The Winnable Battles initiative was created by the Centers for Disease Control and Prevention (CDC) to help more quickly address some leading causes of death and disability in the United States. These Winnable Battles exist in areas of public health where significant health issues can be addressed and, where proven, effective strategies are available to focus on them. The initiative focuses on identifying the most promising strategies and clearly defined targets so that measurable results can be achieved in a relatively short time, usually within one to four years. CDC’s Winnable Battles include:

- Nutrition, Physical Activity, Obesity and Food Safety
- Healthcare-Associated Infections
- HIV
- Motor Vehicle Injuries
- Teen Pregnancy
- Tobacco

The Winnable Battles initiative seeks to focus more attention on diseases, conditions and injuries that place tremendous health and economic burdens on the country. By using proven prevention strategies, focusing resources and forging partnerships, the Winnable Battles initiative can significantly affect health and may provide a return on investment for state budgets.

According to an Institute of Medicine (IOM) report, *For the Public’s Health: Investing in a Healthier Future,* investing in prevention efforts that reach all people can improve health status more efficiently than clinical care alone. Research from the Trust for America’s Health report, *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities,* indicates programs that address behavioral risk factors, such as physical inactivity, poor nutrition and smoking, often can successfully lower chronic disease rates, resulting in a return on investment of $5.60 for every $1 invested. The Trust for America’s Health report also indicates that an investment of $10 per person in proven community-based programs that increase physical activity, improve nutrition, and prevent smoking and other tobacco use over five years could save Medicare, Medicaid and private insurers $16 billion annually.

The Winnable Battles, highlighted below, reference some of the efforts that have successfully addressed these important health areas. Each section also includes examples of proven or promising strategies, policy options and programs that state and local health departments have implemented to make progress in these Winnable Battles.

**Nutrition, Physical Activity and Obesity**

Obesity contributes to many leading causes of death, including heart disease, stroke, diabetes and some cancers. Although only 15 percent of U.S. adults were obese in 1980, the obesity rate doubled to 30.9 percent by 2000. In 2011, the adult obesity rate in all states was 20 percent or more, and in 12 states was 30 percent or more. U.S. childhood obesity rates have nearly tripled during the past three decades. Today, more than 12 million American children and adolescents are obese, and more than 23 million are either obese or overweight. Obese children and teenagers are at greater risk of developing serious chronic diseases such as type 2 diabetes, heart disease, high blood pressure, cancer and other conditions, including asthma, sleep apnea, and psychosocial effects such as decreased self-esteem. The CDC estimates that national health care spending on obesity-related conditions in children is nearing $150 billion annually.

According to new estimates published in the American Journal of Preventive Medicine, leveling the rate of childhood and adult obesity could yield savings of nearly $550 billion in medical expenditures during the next two decades. Approaches to fighting obesity and promoting nutritious diets and increased physical activity include improving food choices in various settings; increasing access to affordable fruits and vegetables so...
more people are able to meet U.S. dietary guidelines; and supporting safe places to exercise and play to increase the number of people who are able to meet recommended physical activity guidelines. CDC invests in comprehensive strategies to improve nutrition and increase physical activity for the entire population at the state and local levels, emphasizing strategies to increase physical activity; improve healthy eating; and reduce sodium consumption in schools, early care and education facilities, worksites and communities.

**Strategies That Have Been Implemented**

- Support development of school health councils and school health planning processes.
- Establish and implement nutrition education and standards in schools, child care facilities, worksites and hospitals.
- Adopt school wellness policies with provisions for physical education and health education at school and include all food served or sold on school campuses.
- Promote high-quality health education and physical education in schools and establish requirements for how much time students must spend in physical education at school.
- Increase opportunities for quality physical education, physical activity and recess in schools and licensed child care facilities.
- Measure students’ body mass index in school and report the information confidentially to parents.
- Expand programs that increase access to fresh produce in schools, businesses and communities, such as farm-to-school programs, farmers’ markets and incentives to develop grocery retail outlets that offer fresh fruits and vegetables in areas that lack them.
- Encourage schools and local governments to enter into joint use agreements to increase community access to indoor and outdoor recreation facilities at schools before or after the school day.
- Create and maintain safe neighborhoods for physical activity by improving access and conditions in parks and playgrounds; promoting dedicated lanes for bicycle and public transit; and promoting walk-to-school and work initiatives.
- Promote active modes of transportation in community planning and regional transportation design.
- Encourage comprehensive worksite wellness programs that address physical activity, nutrition and tobacco use, including for state employees.
- Support “baby friendly” hospital programs that encourage breast feeding and provide peer-to-peer breastfeeding support programs.
- Support preventive lifestyle services within the health care system, such as coverage for weight management; nutrition education; and diabetes, blood pressure, and cholesterol screening and management.

**State Example: New York**

The New York State Department of Health and New York’s Hunger Prevention and Nutrition Assistance Program implemented the Taste ‘n’ Take program to improve access to retail venues that sell or increase availability of high-quality fruits and vegetables in underserved communities. The Taste ‘n’ Take program provides a weekly bag of fresh produce to individuals and families living in low-income housing in Troy, Albany and Schenectady, N.Y. Through sample tastings, participants are introduced to a variety of fresh produce and learn how to prepare the fresh produce.

After one year, the Taste ‘n’ Take program was transformed into a Veggie Mobile Market site that provides access to fresh produce at a reasonable price to customers in urban areas. Since the start of the program in 2007-08, the funds raised and fresh produce sold have steadily increased. In 2007-08, 10,000 pounds of fresh produce were distributed, with revenue of $7,646. By the 2010-11 season, 291,000 pounds of fresh produce were distributed.

**Food Safety**

Each year, foodborne pathogens cause about one in six Americans to become ill, nearly 128,000 to be hospitalized and about 3,000 to die, according to CDC estimates. Foodborne illnesses account for billions of dollars in health care-related and industry-related costs. Reducing foodborne illnesses by 10 percent
would prevent 5 million people from becoming sick each year.

The good news is that during the past 15 years, occurrences of a dangerous type of E. coli infection—once responsible for the recall of millions of pounds of ground beef—has been reduced by half. During that same time, however, Salmonella infection, which causes more hospitalizations and deaths than any other type of foodborne germ and has a direct annual medical cost of $365 million, has not decreased. Declining federal, state and local resources have impaired the ability to reduce food-related illness outbreaks, such as those caused by Salmonella.

The 2011 federal Food Safety Modernization Act (FSMA) represented the first major change to U.S. food safety laws since 1938. The act includes new inspection and compliance controls to reduce health and economic effects of foodborne illnesses. The act allows the Food and Drug Administration (FDA) to respond to food safety problems as they arise and holds both imported and domestically produced foods to the same standards.

The FSMA also directs the CDC to work with states to expand and improve their foodborne disease surveillance systems that are used to detect outbreaks of foodborne illness. Combined with the new authorities for FDA, the enhanced surveillance and response capacity at local, state and federal levels authorized in the act can increase the capabilities of U.S. food safety systems. The new food safety systems will provide additional opportunities for detecting more problems sooner; responding to them faster and more efficiently; monitoring the effectiveness of interventions to prevent foodborne illness; and providing data to guide food safety policy.

Each state retains independent authority to regulate food safety standards. State and local governments maintain primary responsibility for inspecting facilities such as restaurants, nursing homes and schools, and for responding to foodborne outbreaks. These state and local efforts are essential to strengthening the national food safety system, and a coordinated national system can improve overall surveillance and public health system response to contain outbreaks.

**Strategies That Have Been Implemented**

**Surveillance and Outbreak Detection and Response**

- Integrate, expand where needed and make more efficient the foodborne disease surveillance systems used by state and local health departments to detect and respond to foodborne disease outbreaks.
- Track trends, report progress and ensure that policies aimed at reducing infections are effective.
- Develop new tools to more quickly find sources of contamination and characterize germs.
- Assist long-term efforts of state and local public health laboratories to adopt new diagnostic technologies that identify specific foodborne pathogens and their disease-causing characteristics.
- Improve the rapid investigation of outbreaks and identification of outbreak sources, and use control strategies when outbreaks are identified.

**Inspection**

- Concentrate inspection efforts on the most common food safety issues in your state.
- Support state and local inspection activities.
- Improve education and training for food workers and government inspectors.
- Use licensing and inspection powers to protect consumers.

**Use of Standards and Guidelines**

- Adopt the latest FDA Hazard Analysis and Critical Control Point (HACCP) plan guidelines.
- Set standards for the sanitary growth, production and preparation of specific food items, such as shellfish and dairy products.
- Outline sanitation standards for safe food storage, handling and preparation in food service establishments and retail food operations.

**State Example: Colorado**

In 2011, cantaloupes contaminated with the bacterium *Listeria monocytogenes* caused the most deadly foodborne outbreak seen in the United States in nearly 90 years. The number of deaths would likely have been higher had it not been for an effective, coordinated response by the state and local health departments, CDC and the Food and Drug Administration (FDA). Lives were saved because, within days of the first reported
illness, the food outbreak was detected, its source was identified, and a national warning was issued.

Such effective and efficient coordination can occur only when significant investments have been made in coordinated public health systems. For example, the Colorado Health Department sent samples of *Listeria* from patients to the state’s public health laboratory for PulseNet “DNA fingerprinting,” which allowed identification of the particular strain of *Listeria*. By matching it with samples from patients in other jurisdictions sent to PulseNet labs throughout the country, the team was able to track the outbreak in other states.

Investigators interviewed patients and their families about the foods they ate, allowing them to determine the one food that caused the illness. By sharing this information, state and federal officials traced the outbreak to its source and promptly issued a national warning.

### Healthcare-Associated Infections

Healthcare-associated infections (HAIs), which affect one of every 20 hospitalized patients, are caused by a wide variety of bacteria, fungi and viruses. According to the CDC, more than 1 million infections occur within the health care system every year, including 99,000 associated deaths, resulting in an estimated $30 billion in health care costs annually.

The federal American Recovery and Reinvestment Act (ARRA) of 2009 provided states with $50 million to be used to increase HAI surveillance and prevention. Progress is being made in reducing HAIs. For example, for central line-associated bloodstream infections alone, data from the National Healthcare Safety Network (NHSN) demonstrated a 32 percent reduction in 2010, saving up to 5,000 lives and an estimated $83 million in health care costs. Additional progress toward national HAI targets includes an 8 percent reduction in surgical site infections, and a 6 percent reduction in catheter-associated urinary tract infections between 2009 and 2010.

Although HAIs declined in recent years, infections involving *Clostridium difficile*—a bacterium that can cause symptoms ranging from diarrhea to life-threat-
State Example: New York

In July 2005, New York passed a law requiring all hospitals to report healthcare-associated infections to the New York State Department of Health. Hospital administrators were encouraged to take a closer look at infection rates and institute stricter infection prevention strategies. Beginning in 2007, 187 New York hospitals began reporting HAIs. The mandatory reporting law allowed for an initial one-year pilot phase to ensure the completeness and accuracy of HAI reporting.

According to New York’s 2010-2011 annual report, National Healthcare Safety Network data show that, from 2007 to 2010, adult and pediatric central line-associated bloodstream infection rates decreased by 37 percent among various intensive care units in the state. Stakeholders attributed success to the initial pilot reporting program, which allowed the state to refine requirements and educate facilities about reporting.

HIV

More than 1 million people in the United States are infected with Human Immunodeficiency Virus (HIV), and more than 50,000 become newly infected each year. As many as 18 percent of people with an HIV infection are unaware of their status. CDC’s comprehensive HIV surveillance systems monitor changes in new HIV infections, prevalence and related deaths and identify risk factors for HIV infection. CDC recommends routine testing for all adults and adolescents as a key prevention tool. It also recommends annual testing for those who are at increased risk of acquiring HIV and for women with each pregnancy. CDC provides support and funding to states and territories through prevention and surveillance programs, research and evaluation.

To encourage HIV testing, at least 48 states have adopted laws that are consistent with CDC’s testing recommendations, including provisions that incorporate informed written consent for HIV testing into general consent for medical care with an option to opt out of HIV testing, instead of singling out HIV testing for consent.

Strategies that have been implemented

- Encourage work with faith-based organizations, community groups and local businesses to support HIV prevention education campaigns that promote awareness and address concerns about social stigma.
- Support HIV prevention and education efforts in communities where HIV is most heavily concentrated.
- Target efforts to prevent HIV infection using a combination of effective evidence-based approaches, including behavioral interventions to reduce sex- and/or drug-related risk behaviors and biomedical interventions to support the use of antiretroviral therapy.
- Increase access to condoms and sterile syringes, especially for groups that are at higher risk for HIV infections.
- Increase access to and awareness of HIV testing opportunities, ensuring that people are tested for HIV; screened for other sexually transmitted infections; and linked to prevention, care and treatment services.
- Promote use of national referral systems for places to be tested, such as www.hivtest.org.
- Encourage insurance plans, public programs and health care providers to include HIV testing as part of routine care for adults, adolescents and pregnant women.
- Ensure reporting of CD4 count and viral load data (used to measure disease progression) for people who are HIV positive.
- Report data to surveillance programs (across jurisdictions, private and federal facilities and institutions).
**State Example: Kentucky**

The Kentucky Department of Public Health (KDPH) educates its grantees by using zip-code level surveillance data to target HIV testing, condom distribution, and prevention with HIV-positive people in areas where HIV infection is most heavily concentrated. These programs have improved HIV prevention efforts. After focusing efforts on targeting high-risk populations, for example, a local agency in Lexington increased the HIV positive testing rate from 1 percent to 4 percent.

**Motor Vehicle Injuries**

Motor vehicle-related injuries are the leading cause of death for Americans ages 5 to 34, resulting in $41 billion in medical and work-loss costs and more than 32,000 deaths each year. CDC promotes policies and programs to reduce crashes and improve the safety of drivers, passengers, bicyclists and pedestrians. Strategies include increasing seat belt use, promoting teen driving safety and reducing alcohol-impaired driving.

Most states also have injury and violence prevention units that coordinate and lead state prevention initiatives. In all states and the District of Columbia, the state health and transportation departments collect data on motor vehicle crash-related injuries and deaths. State health departments also collect additional data on the broad range of unintentional and violence-related injuries. Funds for state programs are provided by state general fund appropriations, federal grants and cooperative agreements, and other sources, such as license fees.

**Strategies That Have Been Implemented**

- Establish primary enforcement seat belt laws that are applicable to all passengers in the car, not just front-seat riders.
- Establish fines for seat belt infractions.
- Create high-visibility communications and outreach campaigns to support seat belt enforcement efforts.
- Require universal helmet use for all motorcycle riders.
- Enact distracted driving laws such as prohibiting text messaging or using hand held devices while driving.
- Require age- and size-appropriate child restraints in motor vehicles.
- Support strong graduated driver’s licensing laws.
- Encourage more widespread use of sobriety checkpoints.
- Require ignition interlocks for all impaired driving offenders, including first-time offenders.

**State Example: Georgia**

Beginning in July, 2011, Georgia requires all children under age 8 who are 4’9” or less to be in a car/booster seat appropriate for their height and weight and seated in the rear seat. The law was based on scientific studies of effective methods to reduce child injuries.

To help implement the new law, the Georgia Department of Public Health launched a community education campaign, “Give Kids a Boost,” in collaboration with the Georgia State Patrol and the Governor’s Office of Highway Safety. Public health officials and partners have visited counties across the state to explain the new law to parents and show them how to use car/booster seats correctly. Community partners also launched a public education campaign and trained more than 300 state patrol officers about how to use safety seats.

**Teen Pregnancy**

The U.S. teen birth rate has dropped 49 percent since its peak in 1991, and today stands at an all-time low. In 2011, there were 31.3 births per 1,000 teenagers ages 15 to 19. Simply put, teenagers are having less sex and using more contraception. While better decision making by young people and a corresponding drop in the birth rate is a trend to celebrate, the fact remains that three in 10 girls become pregnant at least once before their 20th birthdays. Rates vary significantly across racial and eth-
nic lines—from 10.9 per 1,000 Asian or Pacific Islander teenagers to 23.5 per 1,000 for non-Hispanic white teens, 51.5 for non-Hispanic black teens, and 55.7 for Hispanic teens. Birth rates also vary from state to state, ranging from 15.7 per 1,000 teens in New Hampshire to 55.0 per 1,000 teens in Mississippi in 2010.9

The economic and social costs of teen childbearing are staggering. The taxpayer burden for teen pregnancy was nearly $11 billion in 2008. This amount includes increased costs for public sector health care, child welfare, incarceration, and lost tax revenues resulting from low educational achievement and reduced earnings of teen parents and their children.10

Fewer than half—40 percent—of teen mothers finish high school, and fewer than 2 percent finish college. Many children of teen mothers may not escape the cycle of poverty into which they were born. These children are more likely to have contact with the child welfare and criminal justice systems and are less likely to graduate from high school than children born to women who are age 20 or 21. Girls born to teen mothers also are more likely to become teen mothers themselves.11

States typically are compelled to address teen pregnancy prevention because of the high economic and societal costs. In some cases, states partner with federal programs to provide health care services or sexual health education programming. Nine states have expanded their Medicaid programs through a state plan amendment to provide services to women who would not otherwise qualify for the program. Twenty-three states operate time-limited demonstration waiver programs to extend the services to such women at higher income levels than would allow them to qualify for traditional Medicaid in their state.12 Almost all states and territories have taken advantage of federal grants available for abstinence education and/or personal responsibility education programs that include comprehensive, prevention-based sex education. Additional federal funding, including some in partnership with the CDC, goes to state health and education departments for evidence-based teen pregnancy prevention programs.

A variety of policies and initiatives at the state and community levels provide young people with the knowledge they need to delay sexual activity or prevent unintended pregnancies should they have sex.

**Strategies That Have Been Implemented**

- Determine which teen populations in the state have the highest rates of unintended pregnancies.
- Understand current state policies regarding how teens and young adults might access and pay for contraception if they are sexually active. Such policies may include Medicaid family planning waivers or state plan amendments; minors’ ability to consent for services; and privacy protections for patients, or the lack thereof, such as rules related to insurance explanation of benefits.
- Review existing state policies for school-based pregnancy prevention education, including both abstinence and abstinence-plus curricula, and check whether the programs are required to be medically accurate, evidence-based and/or age-appropriate.
- Determine whether your state receives federal grant money for teen pregnancy prevention programs and which populations the programs reach. Incorporate teen pregnancy prevention into state efforts to reduce the high school dropout rate and improve educational attainment, and case management requirements for young people in the juvenile justice and/or foster care systems.
- Support and offer programs to educate parents about how to communicate effectively with their teens.
- Take advantage of federal funding to expand school-based health centers, which are effective venues for health education and can refer youth to or, in limited cases, provide family planning services.
- Encourage youth to participate in service learning or other activities that positively support their overall development and, at the same time, may help to prevent teen pregnancy.
STATE EXAMPLE: CONNECTICUT

In New Britain, Conn., the Pathways/Senderos Center’s community-based program for at-risk teens provides academic support, career preparation, family life and sexual health education, recreation, and health care and self-esteem enhancement information and resources. Based on the Carrera Adolescent Pregnancy Prevention Program, an evidence-based program recognized by the federal Office of Adolescent Health, the Pathways/Senderos has improved educational attainment and reduced teen pregnancy rates in the region: 100 percent of participating youth graduate from high school and, since 1993, only 3 percent of participants have become pregnant overall, compared to the 17.7 percent regional teen pregnancy rate.13 Organizations in New Jersey, New York and West Virginia received funding from the federal Office of Adolescent Health to implement the Carrera program in 2011.

TOBACCO

Tobacco use remains the leading preventable cause of disease and death in the United States. An estimated 46.6 million people—about one in five U.S. adults—currently smoke. Each year, an estimated 443,000 people die prematurely from diseases caused by smoking or secondhand smoke exposure. CDC estimates that 88 million nonsmoking Americans, including 54 percent of children ages 3 to 11, are exposed to secondhand smoke. According to the surgeon general’s report, The Health Consequences of Involuntary Exposure to Tobacco Smoke,14 secondhand smoke exposure can cause serious disease and death, including heart disease and lung cancer in nonsmoking adults, as well as sudden infant death syndrome, acute respiratory infections, ear problems, and more frequent and severe asthma attacks in children. Tobacco use also carries a significant economic burden. According to the CDC, tobacco is responsible for $96 billion per year in medical expenditures and another $97 billion per year in lost productivity.

Health departments in the 50 states, the District of Columbia, eight U.S. territories and eight tribal support centers receive funding from the CDC to focus on tobacco use prevention, cessation, smoke-free environments and tobacco-related disparities.

STRATEGIES THAT HAVE BEEN IMPLEMENTED

• Require smoke-free public places, including schools, workplaces, restaurants and bars.
• Increase tobacco prices, which has been shown to both discourage youth from smoking and encourage smokers to quit.
• Provide Medicaid coverage for comprehensive tobacco cessation services.
• Offer state employee programs that provide cessation support and benefits.
• Require private insurers to cover tobacco cessation treatment services.
• Fund comprehensive tobacco control programs at CDC-recommended levels.15
• Support an evidence-based mass media campaign against tobacco use.16
• Encourage physicians to promote cessation to their patients who use tobacco.
• Prohibit tobacco advertising in or near schools.
• Require placement of all tobacco products behind the counter in stores to restrict sales to minors.

STATE EXAMPLE: MASSACHUSETTS

According to a recent study by George Washington University, Massachusetts saved $3.12 for each $1 it invested in Medicaid tobacco cessation treatment coverage. The savings resulted from reduced cardiovascular-related hospital admissions for heart attacks and coronary artery disease complications, which are highly correlated to tobacco use. Savings were seen as early as one year after tobacco cessation coverage was implemented. This study calculated only the short-term savings within Medicaid, however, and did not include other health improvements for people with asthma or long-term effects that tobacco cessation may have for family members. Just two and a half years after implementing cessation coverage, Massachusetts also realized a drop in tobacco use—from 38 percent to 28 percent—in people insured by Medicaid. Tobacco cessation coverage for Medicaid enrollees was required under the Massachusetts health reform law enacted in April 2006.
CONCLUSION

While there is not a single, successful approach that exists to address all these important health areas, there are certainly programs and policies that have been evaluated and proven to be effective. They have demonstrated a clear potential to be adopted or adapted by other communities facing similar health issues. As this document underscores, many states have adopted initiatives that address Winnable Battles in an effort to prevent costly and devastating chronic diseases, reduce injuries and infections, and promote healthy behaviors. From requiring physical education in schools and educating the public about proper seat belt safety to providing Medicaid coverage for tobacco cessation services and creating programs and policies to test people who are at risk for HIV, states are making important progress by implementing what works.

Perhaps the most important take-away is that each state is working on its own Winnable Battles and continues to tackle its own health priorities, focusing on a set of proven, scalable interventions with the greatest health and economic impact.

For more information about the Winnable Battle initiative, visit www.cdc.gov/winnablebattles.
Notes


6. Centers for Disease Control and Prevention, National Center for Emerging Zoonotic Infectious Diseases, Division of Healthcare Quality Promotion, Vital Signs: Making Health Care Safer (Atlanta, Ga.: CDC, 2012).


RESOURCES


Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health. *Vital Signs: Preventing Teen Pregnancy in the U.S.* Atlanta, Ga.: CDC, 2011.


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