




Prevention Status Report – Policy Indicators




Michigan

The Prevention Status Report (PSR) highlights the status of seven public health concerns in Michigan including tobacco; nutrition, physical activity, and obesity; food safety; teen pregnancy; HIV; healthcare-associated infections; and motor vehicle injuries. Data are provided for key public health indicators and ratings are provided based on the status of key policy indicators. The purpose of the PSR is to help advance evidence-based policy and practice by identifying areas where improvements can be made. Many of the policies addressed in the report represent relatively low-cost approaches to achieving broad public health impact.






Below is a summary of policy indicator ratings for Michigan. An explanation of the rating system for each indicator is included in the Annex.

KEY:  = Healthy Achievement  = Healthy Progress  = Recommendations for Progress



Tobacco Control

-  State cigarette excise tax
-  State smoke-free policy
-  State funding for tobacco control


Nutrition, Physical Activity, and Obesity

-  Sale of less nutritious foods and beverages in secondary schools
-  Physical education time requirement for high school students
-  State procurement policy for foods and beverages
-  Inclusion of nutrition and physical activity standards in state regulations of licensed child care facilities
-  Average birth facility score for breastfeeding support




Food Safety

-  Rate that *E. coli* O157 is subtyped using PFGE
-  Completeness of *Salmonella* subtyping



Teen Pregnancy Prevention

-  Medicaid family planning expansion





HIV Prevention

-  Reimbursement for screening
-  HIV testing laws
-  CD4 and VL lab reporting

Healthcare-associated Infection Prevention

- 57% Acute care facilities reporting to CDC
-  Validating HAI data sent to CDC
-  Participation in statewide prevention efforts

Motor Vehicle Injury Prevention

-  Seat belt law
-  Child safety restraint law
-  Graduated drivers license law
-  Alcohol ignition interlock law

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Prevention Status Report

Tobacco Control

Michigan

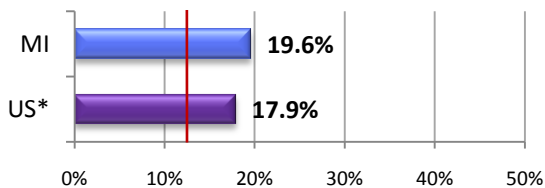
Why is tobacco control important?

Tobacco is the leading cause of preventable death in the US and in Michigan. In the US, 40% of adult nonsmokers and 54% of children (aged 3–11 years) are exposed to secondhand smoke. Tobacco use results in \$96 billion in medical expenditures and \$97 billion in lost productivity annually in the US. In Michigan, smoking causes \$3.3 billion in personal health care expenditures and \$3.95 billion in lost productivity. States that invest in proven strategies protect kids from tobacco, decrease smoking rates, reduce tobacco-related healthcare costs, and prevent deaths.

Public health indicators

Proportion of adults who smoke cigarettes, 2009

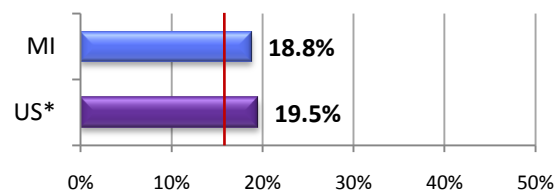
Healthy People 2020 Target = 12.0% (Red line)



* Median state prevalence

Proportion of high school students who smoke cigarettes, 2009

Healthy People 2020 Target = 16.0% (Red line)



*National prevalence among high school students

Policy indicators



State cigarette excise tax, 2010

Michigan's tax is \$2.00 compared to the highest state tax of \$4.35. Healthy People 2020 Target is a state increase of \$1.50 per pack. Doing so would generate an estimated \$243.9 million in revenue annually, prevent more than 145,000 children from starting to smoke, save more than 60,000 lives, and generate an estimated \$3.1 billion in long-term health savings.¹



State smoke-free policy, 2010

Michigan requires smoke-free workplaces, including restaurants, bars, and other public places. Healthy People 2020 Target = All 50 states and the District of Columbia to have statewide smoke-free laws.



State funding for tobacco control, FY2010

Michigan allocated 3.5% of the CDC recommended funding for tobacco control (\$4.29 million of \$121.2 million).

What can be done to prevent illness and death and reduce health care costs?

States can make a significant difference in public health by employing high-impact, cost-effective tobacco control and prevention strategies. **MPOWER**: **M**onitor tobacco use and prevention policies, **P**rotect people from tobacco smoke, **O**ffer help to quit tobacco use, **W**arn people about the dangers of tobacco, **E**nforce bans on tobacco advertising, promotion, and sponsorship, and **R**aise state cigarette taxes on tobacco.

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Prevention Status Report

Nutrition, Physical Activity, and Obesity

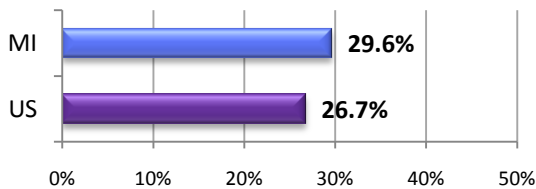
Michigan

Why are nutrition, physical activity, and obesity important?

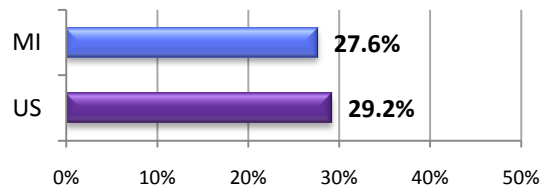
A healthful diet and regular physical activity benefit the health of children and adults. Poor diet and physical inactivity contribute to many serious and costly health conditions including obesity, heart disease, diabetes, some cancers, unhealthy cholesterol and high blood pressure. Obesity is associated with increased blood pressure and unhealthy cholesterol; chronic diseases such as heart disease, diabetes, some cancers, and osteoarthritis; complications of pregnancy; and death at earlier ages. In 2007-2008, 17% of children and adolescents and 34% of adults were obese. Among adults, the medical costs associated with obesity are \$147 billion.

Public health indicators

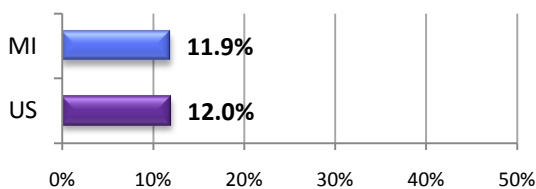
Proportion of adults who are obese, 2009



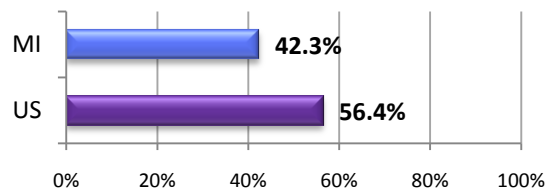
Proportion of high school students who drank a can, bottle, or glass of soda or pop at least one time per day, 2009



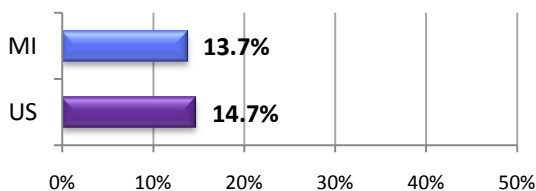
Proportion of high school students who are obese, 2009



Proportion of high school students who attended physical education classes on 1 or more days in an average week when they were in school, 2009



Proportion of low income children 2- < 5 years of age who are obese, 2009



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Prevention Status Report

Nutrition, Physical Activity, and Obesity

Michigan

Policy indicators



Sale of less nutritious foods and beverages in secondary schools, 2008

In 2008, 33.5% of secondary schools in Michigan did not allow students to purchase baked goods that are not low in fat, salty snacks that are not low in fat, candy, or soda pop or fruit drinks that are not 100% juice in vending machines or at the school store, canteen, or snack bar.



Physical education time requirement for high school students, 2010

Michigan does not have a physical education time requirement for high school students.



State procurement policy for foods and beverages, 2010

Michigan does not have a state procurement policy for foods and beverages.



Inclusion of nutrition and physical activity standards in state regulations of licensed child care facilities, 2008

Michigan's child care regulations include some model policies for healthy eating and physical activity.



Average birth facility score for breastfeeding support, 2009

Michigan has an average birth facility score of 65. The US national score is 65.

What can be done to improve nutrition and physical activity and help prevent obesity and other chronic diseases?

- 1) Support school districts in implementing strong nutrition standards that restrict the availability of low-nutrient, energy dense foods and sugar sweetened beverages.
- 2) Pass a state policy to increase physical education (PE) time requirements and do not grant PE exemptions for participation in sports, club memberships, or academic reasons.
- 3) Establish state procurement policy standards for foods and beverages purchased, contracted, distributed or sold in government facilities.
- 4) Implement improvements in nutrition and physical activity standards in state regulations of licensed child care facilities using standards in "Preventing Childhood Obesity in Early Care and Education Programs" as a guide.
- 5) Work with hospitals and birth centers in Michigan to implement evidence-based practices that support breastfeeding.

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Prevention Status Report

Food Safety

Michigan

Why is food safety important?

Diseases spread by contaminated foods continue to challenge the public health system. Each year, an estimated 1 in 6 Americans develop an acute foodborne infection, almost 128,000 are hospitalized and 3000 die, with the worst consequences in the very young and the elderly.² The health costs of four bacterial infections alone were estimated to be \$6.5 billion/year, not including the costs of lost consumer confidence, product advisories and recalls. Large foodborne outbreaks continue to occur with a wide spectrum of implicated foods, including fresh produce and processed foods, as well as foods of animal origin. In recent years, prolonged nationwide outbreaks of *Salmonella* infections strained public health departments and highlighted the need for fast and coordinated action.

Public health response indicators



Proportion of *E. coli* O157 PFGE patterns reported to CDC (i.e., uploaded into PulseNet) within 4 working days of receipt of the isolate in the state Public Health Lab, 10/1/09 – 9/30/10
National Target (CDC Public Health Emergency Preparedness Cooperative Agreement) = 90%

MI = 82.9% (Note: 9 states = 100%; 6 states = 0.0%)
US = 63.4%



Annual proportion of *Salmonella* cases reported to CDC (National Notifiable Diseases Surveillance System) with PFGE patterns uploaded into PulseNet, 2009

MI = 72.2% (Note: 33 states = 100%)
US = 79.1%

What can be done to prevent illness and death and reduce health care costs?

- 1) Improve foodborne disease surveillance and detection activities
 - a. Determine the specific strain and perform DNA fingerprinting for all *Salmonella* and Shiga toxin producing *E. coli* (STEC).
 - b. Interview all *Salmonella*, STEC, and *Listeria* cases with a standardized form.
- 2) Increase the speed and completeness of outbreak investigations
 - a. Employ trained interview team approach to interviews.
 - b. Conduct targeted environmental health investigations.
 - c. Conduct rapid traceback of implicated foods where indicated.
- 3) Increase local and state foodborne disease prevention activities
 - a. Require a certified kitchen manager to be present in each food service establishment.
 - b. Restaurants should publicly post the results of the most recent food safety inspection.
 - c. State and local jurisdictions should adopt and implement as many provisions as possible from the 2009 FDA Model Food Code.
 - d. Conduct inspections of all state-regulated food processors at regular intervals.

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Prevention Status Report

Teen Pregnancy Prevention

Michigan

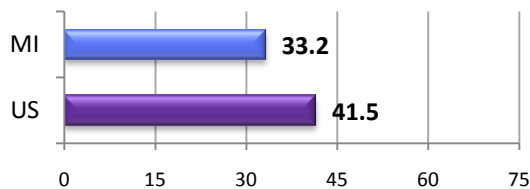
Why is teen pregnancy prevention important?

Each year in the United States, about 750,000 women under age 20 become pregnant. Most teen pregnancies – nearly two-thirds of those to mothers younger than age 18 and more than half among mothers aged 18–19 years – are unintended. The costs of teen childbearing are at least \$9.1 billion annually in the US. The cost to Michigan taxpayers was estimated to be at least \$302 million in 2004.³ Overarching goals for this priority include policy and systems changes to: implement effective prevention programs that fit the unique needs of the youth and community; delay initiation of sexual activity among teens; and increase the use of contraception, particularly long-acting, reversible methods, among sexually active teens.

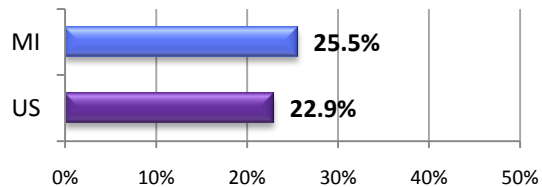
Public health indicators

Teen birth rate, 2008

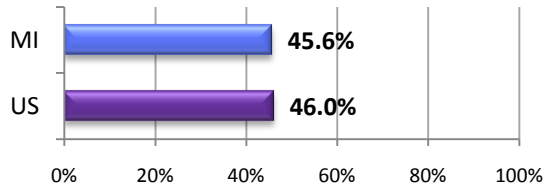
(Per 1,000 women aged 15–19 years)



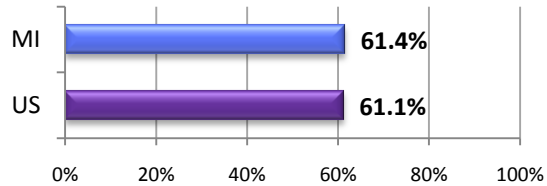
Birth control pill or Depo-Provera use before last sexual intercourse among currently sexually active high school students, 2009



Proportion of high school students who have ever had sex, 2009



Condom use during last sexual intercourse among currently sexually active high school students, 2009



Policy indicator



Medicaid family planning expansion through state approval, 2010

Medicaid expansion for family planning services in Michigan covers women aged 19 years and older.

What can be done to prevent teen pregnancy and reduce health care costs?

In addition to helping the significant proportion of teens who are not sexually active to remain so through evidence-based prevention, education, and support, a key to reducing teen pregnancy is to make sure that sexually active adolescents at risk for pregnancy are connected to family planning services. One way to improve access for teens is to expand Medicaid family planning services to include women less than 19 years of age, either by amending the Medicaid waiver or by converting to the State Plan Amendment recently made available by the Centers for Medicare & Medicaid Services (CMS).

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Prevention Status Report

HIV Prevention

Michigan

Why is HIV prevention important?

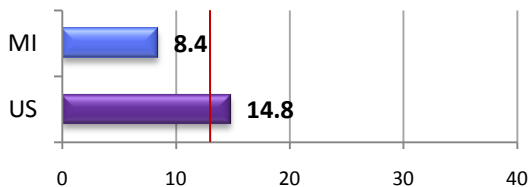
In 2010, the White House released the first National HIV/AIDS Strategy for the United States to promote a national urgency and coordinated response to the ongoing HIV epidemic. Today, more than 1.1 million people in the US are living with HIV infection and 1 in 5 of them is unaware of their infection. Increasing knowledge of serostatus among HIV-infected persons leads to reduction in risk behaviors and reductions in new HIV transmissions and connects people with needed care and treatment. The lifetime cost of medical treatment for HIV-infected persons is more than \$350,000, making HIV prevention an extremely cost-effective public health intervention.

Public health indicators

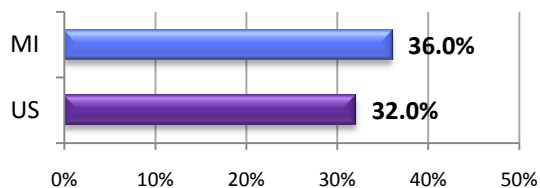
AIDS diagnosis rate, 2008

(New cases per 100,000 population aged 13 years and older)

Healthy People 2020 Target = 13.0 new cases per 100,000 population (Red line)

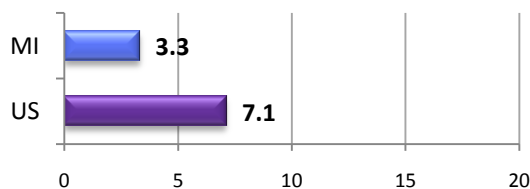


Late HIV diagnosis, 2007



Deaths among persons with AIDS, 2007

(Rate per 100,000 population aged 13 years and older)



Policy indicators



Reimbursement for screening

Medicaid does not reimburse for HIV screening in Michigan.



HIV testing laws

State HIV testing laws are consistent with CDC's 2006 HIV testing recommendations.



CD4 and VL lab reporting

State law or regulation requires reporting of all CD4 and viral load results for surveillance purposes.

What can be done to prevent illness and death and reduce health care costs?

Michigan can work to further expand HIV prevention activities and target resources to interventions, geographic areas, and populations that can have the greatest impact toward achieving the goals of the National HIV/AIDS Strategy.

Improved policies that would support the National Strategy include the following:

- 1) Revise HIV testing consent requirements to be consistent with CDC recommendations.
- 2) Adopt medicaid reimbursement for HIV screening in all populations and settings.

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Prevention Status Report

Healthcare-associated Infection Prevention

Michigan

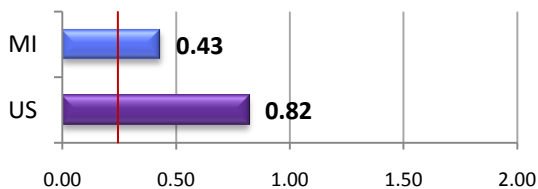
Why is healthcare-associated infection prevention important?

One in every 20 hospitalized patients will contract a healthcare-associated infection (HAI), causing excessive, preventable illness and higher healthcare costs. It is estimated that HAIs incur an estimated \$28 to \$33 billion in excess healthcare costs each year in hospitals in the US. States work with CDC to monitor and prevent HAIs in all types of healthcare facilities. Reporting HAI data allows prevention efforts to be targeted and measured. States also work on broad prevention collaboratives targeting specific infection and bacteria types, such as methicillin-resistant *Staphylococcus aureus* (MRSA). As our knowledge of prevention strategies grows, HAIs are increasingly preventable.

Public health indicators

Central line-associated bloodstream infection (CLABSI) – Standardized Infection Ratio (SIR), 2010

Healthy People 2020 Target = 0.25 Standardized Infection Ratio (SIR) or 75% reduction



Policy indicators

57% Acute care facilities reporting to CDC

Percent of hospitals reporting any HAI data to CDC's National Healthcare Safety Network (NHSN).



Validating HAI data sent to CDC

Michigan had no efforts in place in 2009 to validate data sent to CDC's National Healthcare Safety Network (NHSN) surveillance system.



Participation in statewide prevention efforts

Michigan is leading or taking part in broad prevention collaboratives.

- | | | | | |
|--|-----------------------------------|---|---|--|
| <input type="checkbox"/> CLABSI | <input type="checkbox"/> SSI | <input checked="" type="checkbox"/> CAUTI | <input type="checkbox"/> VAP | <input checked="" type="checkbox"/> MRSA |
| <input type="checkbox"/> <i>C. difficile</i> | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Ambulatory care | <input type="checkbox"/> Long-term care | |

What can be done to prevent illness and death and reduce health care costs?

- 1) Continue to expand HAI prevention efforts inside and outside of hospitals, including setting up broad collaborative partnerships for preventing infections in settings such as long-term care, dialysis centers and outpatient surgery centers.
- 2) Focus efforts on ensuring CDC guidelines are followed by every healthcare provider and facility.
- 3) Advocate and support data validation efforts and ensure Recovery Act investments are being used effectively for maximum impact.

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Prevention Status Report

Motor Vehicle Injury Prevention

Michigan

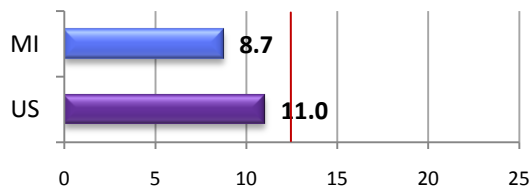
Why is motor vehicle injury prevention important?

Motor vehicle crashes represent one of the largest and most preventable public health problems facing our nation today. Motor vehicle crashes are the leading cause of death among US residents aged 5-34 years. In 2009, nearly 34,000 people were killed and another 2.6 million treated in emergency departments. The economic impact of these injuries totals more than \$230 billion per year. These costs are borne by many, including individuals, employers, the health care system, and public and private insurance.

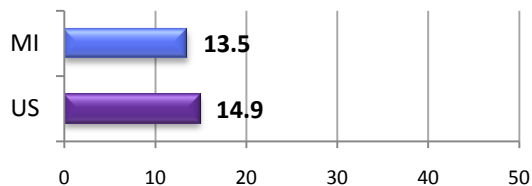
Public health indicators

Motor vehicle-related death rate, 2009 (rate per 100,000 population)

Healthy People 2020 Target = 12.4 per 100,000 population (Red line)

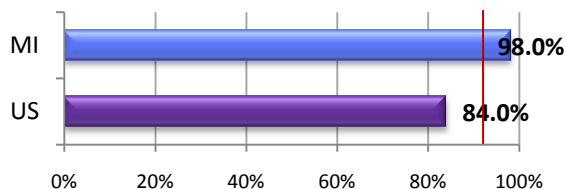


Motor vehicle-related death rate among adolescents, 2009 (rate per 100,000 population aged 15-19 years)



Seat belt use, 2009

Healthy People 2020 Target = 92.4% (Red line)



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Prevention Status Report

Motor Vehicle Injury Prevention

Michigan

Policy indicators



Seat belt law

Michigan has a primary enforcement law for front seating positions.



Child safety restraint law

Michigan requires that all children age 7 years and younger and less than 57 inches must be in a child restraint.



Graduated drivers license (GDL) law

Michigan has achieved a "good" rating.



Alcohol ignition interlock law

Michigan does not require any ignition interlock system for offenders.

What can be done to prevent injury and death and reduce health care costs?

- 1) Expand primary enforcement of seat belt laws to all seating positions.
- 2) Require installation of ignition interlocks for all convicted first-time and repeat offenders.

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Prevention Status Report – Annex

The annex provides definitions, rationale, and data sources for indicators used in the Prevention Status Report (PSR). Explanations of the rating systems used for the policy indicators (and public health response indicators for food safety), are also included. Please note that for some indicators, data may not have been available from the sources referenced; in some cases, data may be available from state or District sources.

The rationale for each indicator includes references to related indicators, objectives, or recommendations from Healthy People, the Institute of Medicine (IOM), and The Guide to Community Preventive Services (Community Guide). Healthy People is a set of goals and objectives with 10-year targets designed to guide national health promotion and disease prevention efforts to improve the health of all people in the United States. Released by the U.S. Department of Health and Human Services each decade, Healthy People reflects the idea that setting objectives and providing science-based benchmarks to track and monitor progress can motivate and focus action. Healthy People 2020 represents the fourth generation of this initiative, building on a foundation of three decades of work. Healthy People 2020 objectives related to PSR indicators are highlighted in the rationale section. More information about Healthy People 2020 and relevant objectives can be found online at: <http://www.healthypeople.gov/2020/>.

The IOM is an independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public. IOM recommendations that relate to PSR indicators are highlighted in the rationale section. More information about the IOM and relevant reports and recommendations can be found online at: <http://www.iom.edu/>.

The Community Guide is a resource for evidence-based recommendations about what works to improve public health based on a scientific, systematic review process. The recommendations are made by the Task Force on Community Preventive Services, an independent, nonfederal, volunteer body of public health and prevention experts, whose members are appointed by the Director of CDC. Community Guide recommendations that support PSR indicators are highlighted in the rationale section. More information about the Community Guide and relevant recommendations can be found online at: <http://www.thecommunityguide.org/>.

Tobacco Control

Public Health Indicators:

Indicator 1: Proportion of adults who smoke cigarettes

Definition: Adults aged 18 years and older who reported ever smoking at least 100 cigarettes and who currently smoke every day or on some days. The questions used to assess this indicator are, "Have you smoked at least 100 cigarettes in your entire life?" and, "Do you now smoke cigarettes every day, some days, or not at all?"

Rationale: Healthy People 2020 Objective TU–1: Reduce tobacco use among adults. TU–1.1: Cigarette smoking.

Source of data: Behavioral Risk Factor Surveillance System (BRFSS) (<http://www.cdc.gov/brfss/>)

Date of data: 2009

Indicator 2: Proportion of high school students who smoke cigarettes

Definition: High school students who reported that they had smoked cigarettes on at least 1 day during the 30 days before the survey. The question used to assess this indicator is, "During the past 30 days, on how many days did you smoke cigarettes?" The 42 states that participated in the 2009 Youth Risk Behavior Survey (YRBS) and had an overall response rate of at least 60% are included in this report. Data are representative of 9th through 12th grade students in public schools in each state. National YRBS data are representative of 9th through 12th grade students in public and private schools in the US.

Rationale: Healthy People 2020 Objective TU–2: Reduce tobacco use by adolescents. TU–2.2: Cigarettes (past month).

Source of data: Youth Risk Behavior Surveillance System (YRBSS) (<http://www.cdc.gov/HealthyYouth/yrbs/>)

Date of data: 2009

Policy Indicators:

Indicator 1: State cigarette excise tax

Definition: The amount of state excise tax, in dollars, on a pack of 20 cigarettes.

Rationale: Healthy People 2020 Objective TU–17: Increase the federal and state tax on tobacco products. TU–17.1: Cigarettes. IOM Recommendation 2: States with excise tax rates below the level imposed by the top quintile of states should substantially increase their own rates to reduce consumption and to reduce smuggling and tax evasion. State excise tax rates should be indexed to inflation (<http://iom.edu/Reports/2007/Ending-the-Tobacco-Problem-A-Blueprint-for-the-Nation.aspx>). The Task Force on Community Preventive Services recommends interventions that increase the price of tobacco products based on strong evidence of their effectiveness in: 1) Reducing tobacco use among adolescents and adults, 2) Reducing population consumption of tobacco products, and 3) Increasing tobacco use cessation.

Source of data: STATE System (<http://apps.nccd.cdc.gov/statesystem/>)

Date of data: December 31, 2010

Rating system: Checkmark = state excise tax \geq \$2.00 per pack. Arrow = \$1.00 - \$1.99 per pack. Rx symbol = < \$1.00 per pack.

Indicator 2: State smoke-free policy

Definition: Presence of smoke-free laws covering workplaces, restaurants, and bars.

Rationale: Healthy People 2020 Objective TU–13: Establish laws in States, District of Columbia, Territories, and Tribes on smoke-free indoor air that prohibit smoking in public places and worksites. IOM Recommendation 4: States and localities should enact complete bans on smoking in all nonresidential indoor locations, including workplaces, malls, restaurants, and bars. States should not preempt local governments from enacting bans more restrictive than the state ban (<http://iom.edu/Reports/2007/Ending-the-Tobacco-Problem-A-Blueprint-for-the-Nation.aspx>). The Task Force on Community Preventive Services recommends smoking bans and restrictions whether used alone or as part of a multi-component community or workplace intervention based on strong evidence of effectiveness in reducing exposure to environmental tobacco smoke.

Source of data: STATE System (<http://apps.nccd.cdc.gov/statesystem/Default/Default.aspx>)

Date of data: December 31, 2010

Rating system: Checkmark = state smoke-free policies cover all three locations without exception. Arrow = two locations are covered. Rx symbol = one or none of the locations are covered.

Indicator 3: State funding for tobacco control

Definition: State funding includes state and federal funding allocated to each state for tobacco control activities. The data are also presented as a percent of CDC's 2007 recommended annual investment in tobacco control. Note: FY2010 funding does not include nongovernment funding sources or Federal funds from the American Recovery and Reinvestment Act Prevention Wellness Initiative announced in March 2010. Additionally, the amount allocated per fiscal year does not always match the amount spent during the year.

Rationale: Healthy People 2020 Objective (Developmental) TU–20: Increase the number of States, and the District of Columbia, Territories, and Tribes with sustainable and comprehensive evidence-based tobacco control programs. IOM Recommendation 1: Each state should fund state tobacco control activities at the level recommended by the CDC. A reasonable target for each state is in the range of \$15 to \$20 per capita, depending on the state's population, demography, and prevalence of tobacco use. If it is constitutionally permissible, states should use a statutorily prescribed portion of their tobacco excise tax revenues to fund tobacco control programs (<http://iom.edu/Reports/2007/Ending-the-Tobacco-Problem-A-Blueprint-for-the-Nation.aspx>).

Source of data: ImpacTeen Project, Health Policy Center, University of Illinois at Chicago, 2010

Date of data: FY 2010

Rating system: Checkmark = funding at 100% or more of CDC recommended annual investment. Arrow = 50% to 99.9% of CDC recommended annual investment. Rx symbol = less than 50% of CDC recommended annual investment.

Nutrition, Physical Activity, and Obesity

Public Health Indicators:

Indicator 1: Proportion of adults who are obese

Definition: Obesity is defined as a body mass index (weight (kg)/height (m)²) ≥ 30. Weight and height are self-reported. BMI was calculated based on answers to the following questions: "About how tall are you without shoes?" in feet and inches; and, "About how much do you weigh without shoes?" in pounds.

Rationale: Healthy People 2020 Objective NWS–9: Reduce the proportion of adults who are obese.

Source of data: Behavioral Risk Factor Surveillance System (BRFSS) (<http://www.cdc.gov/brfss>)

Note: Estimates provided are calculated with the methodology used for the CDC obesity maps. (<http://www.cdc.gov/obesity/data/trends.html#State>). As such, they vary slightly from estimates on the BRFSS website.

Date of data: 2009

Indicator 2: Proportion of high school students who are obese

Definition: Obesity is defined as a body mass index (weight (kg)/height (m)²) ≥ the 95th percentile for age and sex based on the 2000 CDC Growth Charts. Weight and height are self-reported. BMI was calculated based on answers to the following questions: "How tall are you without your shoes on?" in feet and inches; and, "How much do you weigh without shoes on?" in pounds. The 42 states that participated in the 2009 Youth Risk Behavior Survey (YRBS) and had an overall response rate of at least 60% are included in this report. Data are representative of 9th through 12th grade students in public schools in each state. National YRBS data are representative of 9th through 12th grade students in public and private schools in the US.

Rationale: Healthy People 2020 Objective NWS–10: Reduce the proportion of children and adolescents who are considered obese. NWS–10.3: Adolescents aged 12 to 19 years.

Source of data: Youth Risk Behavior Surveillance System (YRBSS) (<http://www.cdc.gov/HealthyYouth/yrbs/>)

Date of data: 2009

Indicator 3: Proportion of low income children 2- < 5 years of age who are obese

Definition: Obesity is defined as a body mass index (weight (kg)/height (m)²) ≥ the 95th percentile for age and sex based on the 2000 CDC Growth Charts. Weight and height are measured. 46 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and six Indian tribe organizations participated in the Pediatric Nutrition Surveillance System (PedNSS) in 2009.

Rationale: Healthy People 2020 Objective NWS–10: Reduce the proportion of children and adolescents who are considered obese. NWS–10.1: Children aged 2 to 5 years. (Note: HP 2020 objective is not specific to low income children).

Source of data: PedNSS (<http://www.cdc.gov/pednss/>)

Date of data: 2009

Indicator 4: Proportion of high school students who drank a can, bottle, or glass of soda or pop at least one time per day

Definition: The question used to assess this indicator is, “During the past 7 days, how many times did you drink a can, bottle or glass of soda such as Coke, Pepsi, or Sprite? (Do not include diet soda or diet pop.)” The 42 states that participated in the 2009 Youth Risk Behavior Survey (YRBS) and had an overall response rate of at least 60% are included in this report. Data are representative of 9th through 12th grade students in public schools in each state. National YRBS data are representative of 9th through 12th grade students in public and private schools in the US.

Rationale: The 2010 Dietary Guidelines for Americans recommends that Americans “reduce the intake of calories from solid fats and added sugars” (<http://www.cnpp.usda.gov/DGAs2010-PolicyDocument.htm>). Healthy People 2020 Objective NWS–17: Reduce the consumption of calories from solid fats and added sugars in the population aged 2 years and older. Healthy People 2020 Objective NWS–17b: Reduce consumption of calories from added sugars.

Source of data: Youth Risk Behavior Surveillance System (YRBSS) (<http://www.cdc.gov/HealthyYouth/yrbs/>)

Date of data: 2009

Indicator 5: Proportion of high school students who attended physical education (PE) classes on 1 or more days in an average week when they were in school

Definition: The question used to assess this indicator is “In an average week when you are in school, on how many days do you go to physical education (PE) classes?” The 42 states that participated in the 2009 Youth Risk Behavior Survey (YRBS) and had an overall response rate of at least 60% are included in this report. Data are representative of 9th through 12th grade students in public schools in each state. National YRBS data are representative of 9th through 12th grade students in public and private schools in the US.

Rationale: Healthy People 2020 Objective PA–5: Increase the proportion of adolescents who participate in daily school physical education. The Task Force on Community Preventive Services recommends implementing programs that increase the length of, or activity levels in, school-based physical education classes based on strong evidence of their effectiveness in improving both physical activity levels and physical fitness among school-aged children and adolescents.

Source of data: Youth Risk Behavior Surveillance System (YRBSS) (<http://www.cdc.gov/HealthyYouth/yrbs/>)

Date of data: 2009

Policy Indicators:

Indicator 1: Sale of less nutritious foods and beverages in secondary schools

Definition: Respondent responds “no” to each of 5 categories when asked the question, “Can students purchase each of the following snack foods or beverages from vending machines or at the school store, canteen, or snack bar – chocolate candy; other kinds of candy; salty snacks that are not low in fat, such as regular potato chips; cookies, crackers, cakes, pastries, or other baked goods that are not low in fat; soda pop or fruit drinks that are not 100% juice? Data are provided for 47 states and the District of Columbia and represent those who participated in the survey and had an overall response rate of at least 70%.

Rationale: Healthy People 2020 Objective NWS–2: Increase the proportion of schools that offer nutritious foods and beverages outside of school meals. NWS–2.1: Increase the proportion of schools that do not sell or offer calorically sweetened beverages to students.

Source of data: School Health Profiles (<http://www.cdc.gov/HealthyYouth/profiles/>)

Date of data: 2008

Rating system: Checkmark = 66.6% or more of secondary schools in the state did not sell baked goods that are not low in fat, salty snacks that are not low in fat, candy, or soda pop or fruit drinks that are not 100% juice in vending machines or at the school store, canteen, or snack bar. Arrow = 50.0% to 66.5% of secondary schools in the state did not sell baked goods that are not low in fat, salty snacks that are not low in fat, candy, or soda pop or fruit drinks that are not 100% juice in vending machines or at the school store, canteen, or snack bar. Rx symbol = less than 50.0% of secondary schools in the state did not sell baked goods that are not low in fat, salty snacks that are not low in fat, candy, or soda pop or fruit drinks that are not 100% juice in vending machines or at the school store, canteen, or snack bar.

Indicator 2: Physical education time requirement for high school students

Definition: Respondent responds “yes” to “Is there a state mandate for the minutes per week that high school students must participate in physical education?”

Rationale: Healthy People 2020 Objective PA–4: Increase the proportion of the Nation’s public and private schools that require daily physical education for all students. PA–4.3: Senior high schools. The Task Force on Community Preventive Services recommends implementing programs that increase the length of, or activity levels in, school-based physical education classes based on strong evidence of their effectiveness in improving both physical activity levels and physical fitness among school-aged children and adolescents.

Source of data: Shape of the Nation (<http://www.aahperd.org/naspe/publications/upload/Shape-of-the-tion-Revised2PDF.pdf>)

Date of data: 2010

Rating system: Checkmark = state has a mandate. Rx symbol = state does not have mandate.

Indicator 3: State procurement policy for foods and beverages

Definition: The presence of a state-wide procurement policy that covers food purchased, contracted, distributed or sold by government agencies in the state executive branch.

Rationale: The IOM report “Strategies to Reduce Sodium Intake in the United States,” recommends that “government agencies, public health and consumer organizations, and the food industry should carry out activities to support the reduction of sodium levels in the food supply.” One strategy identified was that “Food retailers, governments, businesses, institutions, and other large-scale organizations that purchase or distribute food should establish sodium specifications for the foods they purchase and the food operations they oversee.” In the Surgeon General’s “Vision for a Healthy and Fit Nation”, the Surgeon General suggested that to create healthy worksites, employers could “Make healthy food and beverages available and affordable in the workplace.”

Source of data: American Heart Association

Date of data: 2010

Rating system:

Checkmark = food procurement policy present and meets all of the criteria listed below:

- Policy applies to at least 90% of government agencies in the executive branch.
- Policy covers all food purchased, contracted, distributed or sold by government agencies in the state executive branch.
- Policy provides quantifiable standards for foods or nutrients (e.g. sets a maximum for the amount of sodium a food item could include).
- Policy minimally sets standards that limit sodium content, fat content, and the availability of high caloric, low nutrient foods and drinks.

Arrow = food procurement policy present. However, policy does not meet all of the criteria listed below:

- Policy applies to at least 90% of government of government agencies in the executive branch.
- Policy covers all food purchased, contracted, distributed or sold by government agencies in the state executive branch.
- Policy provides quantifiable standards for foods or nutrients (e.g. sets a maximum for the amount of sodium a food item could include).
- Policy minimally sets standards that limit sodium content, fat content, and the availability of high caloric, low nutrient foods and drinks.

Rx symbol = food procurement policy not present.

Indicator 4: Inclusion of nutrition and physical activity standards in state regulations of licensed child care facilities

Definition: State has specific regulations that address healthy eating and physical activity in licensed child care facilities (including child care centers and family child care homes). States regulations are compared to a list of 10 model policies for healthy eating and 10 model polices for physical activity as identified by an expert panel and defined in the data source document.

Rationale: Healthy People 2020 Objective NWS–1: Increase the number of States with nutrition standards for foods and beverages provided to preschool-aged children in child care. PA–9: Increase the number of States with licensing

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regulations for physical activity provided in child care. Preventing Childhood Obesity in Early Care and Education Programs – Selected Standards from Caring for Our Children: National Health and Safety Performance Standards (http://nrckids.org/CFOC3/PDFVersion/preventing_obesity.pdf).

Source of data: Preventing Obesity in the Child Care Setting: Evaluating State Regulations (http://cfm.mc.duke.edu/wysiwyg/downloads/State_Reports_Final.pdf)

Date of data: 2008

Rating system: A grading system was developed by Benjamin and colleagues that considers the extent to which state regulations are consistent with 10 model polices for healthy eating and 10 model policies for physical activity as identified by an expert panel. State grades take into consideration both child care centers and family child care homes. These grades are published in the report “Preventing Obesity in the Child Care Setting: Evaluating State Regulations.” (http://cfm.mc.duke.edu/wysiwyg/downloads/State_Reports_Final.pdf) Checkmark = state was graded “A” in the report. Arrow = state was graded “B” or “C” in the report. Rx symbol = state was graded “D” or “F” in the report.

Indicator 5: Average birth facility score for breastfeeding support

Definition: A birth facility score is averaged across seven categories of supports that hospitals and birth centers can provide for breastfeeding. These categories include: 1) labor and delivery, 2) breastfeeding assistance, 3) mother-newborn contact, 4) newborn feeding practices, 5) breastfeeding support after discharge, 6) nurse/birth attendant breastfeeding training and education, and 7) structural and organizational factors related to breastfeeding. The score can range from 0 to 100. State score represents average score across participating birth facilities in the state.

Rationale: Healthy People 2020 Objective MICH–21: Increase the proportion of infants who are breastfed.

Source of data: Maternity Practices in Infant Nutrition and Care (mPINC) Survey (<http://www.cdc.gov/breastfeeding/data/mpinc/index.htm>)

Date of data: 2009

Rating system: Checkmark = state had an average score of 80 or above. Arrow = state had an average score of 70-79. Rx symbol = state had an average score below 70.

Food Safety

Public Health Response Indicators:

Indicator 1: Proportion of *E. coli* O157 PFGE patterns reported to CDC (i.e., uploaded into PulseNet) within 4 working days of receipt of the isolate in the state Public Health Lab

Definition: Annual proportion of *E. coli* O157 PFGE patterns uploaded within 4 working days by the state public health lab.

Rationale: Healthy People 2020 Objective FS–1: Reduce infections caused by key pathogens transmitted commonly through food. FS–1.2 Shiga toxin-producing *Escherichia coli* (STEC) O157:H7.

Source of data: PulseNet

Date of data: 10/1/09-9/30/10

Rating system: Checkmark = > 90%. Arrow = 60% - 89%. Rx symbol = < 60%.

Indicator 2: Annual proportion of *Salmonella* cases reported to CDC (National Notifiable Diseases Surveillance System) with PFGE patterns uploaded into PulseNet

Definition: Proportion of *Salmonella* cases reported to National Notifiable Diseases Surveillance System (NNDSS) with PFGE patterns uploaded into PulseNet annually.

Rationale: Healthy People 2020 Objective FS–1: Reduce infections caused by key pathogens transmitted commonly through food. FS–1.4: *Salmonella* species.

Source of data: PulseNet, NNDSS

Date of data: 2009

Rating system: Checkmark = > 90%. Arrow = 60% - 89%. Rx symbol = < 60%.

Teen Pregnancy Prevention

Public Health Indicators:

Indicator 1: Teen birth rate

Definition: Live births per 1,000 women 15–19 years of age.

Rationale: Healthy People 2020 Objective FP–8: Reduce pregnancy rates among adolescent females. FP–8.1 Reduce the pregnancy rate among adolescent females aged 15 to 17 years. FP–8.2 Reduce the pregnancy rate among adolescent females aged 18 to 19 years. (Note: HP 2020 objective is “pregnancy” rate vs. birth rate)

Source of data: National Center for Health Statistics, National Vital Statistics System (NVSS)

(http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_01.pdf)

Date of data: 2008

Indicator 2: Proportion of high school students who have ever had sex

Definition: The question used to assess this indicator is, “Have you ever had sexual intercourse?” The 42 states that participated in the 2009 Youth Risk Behavior Survey (YRBS) and had an overall response rate of at least 60% are included in this report. Data are representative of 9th through 12th grade students in public schools in each state. National YRBS data are representative of 9th through 12th grade students in public and private schools in the US.

Rationale: Healthy People 2020 Objective FP–9: Increase the proportion of adolescents aged 17 years and under who have never had sexual intercourse. FP–9.1: Female adolescents aged 15 to 17 years.

Source of data: Youth Risk Behavior Surveillance System (YRBSS) (<http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>)

Date of data: 2009

Indicator 3: Birth control pill or Depo-Provera use before last sexual intercourse among currently sexually active high school students

Definition: Percent of currently sexually active high school students who report using birth control pills or Depo-Provera before last sexual intercourse. The questions used to assess this indicator are, “The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy?” and, “During the past 3 months, with how many people did you have sexual intercourse?” The 42 states that participated in the 2009 Youth Risk Behavior Survey (YRBS) and had an overall response rate of at least 60% are included in this report. Data are representative of 9th through 12th grade students in public schools in each state. National YRBS data are representative of 9th through 12th grade students in public and private schools in the US.

Rationale: Healthy People 2020 Objective FP–6: Increase the proportion of females or their partners at risk of unintended pregnancy who used contraception at most recent sexual intercourse.

Source of data: Youth Risk Behavior Surveillance System (YRBSS) (<http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>)

Date of data: 2009

Indicator 4: Condom use during last sexual intercourse among currently sexually active high school students

Definition: Percent of sexually active high school students who used condoms the last time they had sex. The questions used to assess this indicator are, “The last time you had sexual intercourse, did you or your partner use a condom?” and, “During the past 3 months, with how many people did you have sexual intercourse?” The 42 states that participated in the 2009 Youth Risk Behavior Survey (YRBS) and had an overall response rate of at least 60% are included in this report. Data are representative of 9th through 12th grade students in public schools in each state. National YRBS data are representative of 9th through 12th grade students in public and private schools in the United States.

Rationale: Healthy People 2020 Objective FP–10: Increase the proportion of sexually active persons aged 15 to 19 years who use condoms to both effectively prevent pregnancy and provide barrier protection against disease. FP–10.3: Increase the proportion of sexually active females aged 15 to 19 years who use a condom at last intercourse.

Source of data: Youth Risk Behavior Surveillance System (YRBSS) (<http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>)

Date of data: 2009

Policy Indicators:

Indicator 1: Medicaid family planning expansion through state approval

Definition: State expansion of eligibility for Medicaid coverage of family planning services either by securing approval (officially known as “waiver” of federal policy) from the Centers for Medicare and Medicaid Services, or by choosing to implement an expansion through the State Plan Amendment now available under PPACA, through which teens under 19 years old would be covered.

Rationale: Healthy People 2020 Objective FP–14: Increase the number of States that set the income eligibility level for Medicaid-covered family planning services to at least the same level used to determine eligibility for Medicaid-covered, pregnancy-related care.

Source of data: Guttmacher Institute (http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf)

Date of data: 2010

Rating system: Checkmark = Medicaid expansion for family planning services covers all women, including teens. Arrow = Medicaid expansion for family planning services covers women aged 19 years and older. Rx symbol = family planning services have not been expanded through Medicaid.

HIV Prevention

Public Health Indicators:

Indicator 1: AIDS diagnosis rate

Definition: Number of AIDS diagnoses among adults and adolescents per 100,000 population.

Rationale: Healthy People 2020 Objective HIV–4: Reduce the number of new AIDS cases among adolescents and adults.

Source of data: HIV surveillance, CDC

Date of data: 2008

Indicator 2: Late HIV diagnosis

Definition: HIV diagnosed less than 12 months before progression to AIDS.

Rationale: Healthy People 2020 Objective HIV–9: (Developmental) Increase the proportion of new HIV infections diagnosed before progression to AIDS.

Source of data: HIV surveillance, CDC

Date of data: 2007

Indicator 3: Deaths among persons with AIDS

Definition: Number of deaths per 100,000 adults and adolescents diagnosed with AIDS.

Rationale: Healthy People 2020 Objective HIV–12: Reduce deaths from HIV infection.

Source of data: HIV surveillance, CDC

Date of data: 2007

Policy Indicators:

Indicator 1: Reimbursement for screening

Definition: State Medicaid plan reimburses for routine HIV screening.

Rationale: Healthy People 2020 Objective HIV-14: Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months.

Source of data: Data collected by National Association of State and Territorial AIDS Directors (NASTAD), shared with permission.

Date of data: 2010

Rating system: Checkmark = reimburses for routine HIV screening in all settings/populations. Arrow = reimburses for routine HIV screening in some settings and populations. Rx symbol = does not reimburse for routine HIV screening.

Indicator 2: HIV testing laws

Definition: State testing laws consistent with CDC’s 2006 HIV testing recommendations. The recommendations are available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>.

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Rationale: Healthy People 2020 Objective HIV-14: Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months.

Source of data: National HIV/AIDS Clinicians' Consultation Center (NCCC) at the University of California, San Francisco (www.nccc.ucsf.edu)

Date of data: 2010

Rating system: Checkmark = compatible on key parameters of CDC's 2006 HIV testing recommendations. Arrow = recent legislation has made state policy generally compatible with CDC's 2006 HIV testing recommendations. Rx symbol = incompatible on one or more parameters of CDC's 2006 HIV testing recommendations.

Indicator 3: CD4 and VL lab reporting

Definition: State statutes or regulations require the reporting of all CD4 values and all viral load results (detectable and undetectable) to the HIV surveillance program.

Rationale: National HIV/AIDS Strategy: CD4 and VL data are required to monitor progress toward national goals set by the Strategy (<http://www.whitehouse.gov/administration/eop/onap/nhas/>).

Source of data: Data collected via a 50-State survey using WestlawNext®, Division of HIV/AIDS Prevention, CDC.

Date of data: 2010

Rating system: Checkmark = state requires reporting of all values for CD4 and viral load reporting. Rx symbol = state statutes or regulations do not require reporting of all CD4 values and viral load results.

Healthcare-associated Infection Prevention

Public Health Indicator:

Indicator 1: Central line-associated bloodstream infection (CLABSI) – Standardized Infection Ratio (SIR)

Definition: Standardized Infection Ratio – A statistic used to measure relative difference in HAI occurrence during a reporting period compared to a common referent period (i.e., standard population). In HAI data analysis, the SIR compares the actual number of HAIs in a facility or state with the predicted number based on the baseline U.S. experience (i.e., standard population), adjusting for several risk factors that have been found to be most associated with differences in infection rates.

Rationale: Healthy People 2020 Objective HAI-1: Reduce central line-associated bloodstream infections (CLABSI). The National 5-year prevention target for CLABSIs outlined in the HHS Action Plan to Reduce HAIs (http://www.hhs.gov/ash/initiatives/hai/actionplan/hhs_hai_action_plan_final_06222009.pdf) uses the concept of an SIR equal to 0.5 as the goal.

Source of data: CDC First State-specific Healthcare-associated Infections Summary Data Report (http://www.cdc.gov/hai/pdfs/stateplans/SIR_05_25_2010.pdf). For some states, insufficient data were reported to CDC's National Healthcare Safety Network (NHSN) to produce a reliable standardized infection ratio. Data are available in real-time to facilities and in states where mandates exist.

Date of data: June – December 2009.

Policy Indicators:

Indicator 1: Acute care facilities reporting to CDC

Definition: Percent of eligible facilities in the state that report some HAI data to CDC's National Healthcare Safety Network.

Rationale: HHS Action Plan to Reduce HAIs – Information Systems and Technology: Increase the rate of dissemination of reporting data to external HAI surveillance activities performed by quality improvement organization and public health monitoring efforts. This will permit rapid detection of patterns and trends for predetermined or ad hoc sets of demographics, thus creating the opportunity to formulate appropriately targeted tactics and execute early prevention and intervention techniques.

(http://www.hhs.gov/ash/initiatives/hai/actionplan/hhs_hai_action_plan_final_06222009.pdf)

Source of data: CDC First State-specific Healthcare-associated Infections Summary Data Report

(http://www.cdc.gov/hai/pdfs/stateplans/SIR_05_25_2010.pdf)

Date of data: 2010

Rating System: NA

Indicator 2: Validating HAI data sent to CDC

Definition: Data sent to CDC's National Healthcare Safety Network (NHSN) are validated.

Rationale: HHS Action Plan to Reduce HAIs – Information Systems and Technology: Increase the rate of dissemination of reporting data to external HAI surveillance activities performed by quality improvement organization and public health monitoring efforts. This will permit rapid detection of patterns and trends for predetermined or ad hoc sets of demographics, thus creating the opportunity to formulate appropriately targeted tactics and execute early prevention and intervention techniques.

(http://www.hhs.gov/ash/initiatives/hai/actionplan/hhs_hai_action_plan_final_06222009.pdf)

Source of data: CDC First State-specific Healthcare-associated Infections Summary Data Report (http://www.cdc.gov/hai/pdfs/stateplans/SIR_05_25_2010.pdf)

Date of data: CDC last publicly reported national and state CLABSI data in December 2010.

Rating system: Checkmark = any effort in place in 2009 to validate data sent to CDC's NHSN. Rx symbol = no effort in place in 2009 to validate data sent to CDC's NHSN.

Indicator 3: Participation in statewide prevention efforts

Definition: The state health department is leading or taking part in broad prevention collaboratives addressing one or more of the following HAIs: CLABSI, SSI, CAUTI, VAP, MRSA, C. difficile.

Rationale: HHS Action Plan to Reduce HAIs – Research: Recent multicenter demonstration projects involving large numbers of healthcare facilities working collaboratively to decrease HAIs by simultaneously implementing a multifaceted prevention program have been able to demonstrate, through standardized data collection, deep reductions in central-line associated bloodstream infections (CLABSIs) in ICUs.

(http://www.hhs.gov/ash/initiatives/hai/actionplan/hhs_hai_action_plan_final_06222009.pdf)

Source of data: State health department HAI Coordinators

Date of data: 2010

Rating system: Checkmark = state health department is leading or taking part in a broad prevention collaborative addressing at least one HAI. Rx symbol = state health department is not participating in a broad prevention collaborative addressing an HAI.

Motor Vehicle Injury Prevention

Public Health Indicators:

Indicator 1: Motor vehicle-related death rate

Definition: Motor vehicle-related death rate per 100,000 population among all ages.

Rationale: Healthy People 2020 Objective IVP-13: Reduce motor vehicle crash-related deaths. IVP-13.1: Deaths per 100,000 population. (Note: HP 2020 objective uses National Vital Statistics System mortality data to calculate motor vehicle traffic-related death rates and is age-adjusted to the year 2000 standard population.)

Source of data: National Highway Transportation Safety Administration, Fatality Analysis Reporting System (<http://www-fars.nhtsa.dot.gov/Main/index.aspx>)

Date of data: 2009

Indicator 2: Motor vehicle-related death rate among adolescents

Definition: Overall motor vehicle traffic-related death rate per 100,000 population aged 15–19 years.

Rationale: Healthy People 2020 Objective IVP-13: Reduce motor vehicle crash-related deaths. IVP-13.1: Deaths per 100,000 population. (Note: HP 2020 objective uses National Vital Statistics System mortality data to calculate motor vehicle traffic-related death rates, is age-adjusted to the year 2000 standard population, and is not specific to adolescents.)

Source of data: National Highway Transportation Safety Administration, Fatality Analysis Reporting System (<http://www-fars.nhtsa.dot.gov/Main/index.aspx>)

Date of data: 2009

Indicator 3: Seat belt use

Definition: Observed belt use based on probability samples in all 50 states and DC.

Rationale: Healthy People 2020 Objective IVP-15: Increase use of safety belts. (Note: HP 2020 objective uses National Occupant Protection Use Survey data.)

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Source of data: National Highway Transportation Safety Administration State Belt Survey (<http://www-nrd.nhtsa.dot.gov/Pubs/811324.pdf>)

Date of data: 2009

Policy Indicators:

Indicator 1: Seat belt law

Definition: Primary or standard seat belt laws mean that it is permissible for police to stop vehicles solely for their drivers or passengers not wearing a seatbelt. Secondary seat belt laws require police to have some other reason for stopping the vehicle before they may cite drivers or passengers for not buckling up. Some states have primary laws that only cover the front seat occupants. Ideally states should have primary laws that cover all occupants regardless of their location in the vehicle.

Rationale: The Task Force on Community Preventive Services recommends primary safety belt laws based on strong evidence of their superior effectiveness over secondary enforcement laws in reducing motor vehicle-related injuries and deaths.

Source of data: Insurance Institute for Highway Safety (<http://www.iihs.org/laws/SafetyBeltUse.aspx>)

Date of data: 2010

Rating system: Checkmark = state has a primary law covering all seating positions. Arrow = state has a primary law covering only the front seat. Rx symbol = state has a secondary seat belt law or no law.

Indicator 2: Child safety restraint law

Definition: Child restraint laws require children to travel in approved child restraint devices, until they are big enough to use adult seat belts. All 50 states and the District of Columbia have child restraint laws. However, the age at which belts can be used instead of child restraints differs among the states.

Rationale: The Task Force on Community Preventive Services recommends child safety seat laws based on strong evidence of their effectiveness in increasing child safety seat use.

Source of data: Insurance Institute for Highway Safety (<http://www.iihs.org/laws/ChildRestraint.aspx>)

Date of data: 2010

Rating system: State ratings were based on the Insurance Institute for Highway Safety (IIHS) rating for child safety/booster seat laws. IIHS rating categories by age were collapsed. See <http://www.iihs.org/laws/HowLawsAreRated.aspx> for specific details about how ratings are derived. Checkmark = up to at least age 7 covered. Arrow = up to age 5 or 6 covered. Rx symbol = under age 5 covered.

Indicator 3: Graduated drivers license law

Definition: Graduated driver licensing (GDL) laws address the high risks faced by new drivers by helping them to gain experience under low-risk conditions through granting driving privileges and lifting restrictions in stages.

Rationale: Healthy People 2020 Objective IVP-17: Increase the number of States and the District of Columbia with "good" graduated driver licensing (GDL) laws.

Source of data: Insurance Institute for Highway Safety (http://www.iihs.org/laws/pdf/us_licensing_systems.pdf)

Date of data: 2010

Rating system: State ratings were based on the Insurance Institute for Highway Safety (IIHS) rating for GDL systems. See <http://www.iihs.org/laws/HowLawsAreRated.aspx> for specific details about how ratings are derived. Checkmark = any state that received a good rating from IIHS. Arrow = any state that received a fair IIHS rating. Rx symbol = any state that received a marginal rating by IIHS.

Indicator 4: Alcohol ignition interlock law

Definition: Ignition interlocks are considered to be any devices that analyze a driver's breath and disable the ignition if the driver has been drinking alcohol.

Rationale: The Task Force on Community Preventive Services recommends the use of ignition interlocks for people convicted of alcohol-impaired driving on the basis of strong evidence of their effectiveness in reducing re-arrest rates while the interlocks are installed. Public health benefits of the intervention are currently limited by the small proportion of offenders who install interlocks in their vehicles. More widespread and sustained use of interlocks among this population could have a substantial impact on alcohol-related crashes.

Source of data: Insurance Institute for Highway Safety (<http://www.iihs.org/laws/dui.aspx>)

Date of data: 2010

Rating system: For the rating, the Insurance Institute for Highway Safety description of ignition interlocks was referenced. Checkmark = states with a mandatory requirement for installation of ignition interlocks for all convicted offenders (including both first time and repeat offenders). Arrow = states with mandatory ignition interlocks for repeat offenders or high BAC first time offenders. Rx symbol = states with no laws or no mandatory law for ignition interlocks.

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