

## What Works from the Community Guide

The Guide to Community Preventive Services is a free resource with information on programs and policies to improve health and prevent disease at the community level. The Guide uses systematic reviews to evaluate what interventions have been proven effective. Here are a few highlights on evidence-based strategies for chronic disease prevention. Access the full resource at: [www.thecommunityguide.org](http://www.thecommunityguide.org).

### Highlights of Community Guide Recommendations: Increasing Cancer Screening Rates for Breast, Cervical & Colorectal Cancer

Client-Oriented Interventions			
<i>Intervention</i>	<i>Breast Cancer</i>	<i>Cervical Cancer</i>	<i>Colorectal Cancer</i>
Client reminders	Recommended	Recommended	Recommended
Client incentives	Insufficient Evidence	Insufficient Evidence	Insufficient Evidence
Small media	Recommended	Recommended	Recommended
Mass media	Insufficient Evidence	Insufficient Evidence	Insufficient Evidence
Group education	Recommended	Insufficient Evidence	Insufficient Evidence
One-on-one education	Recommended	Recommended	Recommended
Reducing structural barriers	Recommended	Insufficient Evidence	Recommended

Reducing client out-of-pocket costs	Recommended	Insufficient Evidence	Insufficient Evidence
<b>Provider-Oriented Interventions</b>			
<i>Intervention</i>	<i>Breast Cancer</i>	<i>Cervical Cancer</i>	<i>Colorectal Cancer</i>
Provider assessment & feedback	Recommended	Recommended	Recommended
Provider incentives	Insufficient Evidence	Insufficient Evidence	Insufficient Evidence
Provider reminder & recall systems	Recommended	Recommended	Recommended

*What the findings mean:*

**Recommended:** There is strong or sufficient evidence that the intervention strategy is effective. This finding is based on the number of studies, how well the studies were designed and carried out, and the consistency and strength of the results.

**Insufficient Evidence:** There is not enough evidence to determine whether the intervention strategy is effective. This does not mean the intervention strategy does not work. There is not enough research available or the results are too inconsistent to make a firm conclusion about the intervention strategy’s effectiveness.

*Summaries of Recommended strategies:*

**Client Reminders**

Reminders directed toward patients can be written, such as letters or postcards, or telephone messages, including automated messages. This reminders advise people they are due for a screening test. They are enhanced by follow-up messages, additional information with benefits of screening and help with scheduling appointments.

**Small Media**

Small media includes videos, brochures, letters and newsletters. They can be tailored toward a specific population or directed toward a general audience.

**One-on-one education**

One-on-one education about the benefits of screening can be conducted by a healthcare professional, lay health worker or volunteer, either in person or via phone. It is designed to deliver information to the individual and help them overcome barriers to screening.

### **Reducing structural barriers**

Structural barriers are non-economics barriers to getting a screening test. Reducing these barriers can include offering expanded clinic office hours; assisting patients with transportation to their appointments; patient navigation services; and child care.

### **Provider Assessment and Feedback**

The Community Guide recommends provider assessment and feedback on the basis of sufficient evidence of effectiveness in increasing screening for breast cancer (mammography), cervical cancer (Pap test), and colorectal cancer (FOBT). Evidence was insufficient, however, to determine the effectiveness of this intervention in increasing colorectal cancer screening using methods other than FOBT.

Provider assessment and feedback interventions both evaluate provider performance in delivering or offering screening to clients (assessment) and present providers with information about their performance in providing screening services (feedback). Feedback may describe the performance of a group of providers (such as mean performance for a practice) or an individual provider, and may be compared with a goal or standard.

### **Provider reminder & recall systems**

Reminders inform health care providers it is time for a client’s cancer screening test (called a “reminder”) or that the client is overdue for screening (called a “recall”). The reminders can be provided in different ways, such as in client charts, electronic health records or by e-mail.

Source: Guide to Community Preventive Services. Cancer prevention and control: provider-oriented interventions to increase breast, cervical, and colorectal cancer screening.

[www.thecommunityguide.org/cancer/screening/provider-oriented/index.html](http://www.thecommunityguide.org/cancer/screening/provider-oriented/index.html).

Source: Guide to Community Preventive Services. Cancer prevention and control: client-oriented interventions to increase breast, cervical, and colorectal cancer screening.

[www.thecommunityguide.org/cancer/screening/client-oriented/index.html](http://www.thecommunityguide.org/cancer/screening/client-oriented/index.html).

## **Highlights of Community Guide Recommendations: Cardiovascular Disease Prevention & Control**

<b>Intervention</b>	<b>Recommendation</b>
Clinical Decision-Support Systems	Recommended

Reducing Out-of-pocket Costs	Recommended
Team-Based Care	Recommended

*Summaries of Recommended strategies:*

**Clinical Decision-Support Systems (CDSS)**

Clinical Decision-Support Systems are computer-based information systems that use patient data to provide tailored assessments and evidence-based treatments to aid providers in making recommendations at the point of care. Examples include reminders for overdue preventive services including screening for high blood pressure, diabetes, and high cholesterol; or recommendations for health behavior changes to discuss with patients such as quitting smoking or increasing physical activity. They are often integrated into a clinic’s Electronic Health Record to offer features such as patient summary reports or feedback on quality indicators.

**Reducing Out-of-Pocket Costs**

This strategy involves reducing out-of-pocket costs for patients with high blood pressure or cholesterol. Interventions can include reducing costs of medications, lowering or eliminating copayments or deductibles, and making preventive services (such as nutrition counseling) more affordable. This strategy was shown to be effective in improving medication adherence and blood pressure and cholesterol outcomes.

**Team-Based Care**

The Community Guide recommends a team-based approach to improve blood pressure control for patients with hypertension. Team-based care is an organizational intervention that may add new staff or change the role of existing staff to provide a team (nurses, pharmacists, dietitians, social workers) who complement the role of the primary care provider. The team shares the responsibility of delivering hypertension care to the patient.

Source: Guide to Community Preventive Services. Cardiovascular disease prevention and control.  
<http://www.thecommunityguide.org/cvd/index.html>

## **Highlights of Community Guide Recommendations: Diabetes Prevention & Control (Healthcare Level Interventions)**

<b>Intervention</b>	<b>Recommendation</b>
Case Management Interventions to Improve Glycemic Control	Recommended
Disease Management Programs	Recommended

*Summaries of Recommended strategies:*

### **Case management Interventions to Improve Glycemic Control**

Diabetes case management involves the services of a professional case manager who does not provide direct healthcare services but plans and coordinates a patient's care. The Community Guide's review showed the case management led to decreased glycated hemoglobin (average blood sugar) levels and increased providers' monitoring of glycated hemoglobin when implemented with disease management.

### **Disease management programs**

Disease management is an organized, integrated approach to healthcare delivery for people with a certain condition, such as diabetes. Disease management identifies client affected by the diseases and aims to integrate care to prevent complications and comorbid conditions. Disease management has been shown to improve glycemic control, provider monitoring of glycated hemoglobin and screening for diabetic retinopathy.

Source: Guide to Community Preventive Services. Diabetes prevention and control.

[www.thecommunityguide.org/diabetes/index.html](http://www.thecommunityguide.org/diabetes/index.html).