "new morbidity" of Virginia youth.[28]

Reviewed in another report were the Commonwealth's AIDS-related disease control measures and the efforts of the AIDS Medical Advisory Committee, appointed in 1985 to advise the Health Commission regarding the most effective control measures.[29] The Governor's 1988 Task Force on Indigent Care encouraged additional funding of prevention programs, rather than a transfer or redirection of funds from restorative programs. The Task Force noted that "from an economic as well as a humane perspective, preventive health measures are sound investments when compared to the extensive costs of curative treatment and rehabilitation."[30] Prevention issues have continued to surface in a number of recent studies on topics as diverse as AIDS, emergency medical services, and the needs of head and spinal cord injured persons.[31]

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25. Mason, supra note 14, at 28.

26. Id. at 23.

27. Final Report of the Program on Food and Nutrition, Senate Document No. 3 at 1, 2 (1987). The Program, established in 1982, was terminated due to lack of funding.

28. Report of the Secretary of Human Resources: The Health Needs of School-Age Children, Senate Document No. 22 at *vii, vi* (1987).

29. Report of the Secretary of Human Resources on Senate Joint Resolution 90, Senate Document No. 4 at 7, 11 (1987).

30. Report of the Governor's Task Force on Indigent Health Care, Senate Document No. 11 at 19, 20 (1988) [hereinafter referred to as Senate Document No. 11].

31. A legislative joint subcommittee studying human immunodeficiency virus was established in 1988 by HJR 31 and SJR 28, and has been continued by HJR 431 (1989) and HJR 129 (1990). The needs of head and spinal cord injured persons were reviewed by a joint subcommittee established by HJR 135 in 1988 and continued in 1989 by HJR 287. A joint subcommittee of members of the House Committees on Health, Welfare and Institutions and Counties, Cities and Towns and the Senate Committees on Education and Health and Local Government have studied emergency medical services personnel pursuant to HJR 134 (1988) and SJR 86 (1988).

Spearheading Virginia's health promotion and disease prevention initiatives was the work of the 1987 Governor's Task Force on Coordinating Preventive Health, Education and Social Programs. Under the direction of the Secretary of Human Resources, the Task Force was comprised of the Commissioners of the Departments of Health, of Mental Health and Mental Retardation, and of Social Services; the Directors of the Departments of Corrections, for Children, of Criminal Justice Services, for the Aging, and of Medical Assistance Services; and the Superintendents of Public Instruction and Correctional Education. The Task Force reviewed ongoing state programs which included prevention as a goal, and cited the development of personal skills, early screening, research, training and education, and legislation as key prevention strategies for the Commonwealth.[32]

Guided by the premise that "prevention is a responsibility and a necessary function of all levels of government," the Task Force recommended the creation of a special council not only to provide the direction necessary to coordinate the development and implementation of governmental prevention initiatives, but also to ensure that these measures complement private sector prevention efforts. The existence of a coordinating entity might facilitate the strategic planning, agency cooperation, and collection of public and private resources necessary for the development of effective prevention programs.[33]

The Virginia Council on Coordinating Prevention and the Comprehensive Prevention Plan

As a result of the Task Force recommendations, the 1987 General Assembly established the Virginia Council on Coordinating Prevention, consisting of representatives from the governing or advisory boards of a number of agencies, five citizens "interested in prevention," and the Secretary of Health and Human Resources as an *ex officio* member.[34] Possessing no independent regulatory or enforcement authority, the Council is statutorily empowered to make recommendations to the Governor regarding policies, legislation, regulations, and funding furthering Council purposes as well as local prevention programs. The Council is expressly charged to consider prevention activities "which promote the maximum independence of individuals and strengthen families; which avoid or minimize physical or mental disability or dysfunction; which reduce the likelihood of dependency on governmental and private sector support, treatment and rehabilitative services; and which encourage future cost savings through early intervention or treatment."[35]

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32. Report of the Governor's Task Force on Coordinating Preventive Health, Education and Social Programs, House Document No. 5 at 3, 9, 10 (1987) [hereinafter referred to as House Document No. 5]; see also, Senate Document No. 11, supra note 30, at 18. At the time of the Task Force Report, there were 105 state government programs which included prevention goals; about one-fourth of these programs were directed at improving personal health.

33. House Document No. 5, supra note 32, at 25, 26, 1.

34. Va. Code § 9-268 (1990 Supp.). The statute provides for "one member each" from the Advisory Boards for the Departments for the Aging, for Children, and of Volunteerism; the Boards of Correctional Education, Corrections, Youth and Family Services, Criminal Justice Services, Education, Health, Medical Assistance Services, Mental Health, Mental Retardation and Substance Abuse Services, for Rights of Virginians with Disabilities, and Social Services; the Council on Child Day Care and Early Childhood Programs; and the Council on the Status of Women. Each of these representatives is approved by the chairman of the respective board or council. Citizen members are appointed by the Governor.

35. Va. Code § 9-270 (1990 Supp.).

Central to the Commonwealth's disease prevention and health promotion efforts is the Comprehensive Prevention Plan. Jointly developed biennially by a number of specified agencies, the Plan was conceived to coordinate state and private efforts, ultimately to provide "a broad prevention agenda for the Commonwealth . . . ." Leadership in Plan development is provided by an agency designated by the Secretary of Health and Human Resources. The Plan is to include prevention goals and objectives as well as public and private strategies. Prior to implementation, the Plan, including a cost analysis of proposed strategies, is reviewed by the House Committee on Health, Welfare and Institutions and the Senate Committees on Rehabilitation and Social Services and Education and Health.[36]

The 1990-92 Comprehensive Prevention Plan for Virginia includes nine positive "goal statements," which were "intentionally broad in the hope that they will be the basis for planning well into the 21st century." (See page 8). The Council recommended that the Plan and its goals be used by state agencies and the administration as a guide for program and budget planning and as a yardstick to measure progress toward prevention objectives. The Plan's goals target a wide range of ideas, from healthy lifestyles and responsible parenthood to gainful employment and literacy. Within each goal are specific priorities containing measurable objectives. (See Appendix).[37] By focusing not only on state level programming, but also on local and private sector initiatives, the 1990-92 Plan recognizes that "the true spirit of prevention is reflected in the unique partnerships that are formed on both the state and local levels and with the private sector to pool existing resources for maximum benefits."[38]

Progress and Challenges in Virginia's Prevention Efforts

Although a seemingly ideal blend of agency cooperation, public and private sector collaboration, and legislative oversight, the Comprehensive Prevention Plan and the Council on Coordinating Prevention still need a clear mechanism for the implementation and funding of effective prevention measures in the Commonwealth. Studies indicate that 36 premature deaths occur daily in the Commonwealth; it is estimated that one-third of these deaths are preventable.[39] While these statistics present a grim reminder of the challenges to be addressed by Virginia's prevention initiatives, the Council has cited improvements in several objectives.[40] In assessing health promotion and disease prevention measures and the feasibility of implementing a

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36. Va. Code § 9-271 (1990 Supp.). The agencies charged with jointly developing the plan have representatives on the Council for Coordinating Prevention.

37. 1990-92 Comprehensive Prevention Plan for Virginia and Report of the Virginia Council on Coordinating Prevention at *i*, *iii*, 3, 1, 64, 72 (1989) [hereinafter referred to as 1990-92 Plan]. To avoid duplication of efforts, a "lead" agency was designated under each objective to coordinate the development of an implementation plan. The Plan contemplates the development of a Model Prevention Program to assist communities in the implementation of effective programs and to provide grant funds. The Model Program would include a guide identifying effective prevention programs and would focus on preparation for parenthood programs, family life education for institutionalized and special needs youth, peer relationship and career development programs, and family communications programs. The Plan also identifies private organizations presently addressing Plan objectives.

38. House Document No. 5, supra note 32, at 4.

39. Virginia Prospers, supra note 11. Premature deaths are described as those occurring between ages 20-64.

40. See generally, Virginia Council on Coordinating Prevention, Status Report on Progress Toward Meeting the Goals of the 1990-92 Comprehensive Prevention Plan (DRAFT) (1990) [hereinafter referred to as Status Report].

GOALS OF THE VIRGINIA COUNCIL ON COORDINATING PREVENTION 1990-92

HEALTHY LIFE STYLES

To promote mentally and physically healthy life styles for all Virginians by providing accessible, affordable, quality community based programs which encourage individuals to set goals and make decisions that result in good health and well-being.

RESPONSIBLE PARENTHOOD

To enhance the ability of individuals to make responsible decisions about becoming parents, as well as focus on the social and economic responsibilities of parenthood through interagency coordination of educational and support programs which stress positive parenting abilities, skills and behaviors.

HEALTHY MOTHERS AND BABIES

To assure the optimum health and well-being of all babies and their mothers through the promotion of educational, psychosocial and nutritional services that include screening for medical risks for women (prior to pregnancy, during pregnancy and after delivery) and their infants; and through provision of accessible, affordable, quality, multidisciplinary care.

POSITIVE CHILD DEVELOPMENT

To promote the development of positive family and community environments in which children can acquire appropriate social skills and optimum education and can be assured of accessible and affordable physical care, mental health care and child care.

POSITIVE YOUTH DEVELOPMENT

To promote policies, conditions, and practices that enable youth to pursue healthy and productive lives, experience socially desirable roles, develop positive self concepts, and increase their sense of personal responsibility and independence.

POSITIVE FAMILY LIFE

To promote the stability and strength of families by the development of programs within communities which enhance positive family relationships, economic stability and community involvement.

GAINFUL EMPLOYMENT AND LITERACY

To provide appropriate educational and employment training programs for individuals throughout their lifetimes which promote literacy and productive employment, so that all Virginians may be contributing members of their community.

INDEPENDENT LIVING

To promote the ability and accessibility of community services and environments which increase the ability of individuals to achieve and maintain independence and self sufficiency.

SAFE ENVIRONMENT

To promote policies, conditions and practices the recognize the need to create a safe and healthful environment for all Virginians.

Source: 1990-92 Comprehensive Prevention Plan for Virginia and Report of the Council on Coordinating Prevention (1989).

comprehensive prevention plan, the Committee attempted to balance its consideration of continuing challenges to public health with recognition of progress realized through current prevention efforts.

• *School Health Education*

The Commonwealth has made progress in the promotion of healthy lifestyles through a number of public school initiatives. Physical and health education, as well as accident prevention, are already a required part of the public school curriculum.[41] School-based programs for substance abuse prevention also provide important information for young people.[42] Fluoridation is promoted though elementary school "rinse programs."[43] Although these prevention initiatives have already seen positive results, testimony before the Committee indicated a need for a "comprehensive " approach to health education in the public schools. Presenting health issues in a planned, sequential approach, a comprehensive, interdisciplinary program might demonstrate the pervasiveness of health concerns in everyday existence. Because many of the leading causes of death are behavior-linked, reinforcing and enhancing healthy behaviors, skills, and attitudes among young persons are especially important.[44]

• *Worksite Wellness Programs*

Offering additional opportunities for the promotion of health education and prevention services, worksite wellness programs improve the overall health of the workforce, reduce the risk of premature disability and death, and enhance employee mental health. Key concerns in worksite health promotion programs include the identification of health care utilization trends for high and low risk individuals, the correlation between a particular risk factor and the incidence of disease, and the promotion of those interventions having the greatest positive impact on health care trends. Cost-savings are also an important benefit of these programs, as demand for health care is reduced. Responding to increased insurance premiums for state employee health coverage, more than half of all states have developed some form of wellness activity for their employees. In the Commonwealth, the Department of Personnel and Training has already instituted a pilot wellness program, CommonHealth, in which over 190 agencies across Virginia participate. Now in its fourth year, CommonHealth is a comprehensive health promotion program, including onsite screening services, consideration of utilization practices, and health-risk appraisals.

Although 65 percent of all worksites employing 50 or more people already support at least one health promotion activity, testimony before the Committee indicated that the establishment of a grants program for quality worksite health promotion programs might encourage the expansion of wellness activities in the private sector. Programs eligible for grants might target behavioral risk factors and integrate program evaluation, health education, and medical screening. Proponents of worksite wellness programs have also suggested the creation of tax benefits for businesses having

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41. Va. Code §§ 22.1-207; 22.1-204 (1985). Required in one or more elementary or secondary grades in every school division is a course of study including"elementary training in accident prevention in proper conduct on streets and highways, ... and in ways and means of preventing loss of lives and damage to property through preventable fires."

42. Status Report, supra note 40, at 1.

43. "Fluoridation Stretches Resources," Prevention Block Grant News (May 1990). It is estimated that the Division of Dental Health has saved $50 in dental bills for every $1 spent on fluoridation.

44. Minutes, November 12, 1990, Committee meeting.

wellness programs and the development of a clearinghouse within the Department of Health (DOH) to provide information regarding model worksite health programs.[45]

• *Community Health Education*

Health promotion and disease prevention efforts need not be limited to the school or workplace. Successful community coalitions operate on a volunteer basis in a number of Virginia localities, performing services ranging from cholesterol screenings and CPR training to minority outreach programs and health promotion education. Because community and patient health promotion education are not among DOH's mandated programs and services, the efforts of local volunteer groups are especially vital to the survival of many health education programs. Community health education specialists, employed by only a few local health departments, have promoted the development of community coalitions and may also assist smaller businesses in the establishment of worksite health programs. [46]

• *Injury Prevention*

Injuries are the leading cause of death in individuals under the age of 44; indirect and direct costs associated with injuries were estimated to be $180 billion in 1988.[47] Safety belt and child restraint device laws notwithstanding, deaths in car accidents for children under age four quadrupled in the first six months of 1990, compared with the same period in 1989.[48] Reducing the preventable deaths and disabilities resulting from injury requires the successful coordination of state, local, and private sector efforts.

The Commonwealth's injury prevention efforts, largely the responsibility of the Division of Emergency Services within DOH, are primarily supported through federal preventive health and health services block grants and through the federal highway safety program. Evaluation of current injury prevention programs is aided by a statewide trauma registry, created in 1987 to collect from all acute care hospitals data regarding admissions due to injuries. In addition, a statewide injury prevention committee addresses public and private sector efforts and has developed an injury prevention resource directory. Repeated testimony before the Committee confirmed the need for a stable funding source for these initiatives and for increased public awareness of the "preventability" of injuries. [49]

• *Training for Health Care Professionals*

Although the role of health care professionals in promoting health and preventing disease may be evident, curriculum requirements in medical schools often do not reflect the importance of training in health promotion. While prevention issues, such as behavioral factors, nutrition, risk appraisal, accident prevention, immunizations, and prenatal care, may surface in clerkships, prevention and health promotion may not receive concentrated focus within medical school

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45. Minutes, November 12, 1990, and December 18, 1990, Committee meetings.

46. Minutes, November 12, 1990, Committee meeting.

47. Minutes, November 12, 1990, Committee meeting.

48. Virginia's Health Risks, supra note 12; R. Sullivan, "Car crash fatalities quadruple--Non-use, misuse of safety seats cited in children's deaths," Richmond Times-Dispatch B-1 (July 15, 1990); see also, Va. Code §§ 46.2-1094; 46.2-1095 (1989).

49. "Injury--prevention is the Key," Prevention Block Grant News (May 1990). See also, Minutes, November 12, 1990, Committee meeting.

curriculum. To facilitate the inclusion of these issues in health care training and educational policies, incentives, rather than mandates, might be developed that enhance cooperation among medical schools, hospitals, and health departments.[50]

• *Minority Health*

That a disproportionately high number of racial and ethnic minorities are victims of the leading causes of death and disability is evidenced in a number of national and state studies. Disparities in the incidence of homicide, cancer, stroke, hypertension, and diabetes may be attributable to socio-economic factors as well as other concerns. Focus on population groups bearing a disproportionate share of preventable death and disease is considered "especially critical," as these groups appear to be growing faster than the population as a whole.[51] Addressing these concerns in the Commonwealth is the Minority Health Advisory Committee, whose threefold mission includes the examination and improvement of minority health data collection, the interpretation of data to determine the reasons for health disparities, and the development of recommendations to eliminate these disparities. Refinement of data collection, analysis, and reporting of vital statistics to facilitate the presentation of data in specific racial and ethnic subgroups would also enhance the development of effective health initiatives to reduce preventable deaths and disabilities in minority populations.[52]

• *Independent Living*

Initiatives addressing the independence and self-sufficiency of youth and the elderly are a critical component of any health promotion and prevention plan. The federal Independent Living Initiative, established in the mid-1980s, was designed to help states develop programs to assist older adolescents in foster care. Because these children statistically are more likely to demonstrate low self-esteem and poor academic performance, to drop out of school, and to require public assistance, specific programs are necessary to provide education, training, employment opportunities, and personal and social development services for these young people. Since 1986, the Virginia Department of Social Services has received nearly $4.5 million in federal funds for its independent living initiatives; current grants will provide independent living services for about 1,200 teens. Alternatives to costly institutional care, such as early intervention efforts, are being explored.[53]

Initiatives promoting the independence of the elderly may target the "compression of morbidity," or extending years of healthy life. Testimony before the Committee confirmed that health maintenance and surveillance for older citizens are more effective when offered in a comprehensive, integrated system at a single location. Current efforts by the Department of Social Services seek to enable persons to remain in their homes rather than receive care in a more restrictive environment. The Department's Adult Services Program is designed to prevent abuse, neglect, and exploitation of the elderly and incapacitated and to ensure the most appropriate, least restrictive placement for individuals requiring care outside the home. Components of the program include case management and assessment, in-home and community-based services, and placement and protective services. In addition, services are available for persons released from institutions and re-entering the community. Funding for adult services is derived from the federal Social Services Block Grant, state appropriations for home- and community-based services, and local

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50. Minutes, December 4, 1990, Committee meeting.

51. 2000 Fact Sheet, supra note 24; see also, Minutes, December 4, 1990, Committee meeting.

52. Minutes, December 4, 1990, Committee meeting.

53. Minutes, November 12, 1990, Committee meeting.

governments. Possible future directions for the Program include emphasis on streamlining in the case management process, increased utilization of families as the primary resource in the delivery of family-based services, and continuing home- and community-based care.[54]

• *Health Insurance*

Although health promotion is not currently part of the "mainstream" corporate activity, the insurance industry may benefit greatly from the promotion of prevention and health education efforts. Studies indicate that, between 1990 and 1995, one-half of Fortune 500 companies will spend their entire projected after-tax profit on increasing health care costs. Documented correlations between healthy lifestyles and health care costs have encouraged some insurers to consider the development of risk-rated insurance. In 1988, the National Association of Insurance Commissioners adopted a model regulation that would condition licensing of insureds upon the provision of "significant economic incentives" to encourage insureds to practice healthy lifestyle behaviors. The model regulations address the establishment of economic disincentives and penalties for insureds who incorrectly certify participation in healthy lifestyles and the provision of benefits for appropriate health screenings and adult immunizations. Only Delaware has adopted legislation reflecting this model.

Insurance discounts for no tobacco use and other healthy lifestyles are available already through certain insurers. Also available are benefit enhancement packages for individuals whose health risk appraisal indicates a "health age" below that of their actual age. Financial penalties are included in some insurance policies; state employees in Kansas and Colorado must pay an additional fee for insurance if they are smokers. Inaccurate reporting in health measurements and assessments and the potentially discriminatory impact of risk-rating, however, remain challenges in the development of effective risk-rated insurance. The development of risk-rated insurance based on measurable cost- and lifestyle-related criteria, such as smoking, weight, and measured blood pressure and cholesterol levels, and funded as a pilot project for state employees merits further exploration as an effective health promotion measure.[55]

• *Support for Health Promotion and Disease Prevention*

Funding for prevention initiatives has been provided through a number of federal grant programs. The Health Education Risk Reduction Grants Program (HERR), initiated in 1980, is managed by the Centers for Disease Control and assists state health departments in the organization and delivery of local health promotion programs.[56] The Preventive Health and Health Services Block Grant, created in 1981, combined several public health programs to provide states with

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54. Minutes, November 12, 1990, and December 18, 1990, Committee meetings. The typical adult services client is female, between the ages of 70 and 79, widowed and living alone, and is partially dependent on others for assistance in daily activities. In fiscal year 1990, local departments of social services investigated 5,690 reports of abuse, neglect, or exploitation of elderly and incapacitated adults. Persons seeking adult services must meet certain income and other eligibility criteria.

55. Minutes, December 12, 1990, Committee meeting.

56. Michigan Study, supra note 7, at 2.

funds to "reduce preventable morbidity and mortality and to improve the quality of life."[57] These Prevention Block Grants were designed to allow the states a degree of flexibility in establishing and adjusting prevention priorities.[58] Also available to the states are a variety of federal project grants for the prevention and control of tuberculosis, sexually transmitted diseases, and substance abuse.[59]

Although many of the Commonwealth's prevention initiatives are federally funded through the Prevention Block Grant or HERR programs,[60] the continuation of legislative and executive health promotion efforts is contingent upon adequate funding. While those agencies responsible for the development of the Comprehensive Prevention Plan are statutorily directed to include in the planning process for prevention initiatives "an analysis of their prevention component or potential and their potential impact on budgetary requests," no direct funding for agency or Council prevention initiatives appears in the Appropriations Act.[61] In addition, these agencies are directed to "set funding priorities" and guidelines for the Community Prevention Initiative Grants Program, which is to provide grants to localities for programs to prevent substance abuse, delinquency, and other behaviors and conditions. This Grants Program is, of course dependent upon "such funds as may be appropriated for this purpose".[62] The Council has also requested a "mechanism and defined policy for joint funding efforts."[63]

For fiscal year 1991, it is expected that Prevention Block Grants will support health education risk reduction, cardiovascular risk reduction, dental disease prevention, injury prevention, and rape crisis prevention and treatment.[64] Program supporters contend that block grant funds alone, however, are not sufficient to meet the Commonwealth's needs in chronic

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57. U.S.C.A. § 300w et seq. (1982 and West Supp. 1990); see also, H.R. Rep. No. 100-778, 100th Cong., 2nd Sess. at 2, reprinted in [1988] U.S. Code Cong. & Ad. News 4224 at 4224, 4225. Congress amended the Prevention Block Grant program in 1988 to make funds available for elevated serum cholesterol detection and prevention and for community-based programs for the reduction of chronic disease. 42 U.S.C.A . § 300w-3 (West Supp. 1990).

58. H.R. Rep. No. 100-778 100th Cong., 2d Sess. at 2, reprinted in [1988] U.S. Code Cong. & Ad News 4224 at 4225. In the Commonwealth, responsibility for obtaining and administering the Prevention Block Grant lies with the Department of Health. A report on the proposed use of these funds is subject to public review and legislative hearing pursuant to 42 U.S.C.A. § 300w-4 (1987 and Wst Supp. 1990). Revisions are incorporated and the grant application is then submitted to the U.S. Secretary of Health and Human Services. Virginia Department of Health, Preventive Health and Health Services Block Grant Application and Report on Proposed uses of Funds--Fiscal Year 1991 at 1 (1990) [hereinafter referred to as Block Grant Report].

59. 42 U.S.C.A. §§ 247b, 247c, 300x (West Supp. 1990).

60. Block Grant Report, supra note 58, at 9; see also, "Prevention: A Cost-Effective Choice in American Health Care," Prevention Block Grant News (May 1990) [hereinafter referred to as "Cost Effective Choice]. The Division of Health Education has received HERR funds since 1979.

61. Va. Code § 9-272 (1990 Supp.).

62. Va. Code § 9-272.2 (1990 Supp.).

63. 1990-92 Plan, supra note 37, at 88.

64. Testimony before Legislative Public Hearing, PHHS Block Grant FY 1991 Proposals (June 7, 1990). Prevention Block Grant funds support programs in each of Virginia's 36 health districts.

disease control; these federal dollars are sometimes supplemented by local funds and private sector contributions generated by community coalitions.[65]

• *Data Collection*

Repeated testimony before the Committee emphasized that evaluation of health statistics and prevention initiatives is essential to ensure the development and continuation of effective programs.[66] Aiding in the measurement and evaluation of state and national health objectives are a national disease prevention data profile, provided periodically by the U.S. Secretary of Health and Human Services through the National Center of Health Statistics,[67] and the Behavioral Risk Factor Surveillance System (BRFSS), a data base developed by the Centers for Disease Control identifying the prevalence of risk factors contributing to premature death and disability. Experts maintain that the use of measurable objectives will enhance accountability in goal-setting and health policy adjustment.[68]

Assisting in the evaluation and measurement of Virginia's health promotion initiatives and objectives are several innovative computer databases. The Virginia Department of Health implemented the BRFSS in 1989 to track health-related behavioral trends; data obtained will be used to "identify basic health problems in Virginia and to assist in setting priorities for prevention education and programs."[69] Another technological tool, the Population Attributable Risk computer software statistical package (PAR), illustrates the need for health risk prevention efforts by compiling information regarding the impact of certain health risk factors on the vital characteristics of a community. The PAR program, employed by the Virginia Department of Health, estimates lives saved when various risk factors are reduced.[70]

Documenting the beneficial effects of prevention programs will ensure the continued implementation and funding of the most effective programs.[71] The availability of BFRSS and PAR, while invaluable in assessing behavioral trends, may not provide the comparative data necessary to evaluate ongoing programs. While the Council is charged with developing recommendations for the establishment and operation of an information clearinghouse, the

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65. See "Cost-Effective Choice," supra note 60, and "Virginians Fighting Disease," Prevention Block Grant News (May 1990).

66. Minutes, October 30, 1990, and December 4, 1990, Committee meetings.

67. 42 U.S.C.A. § 242p (1982 and West Supp. 1990). The data base, submitted every three years, is to include mortality and morbidity rates for preventable disease as well as physical and behavioral determinants and their relationship to these rates.

68. Block Grant Report, supra note 58, at 5; see also, Mason, supra note 14, at 27. The BRFSS is used by the Commonwealth and 38 sister states to collect data for annual analysis.

69. "System Will Help State Set Priorities," Prevention Block Grant News (May 1990); see also, "Cost-Effective Choice," supra note 60. The BRFSS is funded by a grant from the Centers for Disease Control. Information is gathered through 10-minute telephone interviews with adults regarding health practices and lifestyles behaviors.

70. Virginia Department of Health, Division of Health Education, Population Attributable Risk (PAR)--Virginia Community Estimates at 1.

71. House Document No. 5, supra note 32, at 17.

development of an evaluation mechanism for program effectiveness is not mandated.[72] This need for "collaborative data collection across agency liens" was echoed by the Council in its 1990-92 report.[73]

• *Prevention Initiatives in Other States*

The Commonwealth is not alone in its disease prevention and health promotion endeavors. Guided by the Centers for Disease Control, 46 states had incorporated prevention initiatives "as integral parts of their agendas" by 1987.[74] In Vermont, state departments are requested to include prevention efforts as line items in their budgets. In South Carolina, a Primary Prevention Council coordinates state initiatives.[75] Renewed interest in prevention is also evident in the 1988 Michigan Health Initiative, which created an advisory commission on risk reduction and AIDS to work cooperatively with the Michigan Department of Public Health. Funding for Michigan prevention initiatives is supported by a sales tax on computer software and a cigarette tax. An information clearinghouse and media campaigns to focus public attention on risk reduction and AIDS were also mandated by the Michigan law.[76]

Now entering its fourth year, the North Carolina Statewide Health Promotion Program is operated by local health departments. Funded by federal block grants and state appropriations, these programs emphasize cardiovascular disease, cancer, and injury prevention. A pilot evaluation program has also been developed.[77]

VI. CONCLUSIONS AND RECOMMENDATIONS

The Commonwealth's commitment to health promotion and disease prevention is already evident in the plethora of programs administered at the state and local level. Repeatedly the focus of governmental study, prevention has been recognized in the Code of Virginia as a valuable tool in reducing unnecessary human suffering and avoiding needless expense. Although preliminary reviews indicate progress, a number of challenges remain. Chronic disease, injuries, and premature deaths continue to plague Virginians. While the Council on Coordinating Prevention and certain state agencies are largely responsible for prevention priorities and the Comprehensive Prevention Plan, no clear mechanism exists for the implementation and funding of the Commonwealth's health promotion and disease prevention initiatives.

In pursuing the directives of HJR 179, the Committee sought the input and expertise of the Council on Coordinating Prevention, the Health Promotion and Education Council of Virginia, the

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72. Va. Code § 9-270 (1990 Supp.).

73. 1990-92 Plan, supra note 37, at 88.

74. Mason, supra note 14, at 24.

75. House Document No. 5, supra note 32, at 22, 23.

76. Michigan Study, supra note 7, at 34, 25, 37. See also, Minutes, December 18, 1990, Committee meeting.

77. Minutes, December 4, 1990, Committee meeting. Specific legislation directed the North Carolina health department to identify risk factors and their prevalence among groups, populations, or geographic areas, to establish and administer contracts for the provision of community-based health promotion programs, to provide technical assistance to localities for health promotion and disease prevention, to develop a performance evaluation system for prevention initiatives, and to encourage the participation of volunteers.

Departments of Health and Social Services, representatives of local and private sector prevention initiatives, leaders of prevention programs in other states, and members of the health care and medical communities. Also included in the Committee's review was consideration of the national health objectives, current state and local programs, and funding concerns. The Committee discovered that the development and implementation of health promotion and disease prevention initiatives requires exploration of a wide range of issues, from the appropriate responsibilities of state and local governments, the private sector, and individuals, to the importance of education and evaluation in the delivery of these services. In addition, the Committee found that prevention programs may address not only personal health, but also the development and enhancement of those attitudes and behaviors that support self-sufficiency and independence. The Committee also recognized that health promotion and disease prevention initiatives must target the health needs of all citizens--particularly those that may be disproportionately at risk for poor health status and premature death and disability. The cost-effectiveness and proven success of current initiatives support the continued development, implementation, and evaluation of further measures that will reduce premature and preventable death and disability.

The Committee therefore makes the following recommendations:

RECOMMENDATION 1:

That patient and community health education be identified as a "core program" within the Department of Health.

Including patient and community health education within the Department's statutorily mandated responsibilities will help ensure the continuation of this important initiative.

RECOMMENDATION 2:

That the Department of Health give greater visibility and support to health promotion and chronic disease and injury prevention initiatives.

The documented effectiveness of health promotion measures supports increased emphasis on these initiatives to help Virginians lead healthy, productive lives.

RECOMMENDATION 3:

That the Department of Health facilitate an in-depth evaluation of current health education demonstration projects to identify elements for successful implementation of health education and health promotion programs in those agencies receiving funding through the Office of Health Education and Information and that the Department seek additional funding for such evaluation through federal block grants.

Three health education demonstration projects are now funded by the Commonwealth; projects that no longer receive state funds have been continued through local health district support. Departmental or block grant funds would be required to support the additional evaluation needed for the implementation and continuation of the most effective programs. Additional funds should be specifically earmarked for evaluation efforts; funding for local programs should not be redirected to support these efforts. Increased evaluation will allow the Commonwealth to apply its resources to the most effective programs and will enhance its ability to compete for private foundation and federal grant funds.

RECOMMENDATION 4:

That the Department of Health develop a statewide health promotion initiative to target a major behavioral risk factor and that this proposed initiative be presented to the Council on Coordinating Prevention and the 1992 General Assembly.

Current public service announcements addressing prevention are federally produced; the Department of Health has no advertising budget. The Behavioral Risk Factor Surveillance System could identify those health risk behaviors which might be effectively addressed through an advertising campaign. Approval and funding for the proposed initiative would be determined by the 1992 General Assembly.

RECOMMENDATION 5:

That local health districts be encouraged to form local health services advisory boards with broad representation to assist health districts in the development and implementation of community-based public health objectives and strategies.

Section 32.1-31 C1 of the Code of Virginia currently permits cities and counties to appoint local health services advisory boards. The Committee agreed that the formation of these boards in more localities would likely enhance the development and delivery of community-based services.

RECOMMENDATION 6:

That community health education specialist positions be funded as full-time state employees within each local health district's budget and that these employees serve as a members of local district management teams under the supervision of the local health director.

While some health districts already employ community health education specialists, the presence of these employees in each of the 36 local health districts would greatly enhance prevention and health promotion efforts. Current health education specialist positions are funded by federal Prevention Block Grants and by the cooperative budget between the Commonwealth and local health districts. Additional positions would be funded through this cooperative budget, which typically represents a 60 percent and 40 percent funding balance by the Commonwealth and the locality, respectively.

These specialists could generate tremendous support for local prevention efforts by pursuing private and federal support and conducting the recommended in-depth evaluations of local programs. In addition, these individuals might assist in the formation of public health services advisory boards.

RECOMMENDATION 7:

That the Commission on Health Care for All Virginians include in its study an examination of health promotion efforts, particularly those at the worksite, and their overall effectiveness and utility as cost containment measures.

Testimony before the Committee cited the value of worksite wellness programs in reducing employee absenteeism and health care costs. The Commission on Health Care for All Virginians, charged to review health care access and cost containment, should include this significant health promotion initiative in its continuing study.

RECOMMENDATION 8:

That the Commonwealth establish a $900,000 small grants program, to be administered by the Department of Health, for application in every health district for the implementation of quality worksite health promotion programs.

A grants program, providing awards ranging for $500 to $2500, should be established as an incentive for businesses to offer worksite health promotion programs. A community health education specialist might assist in the development and implementation of worksite programs.

RECOMMENDATION 9:

That the Department of Health establish a task force to develop a plan for the delivery of worksite health promotion information and services to small and large employers.

Although a substantial portion of worksites now support some form of wellness activity, additional guidance in the development and delivery of the most effective programs might encourage more employers to offer health promotion services.

RECOMMENDATION 10:

That the Department of Personnel and Training undertake a demonstration project that evaluates the feasibility and potential cost benefits of providing risk-rated health insurance for all state employees and retirees.

A state demonstration project to evaluate the cost benefits of risk-rated insurance might be an effective tool for encouraging the private sector to explore programs and benefits packages that support health promotion.

RECOMMENDATION 11:

That the Department of Health (Bureau of Vital Statistics) coordinate with sister states to explore the efficacy of modifying current death certificate forms to require information on behavioral risk factor history.

The inclusion of additional health history data on death certificates would facilitate the development of the most needed prevention initiatives. Because a standardized death certificate format is shared by several states to facilitate data comparison, any modification of the current form to reflect risk-factor behavior would of necessity require coordination with the Bureau of Vital Statistics and other states to ensure consistency in data collection and recordation.

RECOMMENDATION 12:

That the Department of Health study the feasibility of refining its analysis and collection of vital statistics data to include the more specific presentation of racial and ethnic data.

Although DOH's current data collection system has the capability to obtain more specific racial and ethnic data, revision to the data collection system is necessary to provide analysis. More detailed analysis, although expensive, would assist in effective program planning. The Department should explore the possibility of acquiring necessary, compatible computer programs to provide the needed data analysis.

RECOMMENDATION 13:

That the Department of Health develop methods of securing and utilizing existing data sources, such as hospital, public care and emergency care discharge data, and other sources of health information as part of a pilot project morbidity index sampling system.

A variety of health care institutions already maintain patient data that would be of great value to DOH in developing additional health promotion measures.

RECOMMENDATION 14:

That the Minority Health Advisory Committee develop long-range minority initiatives in state health and human services and that the Department of Health continue its efforts to provide necessary staff support to assist the Advisory Committee.

The Commissioner of Health has already expressed commitment to providing additional staff to the Minority Health Advisory Committee. The Committee recognizes the critical importance of addressing minority health concerns in the development and implementation of prevention and health promotion initiatives and supports the efforts of the Commissioner to meet staffing requirements.

RECOMMENDATION 15:

That the Department of Education study current school health education programs, including present curricula requirements and instructor qualifications and training, and the efficacy and appropriateness of adopting a comprehensive approach to school health education.

Public education is an important component of any health promotion and disease prevention plan. The recent reorganization of the Department of Education has created some uncertainty regarding the future staffing and administration of school health programs. While health education efforts in the public schools should be expanded, the effects of incorporating health education into other disciplines, such as the English or social studies curricula, remain unclear. Additional study of this issue by the Department of Education would provide necessary information to determine what specific changes are appropriate.

RECOMMENDATION 16:

That incentives be developed to encourage the Commonwealth's medical schools to increase emphasis on primary care, health promotion, and disease prevention in the curriculum and training requirements for health care professionals.

Prevention and health promotion are critical components of health care and should receive focus in professional training. Because prevention services are typically not reimbursed, teaching hospitals, which must support their budgets in part by services rendered by their physicians, may be disinclined to promote these services. Creating incentives, rather than mandates, for increasing emphasis on prevention and health promotion training in medical schools may bring necessary change to current curriculum requirements.

RECOMMENDATION 17:

That additional funding be provided to ensure the ongoing focus and coordination of injury prevention within the Department of Health.

Despite the success of current initiatives, preventable injuries remain a leading cause of death and disability in Virginia. The Centers for Disease Control may have limited funds available for state injury prevention programs. A stable source of funding might enhance the Department's ability to compete for grants which might support these programs.

RECOMMENDATION 18:

That the Code of Virginia be revised to make seat belt non-use a violation reportable to the Division of Motor Vehicles for the assignment of demerit points and that the traffic violation form be amended to require information on seat belt use.

Section 46.2-1094 of the Code of Virginia provides that no citation for safety belt non-use may be issued unless an officer has cause to stop or arrest a driver for a violation of some other traffic law or criminal statute. The current accident report form requires an indication of seat belt use; adding a similar requirement to the traffic violation form would help ensure stricter enforcement of current law.

RECOMMENDATION 19:

That the Department of Public Safety increase its public education efforts regarding injury and accident prevention, including seat belt and child safety seat use.

Increasing public awareness of current safety requirements as well as effective injury prevention practices may reduce the incidence of injuries and accidents in the Commonwealth.

RECOMMENDATION 20:

That the Board of Housing and Community Development review current injury prevention initiatives in the Uniform Statewide Building Code and consider specific revisions to incorporate anti-scald requirements for new construction and renovation, stricter safety standards for steps, stairs, curbs, railings, and flooring, and requirements for fencing around residential pools.

Strengthening Building Code safety requirements may facilitate the reduction of accidents in the home. The Board of Housing and Community Development is urged to consider additional, specific safety requirements for potential inclusion in the Building Code.

RECOMMENDATION 21:

That data collection for the compilation of injury statistics and the description of injury events reflect the preventability of these occurrences and that "injuries" include accidental as well intentional injuries.

The Committee recognizes the need to sensitize the public to the idea that injuries and accidents can be prevented and that these events occur no more randomly or unpredictably than diseases.

RECOMMENDATION 22:

That the joint subcommittee be continued for one additional year to continue its examination of health promotion and disease prevention and to incorporate in its study emphasis on the Comprehensive Prevention Plan and initiatives addressing social services, independent living, and other related concerns.

While the Committee has focused primarily on health promotion and disease prevention this year, prevention measures may encompass not only healthy lifestyles and behavior, but also initiatives promoting self-sufficiency and independence. The scope of the Committee's study should be broadened to include consideration of the Comprehensive Prevention Plan and initiatives focusing on cost savings realized through prevention and health promotion, social services, independent living, and other related concerns.

The Committee extends its appreciation to the Health Promotion and Education Council of Virginia, the Council on Coordinating Prevention, the Departments of Health and Social Services, the health care and medical communities, and representatives of public and private sector prevention initiatives for their cooperation and assistance throughout the study.

Respectfully submitted,

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TWENTIETH DISTRICT

COMMITTEE ASSIGNMENTS:
ROADS AND INTERNAL NAVIGATION
APPROPRIATIONS
MINING AND MINERAL RESOURCES
MILITIA AND POLICE

Re: Joint Subcommittee Studying Means of Reducing Preventable Death and Disability in the Commonwealth and Examining the Feasibility of Implementing a Comprehensive Prevention Plan in Virginia Pursuant to HJR 179

I agree with the substance and direction of the Report. I respectfully decline, however, to endorse all of the recommendations made therein.

Whittington W. Clement

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HOUSE JOINT RESOLUTION NO. 179

Establishing a joint subcommittee to study means of reducing preventable death and disability in the Commonwealth and to examine the feasibility of implementing a comprehensive prevention plan in Virginia.

Agreed to by the House of Delegates, February 13, 1990
Agreed to by the Senate, March 7, 1990

WHEREAS, experts estimate that thirty-six premature deaths of individuals between the ages of twenty and sixty-four occur in Virginia every day, with 13,000 premature deaths occurring every year; and

WHEREAS, experts also estimate that thirty-seven percent of these deaths are preventable because they can be attributed to one or more health risk behaviors such as failure to control high blood pressure, poor eating nabits, smoking, lack of exercise, alcohol abuse, and failure to use seat belts; and

WHEREAS, lifestyles which include health risk behaviors increase the risk of heart attack, stroke, and cancer; and

WHEREAS, injuries from preventable accidents are the number one cause of death among Virginians between the ages of one and forty-five; and

WHEREAS, nearly half of all health care claims in Virginia are ascribed to lifestyle related problems; and

WHEREAS, funding of health care for the indigent consumes an ever increasing share of Virginia's general fund appropriations; and

WHEREAS, millions of dollars in tax revenue are lost in the Commonwealth due to premature, preventable deaths every year; and

WHEREAS, in this year of economic exigency, there is a profound need to examine the economic and social ramifications of preventable deaths and injuries; and

WHEREAS, various agencies of the Commonwealth are charged with developing a Comprehensive Prevention Plan in Chapter 30 (§ 9-267 et seq.) of Title 9 of the Code of Virginia; however, the implementation of the plan is not mandated; and

WHEREAS, there is a particular need to educate children, teenagers, and young adults about the dangers of lifestyles which include health risks in order to convince these young people to avoid preventable deaths and injuries; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That there is hereby established a joint subcommittee to study means of reducing preventable death and disability in the Commonwealth and to examine the feasibility of implementing a comprehensive prevention plan in Virginia.

The joint subcommittee shall be composed of nine members to be appointed as follows: four members of the House Committee on Health, Welfare and Institutions and one member of the House Committee on Appropriations to be appointed by the Speaker of the House; and two members of the Senate Committee on Education and Health, one member of the Senate Committee on Finance, and one member of the Senate Committee on Rehabilitation and Social Services to be appointed by the Senate Committee on Privileges and Elections.

In its deliberations, the joint subcommittee shall:

1. Determine the economic and social costs to the Commonwealth of health risk behaviors associated with preventable and premature death, disability, and lost productivity;

2. Examine the benefits that would accrue to the Commonwealth and its people through reducing the incidence of preventable premature death, disability, and lost productivity;

3. Recommend effective programs, policies, and funding mechanisms to reduce the incidence of preventable disease and injury in the Commonwealth;

4. Examine the provisions of Chapter 30 (§ 9-267 et seq.) of Title 9 relating to the Virginia Council on Coordinating Prevention to determine if any statutory amendments would be beneficial; and

5. Examine the feasibility of implementing a comprehensive prevention plan in this Commonwealth.

All agencies of the Commonwealth shall provide assistance upon request as the joint subcommittee may deem appropriate. The joint subcommittee shall also seek input from various components of the health care and medical community including the expertise of the Health Promotion and Education Council.

The joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and the 1991 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

The indirect costs of this study are estimated to be $10,650; the direct costs of this study shall not exceed $6,480.

1990-92 Comprehensive Prevention Plan for Virginia

GOALS AND TARGETED OBJECTIVES

Goal - HEALTH LIFE STYLES

HLS 1 - Reduce the use of alcohol and drugs by youth
HLS 2 - Reduce the number of suicides
HLS 3 - Reduce Transmission of HIV (Human Immune Virus) infection and AIDS
HLS 4 - Decrease the percentage of overweight adults
HLS 5 - Decrease the percentage of people who smoke
HLS 6 - Increase the number of Medicaid providers
HLS 7 - Increase the number of employers who provide health benefits

Goal - RESPONSIBLE PARENTHOOD

RP 1 - Reduce the number of adolescent pregnancies
RP 2 - Develop Preparation for Parenthood programs
RP 3 - Increase the numbers of teen males who take financial responsibility for their children
RP 4 - Evaluate the Family Life Education curriculum
RP 5 - Develop Family Life Education programs for institutionalized and special needs youth

Goal - HEALTHY MOTHERS AND BABIES

HMB 1 - Decrease the percentage of low birth weight infants
HMB 2 - Increase the percentage of women who receive prenatal care

Goal - POSITIVE CHILD DEVELOPMENT

PCD 1 - Develop Early Childhood Parenting Programs
PCD 2 - Increase the number of child care providers
PCD 3 -Develop resource and referral services for parents seeking child care

Goal - POSITIVE YOUTH DEVELOPMENT

PYD 1 - Increase high school graduation rate
PYD 2 - Develop peer relationships and career development programs

Goal - POSITIVE FAMILY LIFE

PFL 1 - Decrease the incidence of child abuse and neglect
PFL 2 - Increase pre-crisis counseling to families in stress
PFL 3 - Develop Family Communication programs
PFL 4 - Decrease the need for guardianship

Goal - GAINFUL EMPLOYMENT AND LITERACY

GEL 1 - Increase the percentage of children earning a Literacy Passport in the sixth grade
GEL 2 - Increase the percentage of adults in literacy programs
GEL 3 - Increase services for special education students entering adult life
GEL 4 - Evaluate the effectiveness of vocational and technical training

Goal - INDEPENDENT LIVING

IL 1 - Increase the number of people diverted from nursing homes to community care
IL 2 - Increase services for juveniles leaving penal institutions
IL 3 - Increase services for adults leaving penal institutions
IL 4 - Increase access to affordable, safe housing

Goal -SAFE ENVIRONMENT

SE 1 - Decrease neighborhood crime
SE 2 - Increase community safety
SE 3 - Decrease the number of head injuries in youth
SE 4 - Decrease the number of household injuries

Source: 1990-92 Comprehensive Prevention Plan for Virginia

1991 SESSION

LD6223466

HOUSE JOINT RESOLUTION NO. 342

Offered January 17, 1991

Requesting the Commission on Health Care for All Virginians to include in its ongoing study an examination of the effectiveness and utility of health promotion efforts.

Patrons—Glasscock, DeBoer, Clement and Hamilton; Senators: Scott, Colgan, Holland, E.M. and Wampler

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Referred to the Committee on Health, Welfare and Institutions

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WHEREAS, the Joint Subcommittee Studying Means of Reducing Preventable Death and Disability in the Commonwealth and the Feasibility of Implementing a Comprehensive Prevention Plan in Virginia, created pursuant to House Joint Resolution No. 179 of the 1990 Session of the General Assembly, has examined health promotion efforts as an effective means of reducing premature and preventable death and disability; and

WHEREAS, the United States Department of Health and Human Services has identified among its national health promotion and disease prevention objectives for the year 2000 an increase in employer-sponsored health promotion programs, including physical fitness, nutrition education, and stress management; and

WHEREAS, while worksite health promotion programs may provide employees valuable health information and support for health behavior change, they may especially benefit those employees who may lack adequate health insurance or a regular source of medical care; and

WHEREAS, health promotion efforts may enhance workforce health, decrease employee absenteeism, and ultimately reduce expenditures for preventable disease and disability, thereby contributing to a more competitive economy; and

WHEREAS, although the joint subcommittee has reviewed and endorsed the concept of worksite health promotion, the broad focus of its study has precluded a detailed examination of the overall effectiveness and utility of worksite health promotion efforts as cost containment measures and vehicles for prevention; and

WHEREAS, pursuant to Senate Joint Resolution No. 118 of the 1990 Session of the General Assembly, the Commission on Health Care for All Virginians has been charged to consider a number of issues affecting health care costs, access, and insurance coverage; and

WHEREAS, although the joint subcommittee has developed specific recommendations regarding effective prevention and health promotion initiatives for the Commonwealth, additional study is needed to ensure the development and implementation of effective health promotion programs, particularly those offered at the worksite; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Commission on Health Care for All Virginians is hereby requested to include in its ongoing study of critical health care issues affecting citizens of the Commonwealth an examination of health promotion efforts, particularly those at the worksite, and their effectiveness and utility as cost containment measures.

The Commission is requested to include its findings and recommendations in its final report to the Governor and the 1992 Session of the General Assembly, in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

1991 SESSION

LD9071466

HOUSE JOINT RESOLUTION NO. 343

Offered January 17, 1991

Requesting the Department of Education to study current school health education programs and the efficacy and appropriateness of adopting a comprehensive approach to health education in the public schools.

Patrons—Glasscock, DeBoer, Clement and Hamilton; Senators: Scott, Colgan, Holland, E.M. and Wampler

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Referred to the Committee on Education

WHEREAS, the Joint Subcommittee Studying Means of Reducing Preventable Death and Disability in the Commonwealth and the Feasibility of Implementing a Comprehensive Prevention Plan in Virginia, created pursuant to House Joint Resolution No. 179 of the 1990 Session of the General Assembly, has examined school health education as an effective means of providing young Virginians invaluable health information, focusing on injury prevention, alcohol and substance abuse, physical fitness, and other issues affecting long-term health; and

WHEREAS, school health education is a vital component of any comprehensive plan to promote healthy lifestyles and to prevent disease, injuries, and premature death; and

WHEREAS, quality school health education, encompassing physical fitness activity, nutrition instruction, alcohol and substance abuse prevention, and information about health-risk behaviors, has been included among the national health promotion and disease prevention objectives for the year 2000 developed by the United States Department of Health and Human Services; and

WHEREAS, although Title 22.1 of the Code of Virginia requires the inclusion of physical and health education, accident prevention, and substance abuse issues in the public school curriculum, current school health programs in the Commonwealth may not uniformly provide the classroom time and instruction necessary to adequately address these important and varied topics; and

WHEREAS, the quality of school health education may be greatly enhanced by, among other things, the availability of skilled instructors, appropriate pupil-teacher ratios, adequate class time requirements, and a comprehensive approach to health curriculum; and

WHEREAS, while the joint subcommittee has reviewed and strongly supports school health education programs, further exploration is needed to assess effectively current school health education efforts in the Commonwealth; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Education is hereby requested to study current health education programs, including present curricula requirements and instructor qualifications and training, the efficacy and appropriateness of adopting a comprehensive approach to school health education, and other related issues as it deems appropriate.

The Department is to report its findings and recommendations to the Governor and the 1992 Session of the General Assembly, in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

1991 SESSION

LD6228466

HOUSE JOINT RESOLUTION NO. 344

Offered January 17, 1991

Requesting the Minority Health Advisory Committee to develop long-range minority health initiatives in the Commonwealth's health and human services.

Patrons—Glasscock, DeBoer, Clement and Hamilton; Senators: Scott, Colgan, Holland, E.M. and Wampler

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Referred to the Committee on Health, Welfare and Institutions

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WHEREAS, in its national health objectives for the year 2000, the United States Department of Health and Human Services established "specific targets to narrow the gap between the total population and those population groups that now experience above average incidences of death, disease, and disability;" and

WHEREAS, the Virginia Department of Health has identified minority health as a major public health priority in its Six-Year Plan; and

WHEREAS, the Joint Subcommittee Studying Means of Reducing Preventable Death and Disability in the Commonwealth and the Feasibility of Implementing a Comprehensive Prevention Plan in Virginia, created pursuant to House Joint Resolution No. 179 (1990), recognizes that some populations, such as those including persons with low incomes, certain racial and ethnic minority groups, and disabled persons, are often disproportionately "at risk" for premature death and various preventable diseases and injuries; and

WHEREAS, although the Minority Health Advisory Committee, established within the Virginia Department of Health, has focused on the special health needs of these at-risk populations, greater emphasis on long-term initiatives throughout the Commonwealth's health and social services agencies is necessary to combat effectively the health challenges facing minorities; and

WHEREAS, increased staff support and the development of specific guidelines for programs and long-term initiatives would greatly enhance ongoing efforts to address the health needs of the Commonwealth's minority populations; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Minority Health Advisory Committee is hereby requested to develop long-term minority health initiatives in the delivery of state health and social services and that the Department of Health be encouraged to continue its commitment to provide staff support to the Advisory Committee in its efforts to address these vital issues.

Official Use By Clerks	
Agreed to By The House of Delegates	**Agreed to By The Senate**
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Clerk of the House of Delegates	Clerk of the Senate

LD6227466

HOUSE JOINT RESOLUTION NO. 345

Offered January 17, 1991

Requesting the Department of Personnel and Training to undertake a demonstration project to evaluate the feasibility and potential cost benefits of providing risk-rated health insurance for all state employees and retirees.

Patrons—Glasscock, DeBoer, Clement and Hamilton; Senators: Scott, Colgan and Holland, E.M.

Referred to the Committee on Corporations, Insurance and Banking

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WHEREAS, during the course of its study, the Joint Subcommittee Studying Means of Reducing Preventable Death and Disability in the Commonwealth and the Feasibility of Implementing a Comprehensive Prevention Plan in Virginia (HJR 179, 1990) learned that, while historic public health measures have been stimulated by the need to control communicable diseases, the emphasis now is on health promotion and prevention efforts; and

WHEREAS, while the number of deaths attributable to acute infectious diseases has dropped sharply, deaths due to major chronic diseases—heart disease, cancer, stroke—have increased more than 250 percent between 1900 and 1970; and

WHEREAS, emerging in the medical community is the realization that death and disabilities from these diseases may be reduced effectively through health promotion and disease prevention; and

WHEREAS, in the Commonwealth, it is estimated that at least 40 percent of lives lost to cardiovascular disease, cancer, liver disease, and automobile accidents in 1988 were directly attributable to unhealthy behaviors such as smoking, obesity, alcohol abuse, and lack of exercise; and

WHEREAS, spiralling health care costs and rising insurance premiums have strained budgets in the public and private sectors, leaving more individuals without health care coverage, and by the year 2000 health care costs are expected to comprise 15 percent of the Gross National Product; and

WHEREAS, escalating expenditures for indigent care have challenged federal and state governments to develop cost-effective alternatives which focus on disease prevention and health promotion; in Virginia, the Medicaid budget now exceeds $1 billion a year; and general fund appropriations for Medicaid have increased 103 percent in the last five years; and

WHEREAS, prevention efforts have proven to be cost effective in terms of both human life and have caused a reduction in lost wages and productivity, loss of tax revenue, and use of health care benefits; and

WHEREAS, risk-rated health insurance not only provides incentives to employees and employers to engage in positive health lifestyles, but also rewards such behavior with reductions in health care premiums and represents a total cost savings; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Personnel and Training undertake a demonstration project which will evaluate the feasibility and potential cost benefits of providing risk-rated health insurance for all state employees and retirees. The Department shall make an interim report to the Governor and the 1992 Session of the General Assembly. Upon completion of this project the Department shall report its findings to the Governor and General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.

1991 SESSION

LD6226466

HOUSE JOINT RESOLUTION NO. 346

Offered January 17, 1991

Requesting the Department of Health to establish a task force to develop a plan for the delivery of worksite health promotion information to small and large businesses.

Patrons—Glasscock, DeBoer, Clement and Hamilton; Senators: Scott, Colgan, Holland, E.M. and Wampler

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Referred to the Committee on Health, Welfare and Institutions

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WHEREAS, the value of worksite health promotion programs may be evidenced in lower rates for health claims, slowed increases in health insurance premiums, reduced employee absenteeism, and reductions in health-risk behaviors; and

WHEREAS, the Joint Subcommittee Studying Means of Reducing Preventable Death and Disability in the Commonwealth and the Feasibility of Implementing a Comprehensive Prevention Plan in Virginia, created pursuant to House Joint Resolution No. 179 of the 1990 Session of the General Assembly, has considered the efficacy of worksite health promotion in reducing premature and preventable death and disability; and

WHEREAS, employer-sponsored health promotion programs, including physical fitness, nutrition education, and stress management, have been cited by the United States Department of Health and Human Services among its national health promotion and disease prevention objectives for the year 2000; and

WHEREAS, while § 32.1-23 of the Code of Virginia provides for the publication and distribution of information "as may contribute to the preservation of the public health and the prevention of disease," no guidelines are established to address those health promotion and education programs specifically benefiting employees at the worksite; and

WHEREAS, although some businesses have already introduced on-site programs to enhance employee health promotion through the provision of health screening and disease prevention services, accident prevention information, and physical fitness activities, guidelines for the successful implementation of these services might encourage more employers to sponsor worksite health promotion programs; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Health is hereby requested to establish a task force to develop a plan for the delivery of worksite health promotion information and services by businesses in the Commonwealth. The plan should include, among other things, specific guidelines tailored to the concerns of small businesses as well as larger enterprises.

Official Use By Clerks	
Agreed to By The House of Delegates	**Agreed to By The Senate**
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Clerk of the House of Delegates	Clerk of the Senate

1991 SESSION

LD9057466

HOUSE JOINT RESOLUTION NO. 347

Offered January 17, 1991

Continuing the Joint Subcommittee Studying Means of Reducing Preventable Death and Disability in the Commonwealth and the Feasibility of Implementing a Comprehensive Prevention Plan in Virginia.

Patrons—Glasscock, DeBoer, Clement and Hamilton; Senators: Scott, Colgan, Holland, E.M. and Wampler

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Referred to the Committee on Rules

WHEREAS, the Joint Subcommittee created pursuant to House Joint Resolution No. 179 (HJR 179) by the 1990 Session of the General Assembly has pursued its charge to consider specifically the economic and social costs of health risk behaviors linked to preventable death and disability; and

WHEREAS, the Joint Subcommittee has considered the recommendations of the United States Surgeon General and the United States Department of Health and Human Services regarding national health promotion and disease prevention objectives for the year 2000; and

WHEREAS, in responding to the broad charge of HJR 179, the Joint Subcommittee has reviewed a plethora of issues, including minority health concerns, worksite health promotion, school health education, health education and prevention training for medical professionals, effective data compilation and analysis, and injury prevention; and

WHEREAS, the Joint Subcommittee met five times in 1990 and has weighed the research, recommendations, and the 1990-92 Comprehensive Prevention Plan of the Virginia Council on Coordinating Prevention as well as the work of the Health Promotion and Education Council; and

WHEREAS, specific data presented to the Joint Subcommittee confirmed that although preliminary reviews of the Commonwealth's prevention efforts indicate progress, chronic disease, injuries, and premature deaths continue to plague Virginians; and

WHEREAS, although many effective health promotion and disease prevention initiatives are presently operating at the state and local levels and in the private sector, further exploration of data compilation, financing alternatives, and personnel needs is necessary to ensure the continued implementation of these programs; and

WHEREAS, as recognized by the Council for Coordinating Prevention, a comprehensive plan for prevention initiatives should encompass not only health promotion and disease prevention but also those goals and objectives encouraging, among other things, self-sufficiency, independent living, healthy families, and volunteer and corporate activity; and

WHEREAS, although the Joint Subcommittee has developed specific recommendations regarding effective prevention initiatives for the Commonwealth, additional study is needed to explore fully the continuation and expansion of the Commonwealth's ongoing health promotion and disease prevention efforts and the successful implementation of a comprehensive prevention plan; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee Studying Means of Reducing Preventable Death and Disability in the Commonwealth and the Feasibility of Implementing a Comprehensive Prevention Plan in Virginia be continued. The membership of the Joint Subcommittee shall continue as established by House Joint Resolution No. 179 of 1990. Vacancies shall be filled by the Speaker of the House of Delegates or the Senate Committee on Privileges and Elections, as appropriate. The Joint Subcommittee shall continue to review and evaluate methods of reducing preventable death and disability and shall also focus on the Comprehensive Prevention Plan, financing alternatives, and initiatives addressing independent living, social

All agencies of the Commonwealth shall cooperate with the Joint Subcommittee and, upon request, assist the Joint Subcommittee in the performance of its duties and responsibilities.

The Joint Subcommittee shall submit its findings and recommendations to the Governor and the 1992 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

The indirect costs of this study are estimated to be $13,045; the direct costs of this study shall not exceed $8,100.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

Official Use By Clerks

Agreed to By The House of Delegates		**Agreed to By The Senate**	
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Clerk of the House of Delegates Clerk of the Senate

LD6234466

HOUSE JOINT RESOLUTION NO. 348

Offered January 17, 1991

Requesting the Department of Housing and Community Development to review current injury prevention initiatives in the Uniform Statewide Building Code.

Patrons—Glasscock, DeBoer, Clement and Hamilton; Senators: Scott, Colgan, Holland, E.M. and Wampler

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Referred to the Committee on General Laws

WHEREAS, unintentional injuries are the fourth leading cause of death in the United States and the third leading cause in the Commonwealth; and

WHEREAS, the United States Department of Health and Human Services has targeted the reduction of injuries, such as those resulting from falls and residential fires, in its national health objectives for the year 2000; and

WHEREAS, the Joint Subcommittee Studying Means of Reducing Preventable Death and Disability in the Commonwealth and the Feasibility of Implementing a Comprehensive Prevention Plan in Virginia, created pursuant to House Joint Resolution No. 179 of the 1990 Session of the General Assembly, has also reviewed initiatives to promote injury prevention; and

WHEREAS, the Council on Coordinating Prevention has identified the reduction of fatalities due to household injuries in its 1990-92 Comprehensive Prevention Plan; and

WHEREAS, the incidence of preventable injuries occurring in the home may be effectively reduced through compliance with building and safety code requirements; and

WHEREAS, although the Uniform Statewide Building Code in Virginia already incorporates many significant safety requirements, additional review of current safety measures may facilitate the development of other valuable initiatives to reduce injuries in the home; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Housing and Community Development is hereby requested to review current injury prevention initiatives in the Uniform Statewide Building Code and to consider specific revisions to incorporate, among other things, anti-scald requirements for plumbing, stricter safety standards for smoke detectors and fire suppression systems and for steps, stairs, curbs, railings, and flooring, and requirements for fencing around residential pools.

Official Use By Clerks	
Agreed to By The House of Delegates	**Agreed to By The Senate**
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Clerk of the House of Delegates	Clerk of the Senate

1991 SESSION

LD6224466

HOUSE JOINT RESOLUTION NO. 349

Offered January 17, 1991

Requesting the Department of Health to develop a major statewide health promotion initiative to address health-risk behavior.

Patrons—Glasscock and Hamilton; Senators: Scott, Colgan, Holland, E.M. and Wampler

Referred to the Committee on Health, Welfare and Institutions

WHEREAS, health promotion and disease prevention initiatives may drastically reduce needless suffering and personal tragedy for many Virginians; and

WHEREAS, the Joint Subcommittee Studying Means of Reducing Preventable Death and Disability in the Commonwealth and the Feasibility of Implementing a Comprehensive Prevention Plan in Virginia, created pursuant to House Joint Resolution No. 179 (1990), has learned that, despite renewed emphasis on health promotion, about 49 percent of all health care claims in Virginia arise from lifestyle behaviors, such as improper diet, inadequate exercise, and tobacco use; and

WHEREAS, the link between certain health-risk behaviors and preventable death and disease has been substantiated through studies conducted at the federal and state level; and

WHEREAS, increased public awareness of the critical importance of healthy lifestyles and behaviors may enhance individual efforts to refrain from those behaviors and activities linked to preventable disease and disability; and

WHEREAS, while current federally produced public service announcements and media campaigns have proved effective, no similar initiatives exist in the Commonwealth to target specific health-risk behaviors; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Health is hereby requested to develop a major statewide health promotion initiative to target behavioral risk factors. In identifying those health-risk behaviors that might be effectively addressed through a public awareness initiative, the Department shall consider health promotion and disease prevention information gathered by the Behavioral Risk Factor Surveillance System. The Department shall present its initiative to the Council on Coordinating Prevention and the 1992 Session of the General Assembly.

Official Use By Clerks	
Agreed to By The House of Delegates	**Agreed to By The Senate**
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Clerk of the House of Delegates	Clerk of the Senate

1991 SESSION

LD6222466

HOUSE BILL NO. 1470

Offered January 17, 1991

A BILL to amend the Code of Virginia by adding a section numbered 32.1-11.3, relating to patient and community health education programs.

Patrons—Glasscock, DeBoer, Clement and Hamilton; Senators: Scott, Colgan, Holland, E.M. and Wampler

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Referred to the Committee on Health, Welfare and Institutions

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Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 32.1-11.3 as follows:

§ 32.1-11.3. Patient and community health education services.—The Board shall formulate a program of patient and community health education services to be provided by the Department on a regional, district, or local basis. The program shall include services addressing health promotion and disease prevention and shall encourage the coordination of local and private sector health education services.

Official Use By Clerks	
Passed By The House of Delegates	**Passed By The Senate**
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Clerk of the House of Delegates	Clerk of the Senate

1991 SESSION

LD6225466

HOUSE BILL NO. 1471

Offered January 17, 1991

A BILL to amend the Code of Virginia by adding a section numbered 32.1-11.3, relating to grants for worksite health promotion programs.

Patrons—Glasscock, DeBoer, Clement and Hamilton; Senators: Scott, Colgan, Holland, E.M. and Wampler

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Referred to the Committee on Health, Welfare and Institutions

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Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 32.1-11.3 as follows:

§ 32.1-11.3. Board to establish worksite health promotion grants program.—With such funds as are appropriated for this purpose, the Board of Health shall establish the worksite health promotion grants program. The Board may award grants for the provision of worksite health promotion programs that may include, among other things, on-site health education and screening efforts, information about health risk behaviors linked to preventable disease and disability, occupational safety and health programs, and employer-sponsored physical fitness programs.

The Board shall appoint an advisory committee of specialists in the development and delivery of health promotion and disease prevention programs for the worksite to assist in the establishment of criteria for awarding such grants, the contents of the request for proposals, evaluation and ranking of grant applications, and for making recommendations for grant awards.

Official Use By Clerks	
Passed By The House of Delegates	**Passed By The Senate**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
Clerk of the House of Delegates	Clerk of the Senate