



Prevention Status Reports



PSR

Office for State, Tribal, Local and Territorial Support

National Summary Report

Accessed on October 14, 2020

About the Prevention Status Reports

The Prevention Status Reports (PSRs) highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to address the following important public health problems and concerns:



PSR Framework




Each report follows a simple framework:


- Describe the public health *problem* using public health data
- Identify potential *solutions* to the problem drawn from research and expert recommendations
- Report the *status* of those solutions for each state and the District of Columbia


Criteria for Selection of Policies and Practices

The policies and practices reported in the PSRs were selected because they—

- Can be monitored using state-level data that are readily available for most states and the District of Columbia
- Meet one or more of the following criteria:

 Supported by systematic review(s) of scientific evidence of effectiveness (e.g., *The Guide to Community Preventive Services*)

 Explicitly cited in a national strategy or national action plan (e.g., *Healthy People 2020*)

 Recommended by a recognized expert body, panel, organization, study, or report with an evidence-based focus (e.g., Institute of Medicine)

Ratings

The PSRs use a simple, three-level rating scale—green, yellow, or red—to show the extent to which the state has implemented the policy or practice in accordance with supporting evidence and/or expert recommendations. The ratings reflect the *status of policies and practices* and do not reflect the *status of efforts* of state health departments, other state agencies, or any other organization to establish or strengthen those policies or practices.

Suggested Citations

For a state report:

Centers for Disease Control and Prevention. *Prevention Status Reports: [State name]*. Atlanta, GA: US Department of Health and Human Services; 2016. Accessed [month date, year].

For the National Summary:

Centers for Disease Control and Prevention. *Prevention Status Reports: National Summary*. Atlanta, GA: US Department of Health and Human Services; 2016. Accessed [month date, year].

National Summary Table

The Prevention Status Reports (PSRs) highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to prevent or reduce problems in 10 important public health topics. Below is a summary of the 2015 PSR topics and the percentage of states in each rating category. (Note: States with missing data are not included in the ratings calculation.)

PSR Policies and Practices by Topic	2015		
	Ratings (% of states)		
	Green	Yellow	Red
Alcohol-Related Harms			
State beer excise tax	8	8	84
State distilled spirits excise tax	9	32	59
State wine excise tax	5	21	74
Commercial host (dram shop) liability laws	39	49	12
Food Safety			
Speed of pulsed-field gel electrophoresis testing of reported <i>E. coli</i> O157 cases	90	8	2
Completeness of pulsed-field gel electrophoresis testing of reported <i>Salmonella</i> cases	92	6	2
State adoption of selected foodborne disease-related provisions*	33	31	35
Healthcare-Associated Infections (HAIs)			
State activities to build capacity for HAI prevention*	73	27	0
Stewardship programs to improve antibiotic use in acute care hospitals*	0	22	78
Heart Disease and Stroke			
Meaningful use of electronic health records	96	4	0
State pharmacist collaborative drug therapy management policy	76	18	6
HIV			
State Medicaid reimbursement for routine HIV screening*	82	2	16
Consistency of state HIV testing law with CDC's 2006 HIV testing recommendations	98	N/A	2
State reporting of all CD4 and all viral load data	55	31	14
HIV viral suppression*	0	N/A	100
Motor Vehicle Injuries			
Seat belt law	37	31	31
Child passenger restraint law	4	76	20
Graduated driver licensing: learner's permit age*	18	67	16
Graduated driver licensing: learner's permit holding period*	16	80	4
Graduated driver licensing: nighttime driving restriction *	25	25	49
Graduated driver licensing: young passenger restriction *	86	2	12
Graduated driver licensing: unrestricted licensure age*	12	47	41
Ignition interlock law	51	39	10
Nutrition, Physical Activity, and Obesity			
Secondary schools not selling less nutritious foods and beverages	31	41	29
Nutrition standards policy for foods and beverages sold on state executive branch property*	4	4	92
Inclusion of obesity prevention standards in state licensing regulations of childcare facilities	0	0	100
State average birth facility score for breastfeeding support	29	55	16
Prescription Drug Overdose			
Requirement for timely data submission to prescription drug monitoring program*	47	45	8
Requirement for universal use of state prescription drug monitoring program*	8	8	84
Teen Pregnancy			
Expansion of state Medicaid family planning eligibility	27	59	14

Tobacco Use

State cigarette excise tax	31	33	35
Comprehensive state smoke-free policy	53	20	27
State funding for tobacco control	0	14	86

N/A = Not applicable.

*2015 data not comparable to 2013 data because of changes in the policy/practice indicator or rating scale. Percentages for each policy/practice might not sum to 100 due to rounding.

Alcohol-Related Harms

The Prevention Status Reports highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to address 10 important public health problems and concerns. This report focuses on the following evidence-based policies recommended by the Community Preventive Services Task Force for preventing alcohol-related harms (1,2):

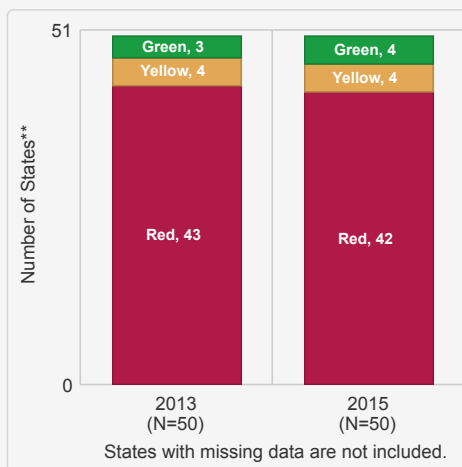


- Increasing state excise taxes on beer
- Increasing state excise taxes on distilled spirits
- Increasing state excise taxes on wine
- Having commercial host (dram shop) liability laws

Other strategies recommended by the Community Preventive Services Task Force and US Preventive Services Task Force for reducing alcohol-related harms include regulating alcohol outlet density, avoiding further privatization of retail alcohol sales, and providing adults (including pregnant women) with screening and brief intervention for excessive alcohol use (3–5).

State beer excise tax

The excise tax rate, in dollars per gallon, imposed by the state on beer containing 5% alcohol by volume. State beer excise tax does not include any additional taxes, such as those based on price rather than volume (e.g., ad valorem or sales taxes) that states have implemented at the wholesale or retail level.



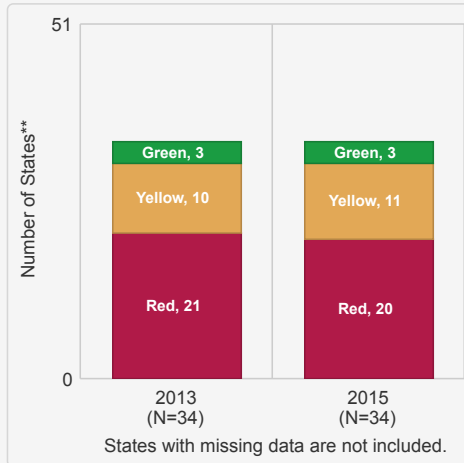
Rating	State beer excise tax
Green	≥\$1.00 per gallon
Yellow	\$0.50–\$0.99 per gallon
Red	<\$0.50 per gallon

How These Ratings Were Determined

Data on state beer excise taxes were obtained from the Alcohol Policy Information System (6). As of January 1, 2014, state beer excise taxes ranged from \$0.02 to \$1.29 per gallon across states for which data were available. The ratings reflect where each state's tax fell within this range. For states with different tax rates for off-premises (e.g., liquor stores) and on-premises (e.g., restaurants) retailers, the off-premises tax rate was reported.

State distilled spirits excise tax

The excise tax rate, in dollars per gallon, imposed by the state on distilled spirits containing 40% alcohol by volume. State distilled spirits excise tax does not include any additional taxes, such as those based on price rather than volume (e.g., ad valorem or sales taxes) that states have implemented at the wholesale or retail level.



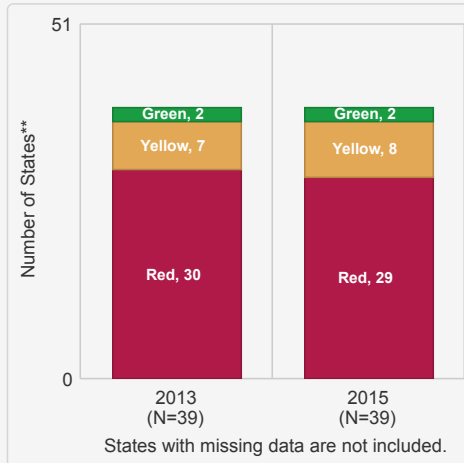
Rating	State distilled spirits excise tax
Green	≥\$8.00 per gallon
Yellow	\$4.00–\$7.99 per gallon
Red	<\$4.00 per gallon

How These Ratings Were Determined

Data on state distilled spirits excise taxes were obtained from the Alcohol Policy Information System (7). As of January 1, 2014, state distilled spirits excise taxes ranged from \$1.50 to \$14.25 per gallon across states for which data were available. The ratings reflect where each state's tax fell within this range. For states with different tax rates for off-premises (e.g., liquor stores) and on-premises (e.g., restaurants) retailers, the off-premises tax rate was reported.

State wine excise tax

The excise tax rate, in dollars per gallon, imposed by the state on wine containing 12% alcohol by volume. State wine excise tax does not include any additional taxes, such as those based on price rather than volume (e.g., ad valorem or sales taxes) that states have implemented at the wholesale or retail level.



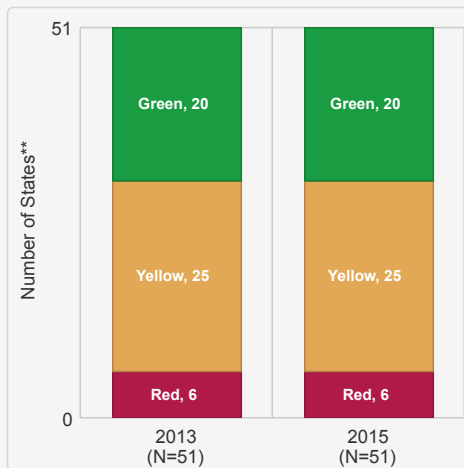
Rating	State wine excise tax
Green	≥\$2.00 per gallon
Yellow	\$1.00–\$1.99 per gallon
Red	<\$1.00 per gallon

How These Ratings Were Determined

Data on state wine excise taxes were obtained from the Alcohol Policy Information System (8). As of January 1, 2014, state wine excise taxes ranged from \$0.11 to \$2.50 per gallon across states for which data were available. The ratings reflect where each state's tax fell within this range. For states with different tax rates for off-premises (e.g., liquor stores) and on-premises (e.g., restaurants) retailers, the off-premises tax rate was reported.

Commercial host (dram shop) liability laws

Laws that permit alcohol retail establishments to be held liable for injuries or harms caused by illegal service to intoxicated or underage customers.



Rating	State had
Green	Commercial host liability with no major limitations
Yellow	Commercial host liability with major limitations
Red	No commercial host liability

How These Ratings Were Determined

These ratings reflect data provided by Alcohol Policy Consultations and ChangeLab Solutions on current state laws for commercial host liability (9–11). A state's commercial host liability law was considered to have major limitations if it 1) covered underage patrons or intoxicated adults but not both, 2) required increased evidence for finding liability, 3) set limitations on damage awards, or 4) set restrictions on who may be sued.

References

1. Community Preventive Services Task Force. [Preventing excessive alcohol consumption: increasing alcohol taxes](http://www.thecommunityguide.org/alcohol/increasingtaxes.html) (<http://www.thecommunityguide.org/alcohol/increasingtaxes.html>). In: Guide to Community Preventive Services. Updated Jun 2007.
2. Community Preventive Services Task Force. [Preventing excessive alcohol consumption: dram shop liability](http://www.thecommunityguide.org/alcohol/dramshop.html) (<http://www.thecommunityguide.org/alcohol/dramshop.html>). In: Guide to Community Preventive Services. Updated Mar 2010.
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5. US Preventive Services Task Force. [Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care](http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care) (<http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care>). Updated May 2013.
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11. ChangeLab Solutions. [2015 PSR Update: Status of State Dram Shop Liability](http://changelabsolutions.org/publications/2015-dram-shop-liability-update) (<http://changelabsolutions.org/publications/2015-dram-shop-liability-update>). Nov 30, 2015.

**State count includes District of Columbia.

Food Safety



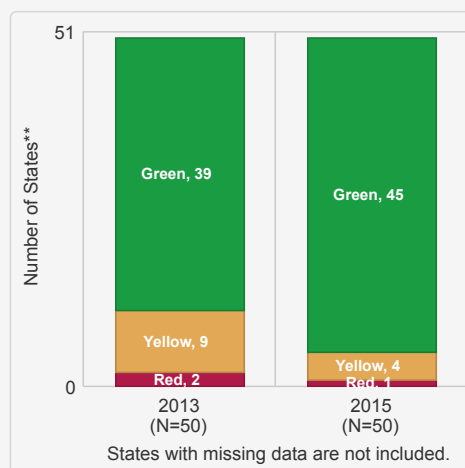
The Prevention Status Reports highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to address 10 important public health problems and concerns. The three practices in this report are recommended by the Council to Improve Foodborne Outbreak Response and the US Food and Drug Administration (FDA) because scientific evidence supports their effectiveness in improving foodborne disease surveillance, detection, and prevention (1–3). These practices are

- Increasing the speed of DNA fingerprinting using pulsed-field gel electrophoresis (PFGE) testing for all reported cases of Shiga toxin-producing *Escherichia coli* (*E. coli*) O157
- Increasing the completeness of PFGE testing of *Salmonella*
- Adopting provisions recommended in the FDA Food Code into state food safety regulations

Other strategies supported by scientific evidence include using trained staff and standardized questionnaires to interview persons with suspected foodborne illness as soon as possible after illness is reported and conducting environmental assessments as a routine component of foodborne disease outbreak investigations (1).

Speed of pulsed-field gel electrophoresis testing of reported *E. coli* O157 cases

The annual proportion of E. coli O157 PFGE patterns reported to CDC (i.e., uploaded into PulseNet, the CDC-coordinated national molecular subtyping network for foodborne disease surveillance) within four working days of receiving the isolate in the state or local public health PFGE lab. PFGE is a technique used to distinguish between strains of organisms at the DNA level.



Rating	Percentage of annual reported cases tested within four days
Green	≥90.0%
Yellow	60.0%–89.9%
Red	<60.0%

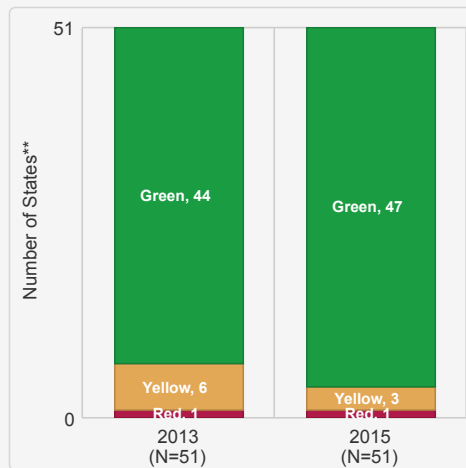
How These Ratings Were Determined

The speed of PFGE testing for reported *E. coli* O157 cases was determined by accessing the [PulseNet](http://www.cdc.gov/pulsenet/) (<http://www.cdc.gov/pulsenet/>) national *E. coli* O157 database for calendar year 2014. Turnaround times were calculated per lab by subtracting the received date (receipt in the PFGE lab) from the upload date (upload to the PulseNet national database), excluding weekends and federal holidays. The percentage of samples tested within four days was calculated by dividing the number tested within four days (numerator) by the total number uploaded to the PulseNet national database (denominator). If the received date for a sample was missing, the sample was counted in the denominator but not the numerator, thus lowering the percentage.

The ratings reflect the extent to which each state tested *E. coli* O157 cases within four days as determined by the PulseNet database.

Completeness of pulsed-field gel electrophoresis testing of reported *Salmonella* cases

The annual proportion of *Salmonella* cases reported to CDC's National Notifiable Diseases Surveillance System with PFGE patterns uploaded into PulseNet.



Rating	Percentage of annual reported cases tested by PFGE
Green	≥90.0%
Yellow	60.0%–89.9%
Red	<60.0%

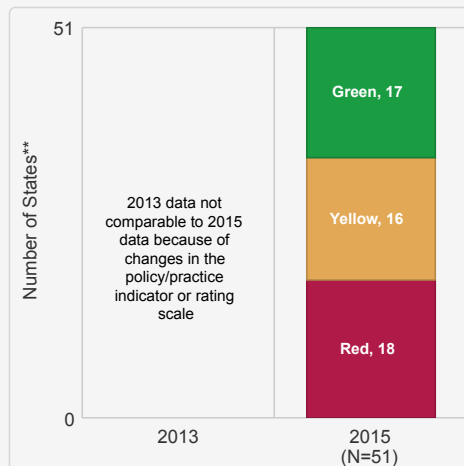
How These Ratings Were Determined

The completeness of PFGE testing of reported *Salmonella* cases was determined by accessing the PulseNet (<http://www.cdc.gov/pulsenet/>) national *Salmonella* database for calendar year 2014. The number of *Salmonella* entries per state was determined and used as the numerator. The denominator was the number of cases reported by each lab to the National Notifiable Diseases Surveillance System for calendar year 2014.

The ratings reflect the proportion of all *Salmonella* cases tested in each state as determined by the PulseNet database.

State adoption of selected foodborne disease-related provisions

Inclusion in the state's food safety regulations of selected provisions contained in the 2013 FDA Food Code related to norovirus and other foodborne illnesses.



Rating	Number of selected provisions contained in the 2013 FDA Food Code adopted into the state food code
Green	All four
Yellow	Three
Red	Two or fewer

How These Ratings Were Determined

Publicly accessible state food code regulations were assessed for the presence of four selected provisions contained in the 2013 FDA Food Code (4):

- Excluding ill food service staff from working until at least 24 hours after symptoms such as vomiting and diarrhea have ended (section 2-2 of the 2013 FDA Food Code)
- Prohibiting bare hand contact with ready-to-eat food (section 3-301.11)
- Requiring at least one employee in a food service establishment to be a certified food protection manager (sections 2-102.12 and 2-102.20)
- Requiring food service employees to wash their hands (section 2-3)

The ratings reflect the number of provisions included in state food safety regulations.

References

1. Council to Improve Foodborne Outbreak Response. [Guidelines for Foodborne Disease Outbreak Response](http://www.cifor.us/CIFORGuidelinesProjectMore.cfm) (<http://www.cifor.us/CIFORGuidelinesProjectMore.cfm>). Second Edition. Atlanta, GA: Council of State and Territorial Epidemiologists; 2014.
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3. Council to Improve Foodborne Outbreak Response. [Foodborne Illness Response Guidelines for Owners, Operators and Managers of Food Establishments](http://www.cifor.us/projind.cfm) (<http://www.cifor.us/projind.cfm>). Washington, DC: National Association of County and City Health Officials; 2013.
4. CDC. State-Level Food Code Provisions. Unpublished data; Sep 2014.

**State count includes District of Columbia.

Healthcare-Associated Infections

The Prevention Status Reports highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to address 10 important public health problems and concerns. This report highlights two practices to reduce healthcare-associated infections (HAIs) and antibiotic resistance (AR):



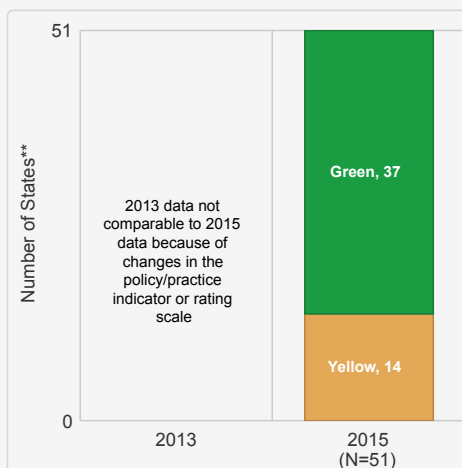
- Implementing state activities to build capacity for HAI prevention
- Implementing stewardship programs to improve antibiotic use in acute care hospitals

Improving health care through HAI and AR prevention, detection, and response are priorities for CDC, the US Department of Health and Human Services (HHS), and the White House. The White House's National Strategy for Combating Antibiotic-Resistant Bacteria (CARB) and National Action Plan stress the judicious use of antibiotics to prevent transmission of AR infections (1,2). The HHS HAI action plan sets national goals for reducing HAIs and provides a framework for state HAI prevention plans (3). In CDC's 2014 National Healthcare Safety Network (NHSN) Annual Hospital Survey, 39.2% of US hospitals reported having antibiotic stewardship programs (4) that included seven core elements CDC deems critical for such programs (5).

Other strategies supported by evidence include optimizing infection control practices within healthcare facilities, using a coordinated regional approach to preventing infections, and implementing CDC's Targeted Assessment for Prevention (TAP) strategy (6,7).

State activities to build capacity for HAI prevention

State health department implementation of activities to improve the state's ability to prevent and control HAIs across four prevention areas: 1) building and maintaining partnerships (e.g., collaborating with quality improvement organizations or hospital associations), 2) supporting HAI-related outbreak response by building infrastructure to identify and respond to reports of outbreaks in healthcare settings, 3) conducting or supporting HAI training, and 4) validating HAI data (i.e., analyzing data for quality and completeness and/or reviewing medical records to check data accuracy).



Rating	Number of HAI prevention areas addressed
Green	All four
Yellow	Three
Red	Two or fewer

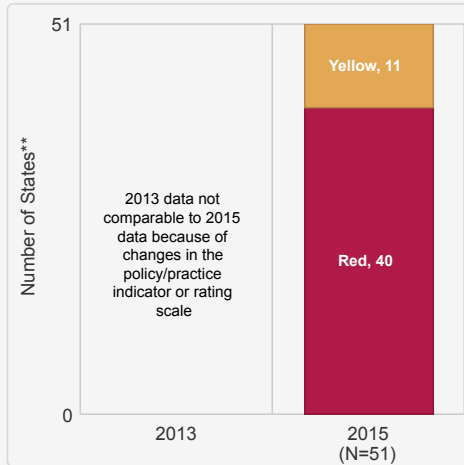
How These Ratings Were Determined

These ratings reflect the number of HAI prevention areas each state has addressed. Ratings are

based on data from a CDC 2015 survey of state HAI coordinators, which asked states whether their HAI prevention activities had addressed the following prevention areas: HAI partnerships, outbreak response, training, and data validation (8). Data validation responses were confirmed using the findings of the 2016 *National and State Healthcare-Associated Infections Progress Report* (9).

Stewardship programs to improve antibiotic use in acute care hospitals

Programs in acute care hospitals that incorporate seven core elements CDC deems critical to successful hospital antibiotic stewardship: 1) leadership commitment, 2) accountability, 3) drug expertise, 4) actions to improve antibiotic use, 5) tracking antibiotic use and outcomes, 6) reporting antibiotic use and outcomes to staff, and 7) education (5).



Rating	Percentage of acute care hospitals with antibiotic stewardship programs
Green	≥75.0%
Yellow	50.0%-74.9%
Red	≤49.9%

How These Ratings Were Determined

These ratings reflect the percentage of each state's acute care hospitals participating in the Patient Safety Component of NHSN that reported having antibiotic stewardship programs that incorporated CDC's seven core elements (5). Ratings are based on data from the 2014 NHSN Annual Hospital Survey Patient Safety Component (4).

References

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9. CDC. National and State Healthcare-Associated Infections Progress Report. Atlanta, GA: US Department of Health and Human Services; 2016.

**State count includes District of Columbia.

Heart Disease and Stroke

The Prevention Status Reports highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to address 10 important public health problems and concerns. This report focuses on one policy and one practice recommended by the Community Preventive Services Task Force, the US Public Health Service, Institute of Medicine, and the American College of Clinical Pharmacy because scientific studies support their effectiveness in managing heart disease and stroke risks (1–4):

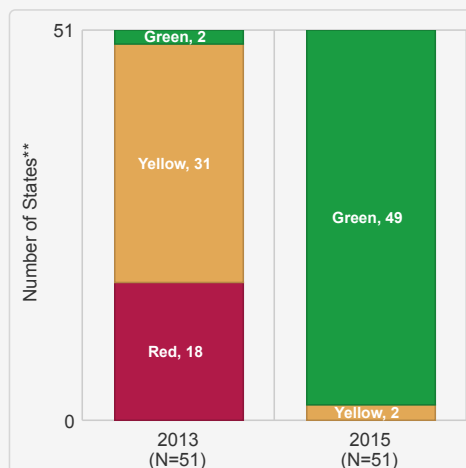


- Implementing meaningful use of certified electronic health records
- Establishing state collaborative drug therapy management (CDTM) policies that authorize pharmacists to provide certain patient services

Other strategies for reducing heart disease and stroke that are supported by scientific evidence and practice include promoting team-based care, implementing clinical decision-support systems, using interventions that engage community health workers, reducing out-of-pocket costs for cardiovascular disease preventive services, and reducing sodium consumption at the community level (5,6).

Meaningful use of electronic health records

The percentage of office-based physicians demonstrating meaningful use of certified electronic health record (EHR) technology, as defined by the Centers for Medicare & Medicaid Services EHR Incentive Program's meaningful use criteria (7).



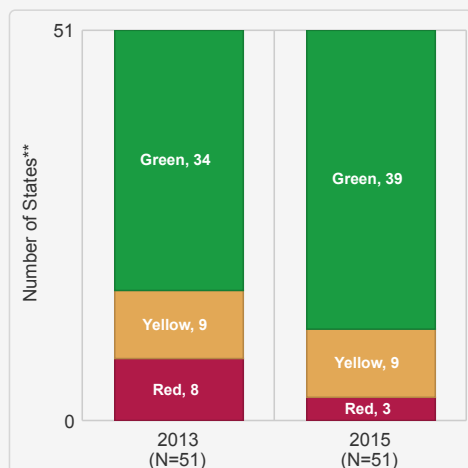
Rating	Percentage of office-based physicians in the state who demonstrated meaningful use
Green	≥62.0%
Yellow	53.0%–61.9%
Red	<53.0%

How These Ratings Were Determined

These ratings reflect meaningful use of certified EHRs in each state as measured by the Centers for Medicare & Medicaid Services (8). Certified EHR technology must include clinical decision supports, such as alerts for elevated blood pressure and cholesterol levels based on laboratory results, to support guidelines-based clinical decision making (9).

State pharmacist collaborative drug therapy management policy

A state legislative, regulatory, or other written administrative policy that authorizes qualified pharmacists working within the context of a collaborative practice agreement or defined protocol to perform patient assessments; order drug therapy-related laboratory tests; administer drugs; and/or select, initiate, monitor, continue, and adjust drug regimens (1–4).



Rating	State CDTM policy
Green	Authorized pharmacists to collaborate or provide patient services under protocol for all health conditions
Yellow	Authorized pharmacists to collaborate or provide patient services under protocol but did not cover chronic diseases, OR collaboration was limited to specified hospital, medical, or clinical practice settings
Red	No policy existed

How These Ratings Were Determined

These ratings reflect the status of state CDTM policies as reviewed by CDC policy analysts (10). CDTM policies were rated on the extent to which pharmacists were able to enter into collaborative practice agreements that included all health conditions and all healthcare settings.

References

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**State count includes District of Columbia.

HIV



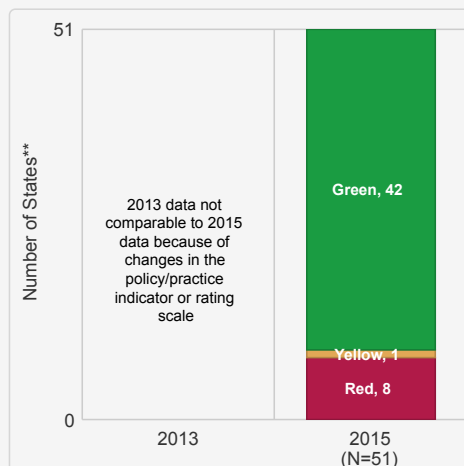
The Prevention Status Reports highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to address 10 important public health problems and concerns. This report highlights four policies that reflect recent scientific advances (1) in HIV prevention and medical care that can reduce new HIV infections and related illnesses and deaths:

- Facilitating state Medicaid reimbursement for HIV screening (2–4)
- Making state HIV testing laws compatible with the 2006 CDC and 2013 US Preventive Services Task Force HIV testing recommendations (3–5)
- Reporting all CD4 and all HIV viral load data to the state HIV surveillance program and complete lab reporting to CDC (6)
- Increasing the percentage of HIV-infected persons who have a suppressed viral load (7)

These policies are important state-level tools that further the goals of the 2010 National HIV/AIDS Strategy (7). Another strategy supported by scientific evidence is use of antiretroviral medications by persons with HIV to prevent transmission to uninfected partners (1).

State Medicaid reimbursement for routine HIV screening

Medicaid (traditional state Medicaid programs and Medicaid expansion programs) reimbursement of healthcare providers for costs associated with routine HIV screening, regardless of the patient's HIV infection risk. (In states with Medicaid expansion, persons insured under the expansion are covered for routine HIV screening as required by law [8], while enrollees in traditional state Medicaid programs might or might not be covered for routine HIV screening.)



Rating	Coverage for routine HIV screening
Green	All Medicaid recipients
Yellow	Some Medicaid recipients
Red	No Medicaid recipients

How These Ratings Were Determined

These ratings reflect the extent to which state Medicaid programs supported routine HIV screening, as assessed by the Kaiser Family Foundation (KFF) and the National Alliance of State and Territorial AIDS Directors (NASTAD) (2,9,10).

Coverage of Routine HIV Screening—Traditional Medicaid: To assess coverage of routine HIV screening in traditional Medicaid fee-for-service programs, KFF surveyed state Medicaid officials in 2010 and 2013 (2). NASTAD updated the results in 2015 for all states without such coverage, except

for two states (Alabama and Mississippi) that did not respond to requests for information (9).

Coverage of Routine HIV Screening—Medicaid Expansion Plans: Routine HIV screening is recommended with an “A” grade by the US Preventive Services Task Force and is covered without cost sharing in the “essential health benefits” package that Medicaid expansion plans provide to enrollees (4,11). Accordingly, all states that have expanded Medicaid coverage under the Affordable Care Act cover routine HIV screening for their expansion populations. State Medicaid expansion status was determined on the basis of data collected and posted by KFF as of April 29, 2015 (10).

Consistency of state HIV testing law with CDC's 2006 HIV testing recommendations

Consistency of the state's HIV testing law with key parameters of consent and counseling outlined in CDC's 2006 HIV testing recommendations (3).



Rating	Consistency of state HIV testing law with consent and counseling parameters
Green	Consistent
Yellow	N/A
Red	Inconsistent

How These Ratings Were Determined

These ratings reflect the extent to which state laws governing HIV testing met every consent and counseling parameter stated below.

CDC researches state laws, regulations, and policies that could influence risk behaviors or alter the environment in which HIV prevention services are accessed and delivered (12). To assess HIV testing laws, staff reviewed laws and regulations in the 50 states and the District of Columbia using WestlawNext[®] (an online legal research system), literature reviews, and web searches. Relevant laws and regulations were coded using the following parameters:

Consent parameters:

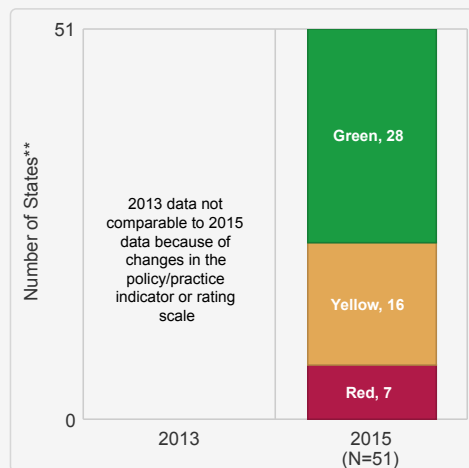
- Opt-out (rather than opt-in) testing
- Inclusion of HIV testing consent as part of general medical consent forms (rather than HIV-specific consent forms)
- Permission to give consent orally

Counseling parameter:

- No requirement for HIV prevention counseling prior to testing

State reporting of all CD4 and all viral load data

Existence of a state statute, regulation, or policy that requires reporting of all CD4 and HIV viral load test results (detectable and undetectable); reporting of $\geq 95\%$ of CD4 and viral load results to the state or local health department; AND reporting by the health department of $\geq 95\%$ of laboratory results to CDC by the end of each year.



Rating	State reporting requirement and completeness of reporting
Green	Reporting of all CD4 and viral load test results required, AND complete data reported to CDC
Yellow	Reporting of all CD4 and viral load test results required, BUT incomplete data reported to CDC
Red	Reporting of all CD4 and viral load test results not required OR no policy existed

How These Ratings Were Determined

These ratings reflect the extent to which state CD4 and viral load reporting requirements were in place, as determined by a policy assessment conducted by CDC (5,6), and whether complete CD4 and viral load data were reported to CDC (5,6,13).

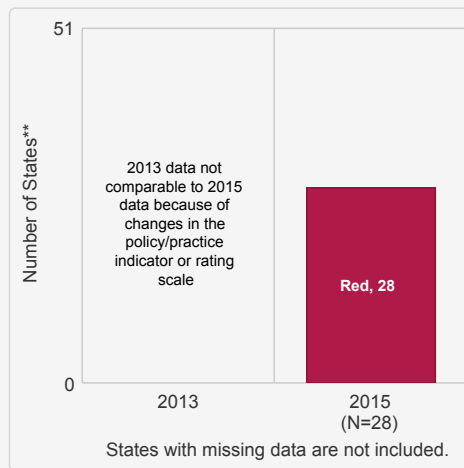
CDC researches state laws, regulations, and policies that could influence risk behavior or alter the environment in which HIV prevention services are accessed and delivered (12). To assess CD4 and viral load reporting requirements, staff reviewed laws, regulations, and directives in the 50 states and the District of Columbia using WestlawNext[®] (an online legal research system), literature reviews, and web searches. Relevant laws, regulations, and directives were coded using the following parameters:

- CD4 reporting: Required laboratories to report all values (not just those below a specified threshold)
- HIV viral load: Required laboratories to report all results (detectable and undetectable)

States were assessed as having complete reporting of laboratory results to CDC if, in addition to having state laws requiring the reporting of all levels of CD4 and viral load, the following criteria were met: 1) laboratories that perform HIV-related testing had reported a minimum of 95% of HIV-related test results to the state or local health department, and 2) by December 2014, the state had reported to CDC at least 95% of all CD4 and viral load test results received during January 2012–September 2014 (13).

HIV viral suppression

Statewide percentage of viral suppression among persons with diagnosed HIV infection. A person's viral load is considered suppressed when the results of a viral load test show either that HIV is undetectable or there are fewer than 200 copies/mL of virus in the blood.



Rating	Percentage of persons with viral suppression
Green	≥80.0%
Yellow	N/A
Red	<80.0%

How These Ratings Were Determined

These ratings reflect whether states had a viral suppression prevalence $\geq 80\%$ among persons aged ≥ 13 years who had HIV infection diagnosed by the end of 2011 and were alive at the end of 2012 (13).

Ratings are reported only for those states that met the following criteria: 1) the state's law or regulations required reporting of all CD4 and all viral load data to the state or local health department (6), 2) laboratories that perform HIV-related testing had reported a minimum of 95% of HIV-related test results to the state or local health department, and 3) by December 2014, the state had reported to CDC at least 95% of all CD4 and viral load test results received during January 2012–September 2014 (13). Geographic designations of viral suppression reflect where persons resided at HIV diagnosis.

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**State count includes District of Columbia.

Motor Vehicle Injuries

The Prevention Status Reports highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to address 10 important public health problems and concerns. The following policies are recommended by the Community Preventive Services Task Force and the National Highway Traffic Safety Administration because scientific studies support their effectiveness in preventing or reducing crash-related injuries and deaths (1–15):



- Implementing primary enforcement seat belt laws that cover occupants in all seating positions
- Mandating the use of car seats and booster seats for motor vehicle passengers through at least age 8 years
- Implementing comprehensive graduated driver licensing (GDL) systems, which help new drivers gain experience under low-risk conditions by granting driving privileges in stages. Research shows that more comprehensive GDL systems prevent more crashes and deaths than less comprehensive GDL systems (4–11). Components of comprehensive GDL systems include
 - A minimum age of 16 years for learner’s permits
 - A mandatory holding period of at least 12 months for learner’s permits
 - Nighttime driving restrictions between 10:00 pm and 5:00 am (or longer) for intermediate or provisional license holders
 - A limit of zero or one young passengers who can ride with intermediate or provisional license holders without adult supervision
 - A minimum age of 18 years for unrestricted licensure
- Requiring the use of ignition interlock devices for everyone convicted of alcohol-impaired driving

Other strategies recommended by scientific evidence for preventing motor vehicle injuries include enhanced seat belt enforcement campaigns (1,4), 0.08% blood alcohol concentration laws (16), minimum legal drinking age laws (4,16), publicized sobriety checkpoint programs (4,16,17), alcohol-impaired driving mass media campaigns (4,18), increased alcohol taxes (19), car and booster seat distribution plus education campaigns (2), and community-wide car seat and booster seat information and enhanced enforcement campaigns (2).

Seat belt law

A primary enforcement seat belt law allows police to stop a vehicle solely because a driver or passenger is not wearing a seat belt. A secondary enforcement seat belt law requires police to have another reason for stopping a vehicle before citing a driver or passenger for not buckling up. The most comprehensive policies are primary seat belt laws that cover all occupants, regardless of where they are sitting.



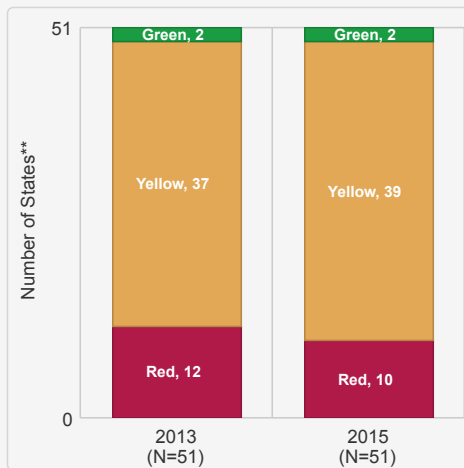
Rating	State seat belt law
Green	Primary enforcement law covering all seating positions
Yellow	Primary enforcement law covering only the front seats
Red	Secondary enforcement law OR no law

How These Ratings Were Determined

These ratings reflect the extent to which states' seat belt laws allowed for primary enforcement and covered all seating positions. Ratings are based on data collected from the Insurance Institute for Highway Safety (IIHS) on July 1, 2015, and therefore reflect IIHS's interpretation of each state's policy at that time (20). The "as of" date referenced in the Motor Vehicle Injuries [state reports](http://www.cdc.gov/psr/) (<http://www.cdc.gov/psr/>)—July 1, 2015—is the date CDC assessed the policy. The date does not reflect when the law was enacted or became effective.

Child passenger restraint law

A law that requires child passengers to travel in appropriate child passenger restraints, such as car seats or booster seats, until adult seat belts fit them properly.



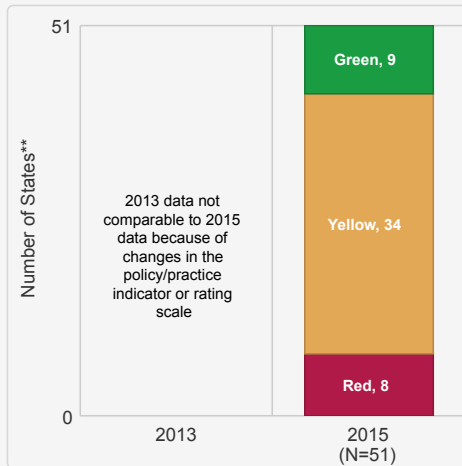
Rating	Age requirement for use of child passenger restraints
Green	Children through age 8 years
Yellow	Children through age 6 or 7 years
Red	Children aged 5 years or younger

How These Ratings Were Determined

These ratings reflect the age through which states required child passengers to travel in appropriate child passenger restraints. Ratings are based on data collected from the Insurance Institute for Highway Safety (IIHS) on July 1, 2015, and therefore reflect IIHS's interpretation of each state's policy at that time (20). The "as of" date referenced in the Motor Vehicle Injuries [state reports](http://www.cdc.gov/psr/) (<http://www.cdc.gov/psr/>)—July 1, 2015—is the date CDC assessed the policy. The date does not reflect when the law was enacted or became effective.

Graduated driver licensing: learner's permit age

Age at which a young driver can first acquire a learner's permit, which requires a novice driver to practice driving under the supervision of an adult.



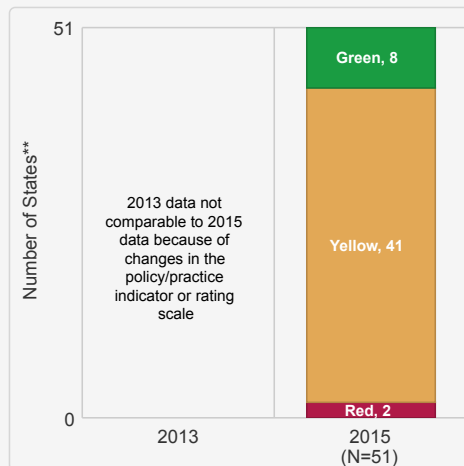
Rating	Minimum age for state learner's permit
Green	≥16 years
Yellow	14 years, 7 months through 15 years, 11 months
Red	≤14 years, 6 months

How These Ratings Were Determined

These ratings reflect the age at which states allowed drivers to first acquire a learner's permit. Ratings are based on data collected from the Insurance Institute for Highway Safety (IIHS) on July 1, 2015, and therefore reflect IIHS's interpretation of each state's policy at that time (21). The "as of" date referenced in the Motor Vehicle Injuries [state reports](http://www.cdc.gov/psr/) (<http://www.cdc.gov/psr/>)—July 1, 2015—is the date CDC assessed the policy. The date does not reflect when the law was enacted or became effective.

Graduated driver licensing: learner's permit holding period

The length of time a driver must maintain a learner's permit before being allowed to apply for an intermediate or provisional license.



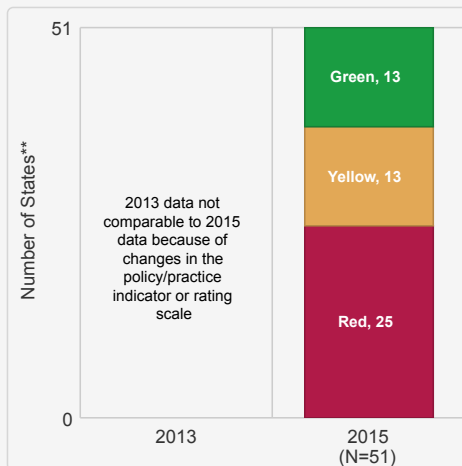
Rating	State learner's permit mandatory holding period
Green	≥12 months
Yellow	6–11 months
Red	<6 months

How These Ratings Were Determined

These ratings reflect the length of time states required a driver to maintain a learner's permit before being allowed to apply for an intermediate or provisional license. Ratings are based on data collected from the Insurance Institute for Highway Safety (IIHS) on July 1, 2015, and therefore reflect IIHS's interpretation of each state's policy at that time (21). The "as of" date referenced in the Motor Vehicle Injuries [state reports](http://www.cdc.gov/psr/) (<http://www.cdc.gov/psr/>)—July 1, 2015—is the date CDC assessed the policy. The date does not reflect when the law was enacted or became effective. If a state had varying holding periods dependent on the age the young driver received his/her learner's permit, its rating was based on the shortest holding period allowable for novice drivers. Exceptions to learner's permit holding periods (e.g., a shorter holding period for completion of a driver's education course) were not considered, and states were rated based on the general law.

Graduated driver licensing: nighttime driving restriction

A restriction against intermediate or provisional license holders driving without adult supervision during certain nighttime hours.



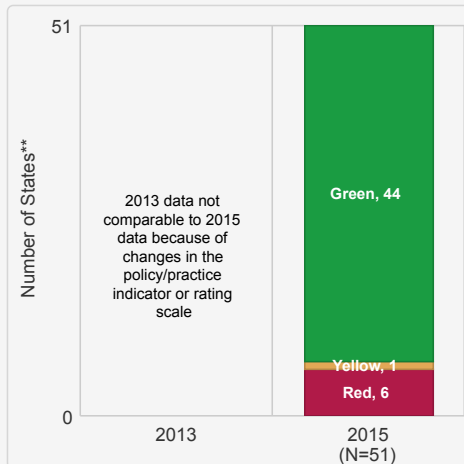
Rating	State nighttime driving restriction
Green	Began on or before 10:00 pm and ended on or after 5:00 am
Yellow	Began between 10:01 pm and 11:59 pm
Red	Began on or after midnight OR no restriction

How These Ratings Were Determined

These ratings reflect the extent to which states restricted intermediate or provisional license holders from driving without adult supervision at night. Ratings are based on data collected from the Insurance Institute for Highway Safety (IIHS) on July 1, 2015, and therefore reflect IIHS's interpretation of each state's policy at that time (21). The "as of" date referenced in the Motor Vehicle Injuries [state reports \(http://www.cdc.gov/psr/\)](http://www.cdc.gov/psr/)—July 1, 2015—is the date CDC assessed the policy. The date does not reflect when the law was enacted or became effective. If a state had varying nighttime driving restrictions dependent on the month of the year or day of the week, its rating was based on the least restrictive requirement. Provisions loosening restrictions based on the length of time the young driver had been licensed were not considered; states were rated based on the initial restriction only.

Graduated driver licensing: young passenger restriction

A restriction against intermediate or provisional license holders transporting more than a certain number of young passengers without adult supervision.



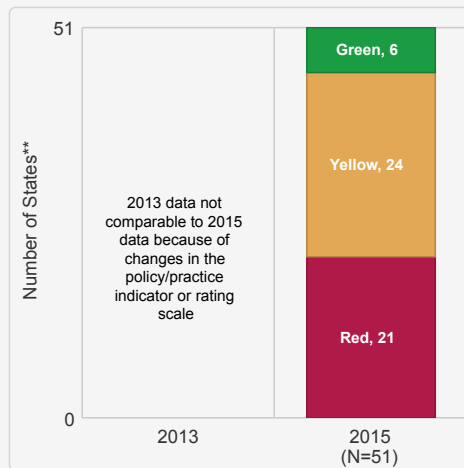
Rating	State young passenger restriction
Green	Limit of zero or one young passengers without adult supervision
Yellow	Limit of two or more young passengers without adult supervision
Red	No limit on young passengers

How These Ratings Were Determined

These ratings reflect the extent to which states restricted intermediate or provisional license holders from transporting young passengers without adult supervision. Ratings are based on data collected from the Insurance Institute for Highway Safety (IIHS) on July 1, 2015, and therefore reflect IIHS's interpretation of each state's policy at that time (21). The "as of" date referenced in the Motor Vehicle Injuries [state reports](http://www.cdc.gov/psr/) (http://www.cdc.gov/psr/)—July 1, 2015—is the date CDC assessed the policy. The date does not reflect when the law was enacted or became effective. If a state had varying young passenger restrictions dependent on the time of day, its rating was based on the least restrictive requirement. Provisions loosening restrictions based on the length of time the young driver had been licensed were not considered; states were rated based on the initial restriction only.

Graduated driver licensing: unrestricted licensure age

The minimum age at which drivers who have met all requirements of intermediate or provisional license may first drive unsupervised without nighttime or young passenger restrictions.



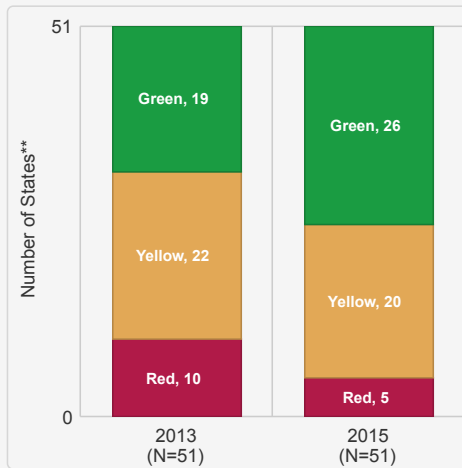
Rating	State unrestricted licensure age
Green	Nighttime and young passenger restrictions existed and were lifted for drivers aged ≥ 18 years
Yellow	Nighttime and young passenger restrictions existed, and one or both were lifted for drivers between ages 16 years, 7 months and 17 years, 11 months
Red	Nighttime and/or young passenger restrictions were lifted for drivers aged ≤ 16 years, 6 months; OR only one or no restriction existed

How These Ratings Were Determined

These ratings reflect the minimum age at which states allowed drivers who have met all requirements of intermediate or provisional license to first drive unsupervised with no nighttime driving or young passenger restrictions. States that did not have both restrictions were rated red. Ratings are based on data collected from the Insurance Institute for Highway Safety (IIHS) on July 1, 2015, and therefore reflect IIHS's interpretation of each state's policy at that time (21). The "as of" date referenced in the Motor Vehicle Injuries [state reports \(http://www.cdc.gov/psr/\)](http://www.cdc.gov/psr/)—July 1, 2015—is the date CDC assessed the policy. The date does not reflect when the law was enacted or became effective.

Ignition interlock law

A law that mandates the use of ignition interlocks for drivers convicted of alcohol-impaired driving. An ignition interlock is a device that analyzes a driver's breath and prevents the vehicle from starting if alcohol is detected.



Rating	State ignition interlock law
Green	Ignition interlocks required for all offenders convicted of alcohol-impaired driving (i.e., driving with a blood alcohol concentration [BAC] ≥ 0.08 g/dL), which includes both first-time and repeat offenders
Yellow	Ignition interlocks required for repeat offenders convicted of alcohol-impaired driving or first-time offenders with a particularly high BAC (e.g., BAC ≥ 0.15 g/dL)
Red	Ignition interlocks not required for any offenders convicted of alcohol-impaired driving

How These Ratings Were Determined

These ratings reflect the extent to which states required use of ignition interlocks for drivers convicted of alcohol-impaired driving. Ratings are based on data collected from the Insurance Institute for Highway Safety (IIHS) on July 1, 2015, and therefore reflect IIHS's interpretation of each state's policy at that time (22). The "as of" date referenced in the Motor Vehicle Injuries [state reports](http://www.cdc.gov/psr/) (<http://www.cdc.gov/psr/>)—July 1, 2015—is the date CDC assessed the policy. The date does not reflect when the law was enacted or became effective.

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**State count includes District of Columbia.

Nutrition, Physical Activity, and Obesity



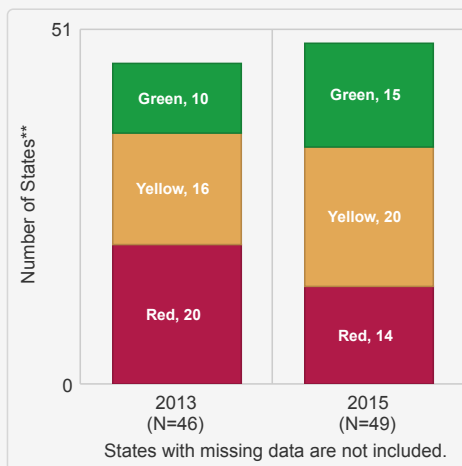
The Prevention Status Reports highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to address 10 important public health problems and concerns. This report focuses on four policies and practices recommended by the Institute of Medicine, Community Preventive Services Task Force, US Surgeon General, CDC, and other expert bodies. The recommendations are based on expert judgment and/or evidence from scientific studies that the policies and practices can improve diet, increase breastfeeding, increase physical activity, or reduce obesity (1–6). These policies and practices are

- Limiting the availability of less nutritious foods and beverages in schools
- Implementing nutrition standards for foods and beverages sold on government property
- Including obesity prevention standards in state regulations of licensed childcare facilities
- Promoting evidence-based practices that support breastfeeding in hospitals and birth centers

Additional strategies to prevent obesity and promote healthy eating, physical activity, and breastfeeding are supported by scientific evidence or expert judgment (2–9). Examples include requiring daily physical education in schools (5), designing communities to support physical activity (7), and improving the availability and promotion of healthier foods in the retail environment (2).

Secondary schools not selling less nutritious foods and beverages

Percentage of secondary schools (middle schools and high schools) in the state that did not allow students to purchase less nutritious foods and beverages from vending machines, school stores, canteens, and snack bars.



Rating	Percentage of secondary schools
Green	≥66.6%
Yellow	50.0%–66.5%
Red	<50.0%

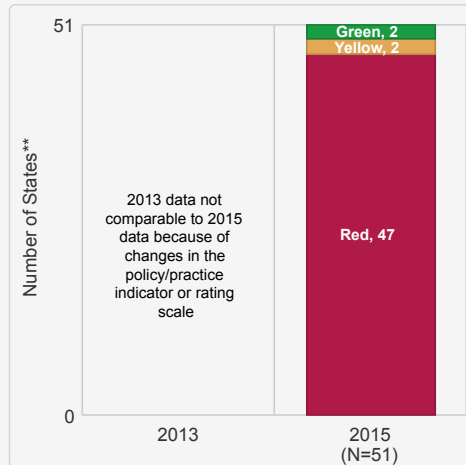
How These Ratings Were Determined

These ratings reflect the extent to which states' secondary schools limited the sale of less nutritious foods and beverages. For a school to be identified as not selling less nutritious foods and beverages, the school principal had to respond "no" to each of the following five items on the CDC School Health Profiles principal questionnaire when asked whether students can purchase that item: 1) chocolate candy; 2) other kinds of candy; 3) salty snacks that are not low in fat, such as regular potato chips; 4)

cookies, crackers, cakes, pastries, or other baked goods that are not low in fat; and 5) soda pop or fruit drinks that are not 100% juice (10). Data were collected prior to implementation of the Smart Snacks in School regulation and do not reflect impact of the regulation on school nutrition standards.

Nutrition standards policy for foods and beverages sold on state executive branch property

A state nutrition standards policy for sale of foods and beverages that meets the following criteria: 1) provides or references quantifiable nutrition standards (e.g., sets a maximum for the amount of sodium a food item can include) addressing four or more of the following nine foods or nutrients: fruits, vegetables, whole grains, water, added sugars, sodium, trans fat, saturated fat, and calories/portion sizes; 2) applies to all property and facilities owned, leased, or operated by the state executive branch; and 3) applies to two or more food service venues (e.g., vending machines, cafeterias, snack bars).



Rating	State's nutrition standards policy for sale of foods and beverages
Green	Provided or referenced quantifiable nutrition standards AND applied to two or more food service venues on state executive branch property
Yellow	Provided or referenced quantifiable nutrition standards AND applied to a single food service venue on state executive branch property
Red	Did not provide or reference quantifiable nutrition standards, did not apply to state executive branch property, OR no policy existed

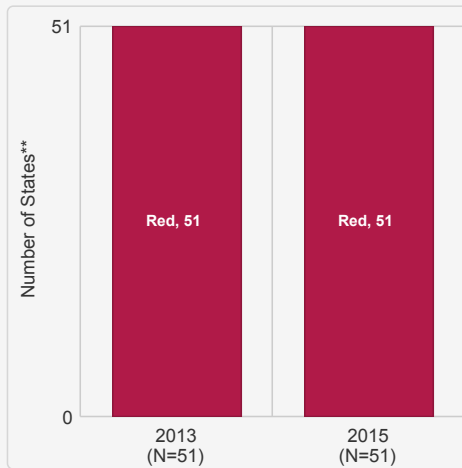
How These Ratings Were Determined

These ratings reflect whether states had a nutrition standards policy for sale of foods and beverages and the extent to which the policy meets the following three criteria: 1) provides or references quantifiable nutrition standards (11,12), 2) applies to all state executive branch property, and 3) applies to two or more food service venues.

A policy was defined as a regulation, statute, or executive order. Policies were identified by searching WestlawNext® (an online legal research system) for statutes and regulations and LexisNexis® (an online database) for executive orders. Ratings indicate the presence of a policy, not whether it was implemented. For the purposes of this report, correctional facilities, schools, nursing homes, and personal care homes were excluded from the analyses.

Inclusion of obesity prevention standards in state licensing regulations of childcare facilities

Inclusion of some or all of the 47 components of national standards considered to have a high impact for obesity prevention into state licensing regulations of childcare facilities.



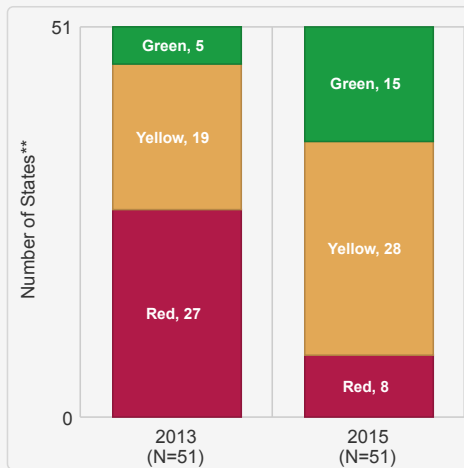
Rating	Number of components included in state licensing regulations
Green	≥38
Yellow	24-37
Red	<24

How These Ratings Were Determined

These ratings reflect the extent to which state licensing regulations for childcare facilities included the 47 recommended components of national standards considered to have a high impact for obesity prevention. Data were compiled from a report of the National Resource Center for Health and Safety in Child Care and Early Education (13). A state was considered to have included a component if its regulations for childcare centers, large family childcare homes, and small family childcare homes fully met the requirements of the component.

State average birth facility score for breastfeeding support

The average score for breastfeeding support in the state's participating birth facilities.



Rating	State average birth facility score
Green	≥80
Yellow	70–79
Red	<70

How These Ratings Were Determined

These ratings reflect the extent to which birth facilities (e.g., hospitals and birth centers) within each state implemented multiple evidence-based strategies that support breastfeeding. State average birth facility scores were obtained from CDC's National Survey of Maternity Practices in Infant Nutrition and Care (mPINC) (14). Each birth facility that responded to a self-administered survey was scored on multiple evidence-based practices that support breastfeeding across seven categories: 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 total score can range from 0 to 100, with a higher score representing more support. The national average score across all states was 75.

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**State count includes District of Columbia.

Prescription Drug Overdose

The Prevention Status Reports highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to address 10 important public health problems and concerns.



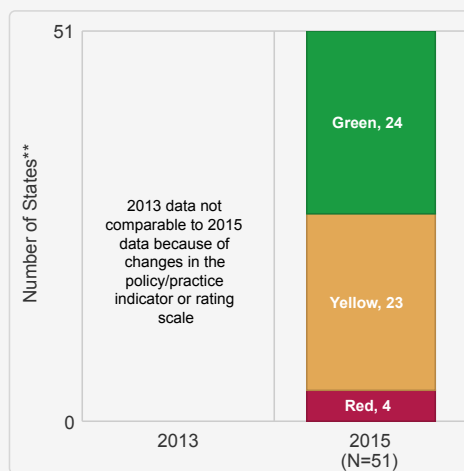
CDC and other agencies continue to identify and evaluate interventions to reduce prescription opioid overdose deaths. This report focuses on two key policies concerning state prescription drug monitoring programs (PDMPs), electronic systems that track the dispensing of controlled substances to patients. The following policies are supported by emerging evidence, expert consensus, and extensive review of the primary drivers of the epidemic (1–3):

- Requiring timely data submission to the PDMP
- Requiring universal PDMP use by prescribers

These policies are especially promising but are not the only interventions needed to address this epidemic. Rather, they should be seen as key pieces in a much larger, multisector approach to preventing prescription drug abuse and overdose. Other important PDMP practices for states to consider include ensuring that their PDMP 1) is easy to use and access (e.g., by allowing delegates of the provider to access the system); 2) can be linked to electronic health records for point-of-care decision making by providers; 3) is accessible to public health agencies for tracking trends; and 4) has the capacity to proactively notify users of high-risk behaviors (1). Also, the Department of Health and Human Services outlines three priority areas to advance a comprehensive approach to reversing the epidemic: improving opioid prescribing practices, expanding use and distribution of naloxone, and expanding medication-assisted treatment to reduce opioid use disorders and overdose (2).

Requirement for timely data submission to prescription drug monitoring program

State-required interval between dispensing a controlled substance and submitting the dispensing data to the state PDMP.



Rating	State dispensing data submission requirement
Green	Within 24 hours
Yellow	More than 24 hours but within one week
Red	More than one week OR no reporting requirement

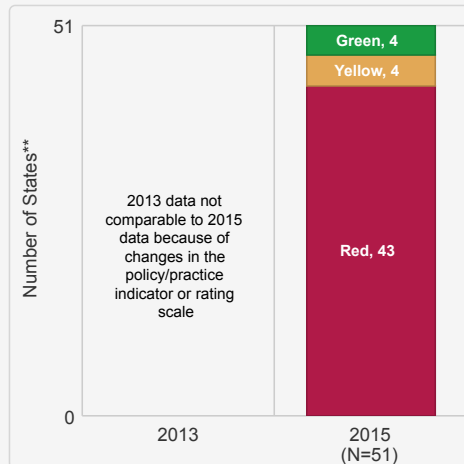
How These Ratings Were Determined

These ratings reflect data provided by the National Alliance of Model State Drug Laws about state legal requirements for the timeliness of data submission to state PDMPs. CDC translated this information into a rating for each state. The rating does not reflect how fully the state has carried out

the law. The “as of” date referenced in the Prescription Drug Overdose [state reports](http://www.cdc.gov/psr/) (<http://www.cdc.gov/psr/>)—July 31, 2015—is the date CDC assessed the law. The date does not reflect when the law was enacted or became effective.

Requirement for universal use of state prescription drug monitoring program

State requirement that prescribers must consult the patient's PDMP history before initially prescribing opioid pain relievers and benzodiazepines, and at least every three months thereafter.



Rating	State PDMP use requirement
Green	Prescribers are required to consult the PDMP before initial opioid and benzodiazepine prescriptions and at least every three months thereafter
Yellow	Prescribers are required to consult the PDMP before initial opioid prescriptions and again within one year
Red	Prescribers are not required to consult the PDMP before initial opioid prescriptions, OR such a requirement does exist but there is no required subsequent check and/or the policy includes subjective standards or broad exceptions

How These Ratings Were Determined

These ratings reflect data provided by the National Alliance of Model State Drug Laws and the PDMP Center of Excellence at Brandeis University about state laws requiring prescriber use of state PDMPs. CDC translated this information into a rating for each state. The rating does not reflect how fully the state has carried out the law. The “as of” date referenced in the Prescription Drug Overdose [state reports \(http://www.cdc.gov/psr/\)](http://www.cdc.gov/psr/)—October 31, 2015—is the date CDC assessed the law. The date does not reflect when the law was enacted or became effective.

For the purposes of this report, a law was deemed to “require” a PDMP check when it applied to most or all prescribers. To be rated green, a state’s policy must have required a check for both opioid and benzodiazepine prescriptions; to be rated yellow, the requirement must have applied to at least opioid prescriptions.

Laws were considered to be requiring a PDMP check even if they had limited exceptions to the requirement (e.g., exempting prescriptions written in emergency departments) or if they exempted short prescriptions (i.e., lasting less than seven days). Laws that applied only to limited classes of providers (e.g., only opioid treatment programs or pain clinics) or that had overly broad exceptions (e.g., exempting prescriptions lasting 90 days or less), were not deemed as requiring PDMP checks in this report and were rated as red. In addition, laws in which the requirement depended on a subjective standard (e.g., the provider was required to check the PDMP only when having a reasonable belief of inappropriate use by the patient or only when treating chronic pain) were rated red.

**State count includes District of Columbia.

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**State count includes District of Columbia.

Teen Pregnancy



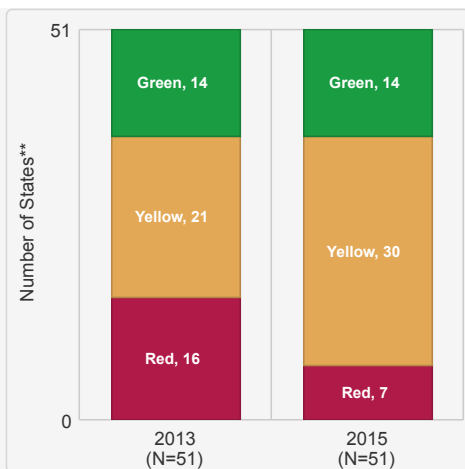
The Prevention Status Reports highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to address 10 important public health problems and concerns. This report highlights the status of a key policy that states can use to reduce teen pregnancy: increasing access to contraceptive counseling and services by expanding the age and income eligibility levels for Medicaid coverage of family planning services to increase teens' access to healthcare services, including contraception and other preventive services.

Prior to the Affordable Care Act (ACA), women qualified for full Medicaid coverage only if their incomes were very low and they belonged to one of Medicaid's categories of eligibility—parent, senior, or disabled. Pregnant women were eligible for prenatal, delivery, and newborn care at a somewhat higher income level but generally lost coverage soon after delivery. Since the 1990s, many states have broadened Medicaid eligibility for family planning services and supplies for people who were not otherwise eligible for Medicaid (1). Many states offered family planning services to women at higher income levels through waivers applied for and granted by the Centers for Medicare and Medicaid Services (CMS). The ACA included an option for states to expand full Medicaid services to individuals based on income eligibility alone. Another ACA provision allowed states to make coverage for family planning services available at the same income level as for pregnancy care through a state plan amendment (2–7). Thus, states have three options to provide Medicaid coverage for family planning services to low-income individuals. Income-based Medicaid expansions have been shown to be effective in reducing births among teens aged 15–19 years (2–5).

States can expand access to their Medicaid family planning program and reduce teen births by 1) extending coverage to teens under age 18 years and 2) setting the income eligibility level for family planning coverage to at least the same income level required for pregnancy care coverage (this level varies by state). Expanding Medicaid coverage for family planning services is consistent with US Department of Health and Human Services recommendations to support reproductive and sexual health services (8) and with *Healthy People 2020* family planning objectives (9). Other strategies for reducing teen pregnancy that are supported by scientific evidence include providing sexual health education for adolescents, using positive youth development approaches, and improving parent-child communication and parental monitoring of youth behavior (10–13).

Expansion of state Medicaid family planning eligibility

State expansion of eligibility for Medicaid coverage of family planning services to include teens under age 18 years and to be set to at least the income eligibility level for coverage of pregnancy care (this level varies by state).



Rating	State Medicaid family planning eligibility
Green	Income-based, meets the income eligibility level for pregnancy-related care, and covers all women, including teens
Yellow	Limited, not income-based, does not meet the eligibility level for pregnancy-related services, and/or excludes some teens
Red	Not expanded

How These Ratings Were Determined

These ratings reflect the extent to which each state had expanded eligibility for Medicaid coverage of family planning services. A review of state Medicaid family planning waivers and state plan amendments (SPAs) was conducted to determine whether each state's income eligibility level for family planning coverage was set to at least the same income level as for pregnancy care coverage (14,15). The income eligibility level for family planning services extended to applicants whose income was up to 5 percentage points above the set FPL for the following states: Alabama, Connecticut, Indiana, Louisiana, Mississippi, Missouri, Montana, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Virginia, and Wisconsin. This review also examined the extent to which state waivers or SPAs covered all teens, regardless of pregnancy status (14). In addition, a review was conducted of those states that had expanded their Medicaid programs under the ACA to cover adults aged <65 years with incomes up to 138% of the FPL (16). Teens aged ≤18 years with family incomes up to 138% of the FPL (or higher, depending on the state) are eligible for free or low-cost health coverage, including family planning services, in all states that have expanded Medicaid.

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**State count includes District of Columbia.

Tobacco Use

The Prevention Status Reports highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to address 10 important public health problems and concerns. The three policies and practices in this report are recommended by the Institute of Medicine, World Health Organization, Community Preventive Services Task Force, US Surgeon General, and Centers for Disease Control and Prevention because scientific studies support their effectiveness in preventing or reducing tobacco use (1-5):

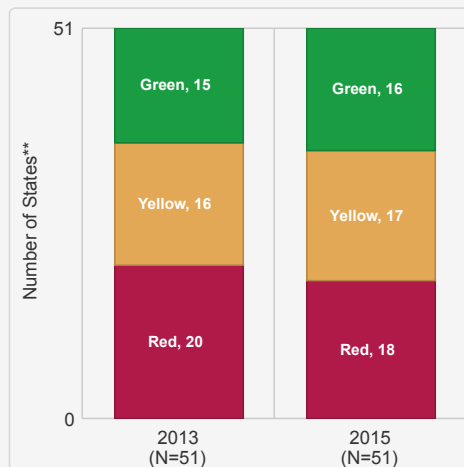


- Increasing the price of tobacco products, such as through state cigarette excise taxes
- Establishing comprehensive, statewide smoke-free policies to protect all nonsmokers from exposure to secondhand smoke
- Sustaining comprehensive tobacco control program funding

Other strategies also supported by scientific evidence include hard-hitting media campaigns and systemic changes to increase access to and use of cessation services (2).

State cigarette excise tax

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



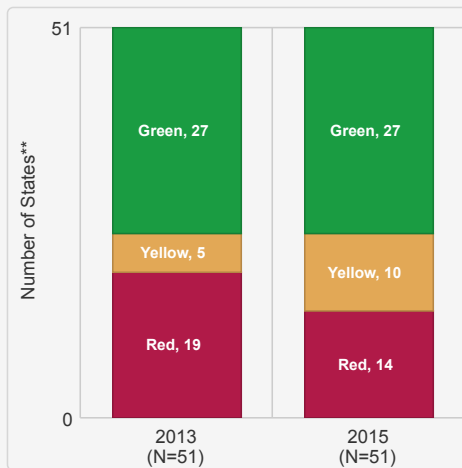
Rating	State excise tax
Green	≥\$2.00 per pack
Yellow	\$1.00–\$1.99 per pack
Red	<\$1.00 per pack

How These Ratings Were Determined

These ratings reflect the amount of cigarette excise tax in each state as reported by CDC's State Tobacco Activities Tracking and Evaluation (STATE) System (6). The data reflect laws in effect as of September 30, 2015; data do not reflect laws that had been enacted but had not yet taken effect.

Comprehensive state smoke-free policy

A state law that prohibits smoking in all indoor areas of private workplaces, restaurants, and bars, with no exceptions.



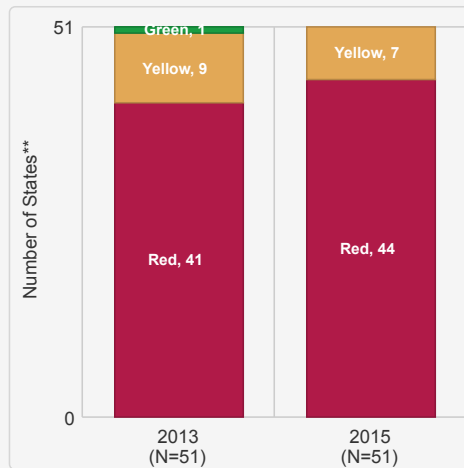
Rating	Locations covered by state smoke-free policy
Green	Workplaces, restaurants, and bars
Yellow	One or two of the three locations
Red	None of the locations

How These Ratings Were Determined

These ratings reflect the comprehensiveness of each state's smoke-free policies as reported by CDC's State Tobacco Activities Tracking and Evaluation (STATE) System (6). The data reflect laws in effect as of September 30, 2015; data do not reflect laws that had been enacted but had not yet taken effect.

State funding for tobacco control

The amount of state funding allocated for state comprehensive tobacco control activities.



Rating	State funding level
Green	≥ 100% of CDC recommendation
Yellow	50.0%–99.9% of CDC recommendation
Red	<50.0% of CDC recommendation

How These Ratings Were Determined

These ratings reflect the extent to which state tobacco control funding meets CDC's recommendations. Ratings were determined by comparing each state's FY 2015 funding for comprehensive tobacco control programs with recommendations from CDC's *Best Practices for Comprehensive Tobacco Control Programs—2014* (2,7). According to the Campaign for Tobacco-Free Kids' *Broken Promises to Our Children* report, the funding data are accurate as of each state's fiscal year 2015—which ended June 30, 2015, for most states—and do not include additional funds that might have been received later (7).

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**State count includes District of Columbia.