

# Translating Evidence into Policy: Lessons Learned from the Case of Lowering the Legal Blood Alcohol Limit for Drivers

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This case study examines the translation of evidence on the effectiveness of laws to reduce the blood alcohol concentration (BAC) of drivers into policy. It was reconstructed through discussions among individuals involved in the processes as well as a review of documentation and feedback on oral presentations. The Centers for Disease Control and Prevention collaborated extensively with federal and non-federal partners and stakeholders in conducting a rigorous systematic review, using the processes of the Guide to Community Preventive Services to evaluate the body of empirical evidence on 0.08% BAC laws. The timely dissemination of the findings and related policy recommendations—made by the independent Task Force on Community Preventive Services—to Congress very likely contributed to the inclusion of strong incentives to States to adopt 0.08 BAC laws by October 2003. Subsequent dissemination to partners and stakeholders informed decision-making about support for state legislative and policy action. This case study suggests the value of: clearly outlining the relationships between health problems, interventions and outcomes; systematically assessing and synthesizing the evidence; using a credible group and rigorous process to assess the evidence; having an impartial body make specific policy recommendations on the basis of the evidence; being ready to capitalize in briefly opening policy windows; engaging key partners and stakeholders throughout the production and dissemination of the evidence and recommendations; undertaking personalized, targeted and compelling dissemination of the evidence and recommendations; involving multiple stakeholders in encouraging uptake and adherence of policy recommendations; and addressing sustainability. These lessons learned may help others working to translate evidence into policy. *Ann Epidemiol* 2010;20:412–420. Published by Elsevier Inc.

**KEY WORDS:** Accidents, Traffic, Alcoholic Intoxication, Evidence-Based Practice, Information Dissemination, Public Policy, Review, Systematic, Translational Research.

“In order to advocate effectively for lifesaving legislation, advocates must have clear and compelling scientific evidence to provide a basis for policy change. The combination of scientific research and advocacy efforts is key to success at the federal level, in state legislatures, and in communities across the nation...We weave research findings into every piece of our advocacy efforts.”—Millie Webb, Mothers Against Drunk Driving (1).

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The findings and conclusions in this article are those of the authors and do not necessarily reflect those of the Centers for Disease Control and Prevention or the National Highway Traffic Safety Administration.

Received March 1, 2010; accepted March 4, 2010.

## INTRODUCTION

This case study examines the successful use of the processes of the Guide to Community Preventive Services (Community Guide) to translate evidence on the effectiveness of laws to reduce the blood alcohol concentration (BAC) of drivers into policy. The case study was reconstructed through extensive discussions among key individuals involved in various components of the processes, supplemented by a review of related documentation and consideration of feedback received on oral presentations. Valuable lessons were learned that may be helpful to others seeking to translate evidence into policy.

## THE CONTEXT

### Alcohol-Impaired Driving: A Serious Public Health Problem

Alcohol is a significant factor in fatal motor vehicle crashes. In 2008, 11,773 people were killed in alcohol-impaired driving crashes, accounting for nearly one-third (32%) of all traffic-related deaths in the United States (2). Of the 1347 fatalities among children ages 0 to 14 years in 2008,

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#### Selected Abbreviations and Acronyms

Community Guide = Guide to Community Preventive Services  
BAC = blood alcohol concentration  
NHTSA = National Highway Traffic Safety Association  
TEA-21 = Transportation Equity Act for the 21st Century  
GAO = General Accounting Office  
DUIP = Division of Unintentional Injury Prevention  
CDC = Centers for Disease Control and Prevention  
Task Force = Task Force on Community Preventive Services  
MADD = Mothers Against Drunk Driving

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approximately one of every six involved an alcohol-impaired driver (2). Every day, 32 people in the United States die in motor vehicle crashes that involve alcohol-impaired drivers, amounting to one death every 45 minutes. The annual cost of alcohol-related crashes in 2000 totaled more than \$51 billion (3).

#### Blood Alcohol Concentration

An alcohol-impaired driving fatality is a death resulting from a crash involving a driver with a BAC of over the legal limit.\* BAC is a measure of the amount of alcohol in a person's bloodstream. State laws specify BAC levels in grams of alcohol per 100 milliliters of blood—often abbreviated as grams per deciliter (g/dL). Thus, a BAC of 0.08 (0.08 BAC) means that a person has 0.08 grams of alcohol per deciliter (1/10th of a liter) of blood in the body. BAC levels can be measured by breath tests or blood or urine samples. According to the National Highway Traffic Safety Administration (NHTSA), on average, a 170-pound man would have to consume more than four drinks in one hour on an empty stomach to reach a BAC of 0.08 (4). A 135-pound woman typically would have to consume three drinks in the same time frame.

#### The Evidentiary Rationale for BAC Laws

A 0.08 BAC law specifies that it is illegal *per se* to operate a vehicle with a BAC of 0.08 g/dL or greater.† Laws setting the BAC limit at 0.08 g/dL were intended to replace older laws that set the BAC limit at 0.10 g/dL. Having a *per-se* national standard at 0.08 BAC is supported by laboratory and epidemiological research showing that virtually all drivers are substantially impaired at 0.08 BAC in tasks such as braking, steering, lane changing, and judgment and that these impairments begin at 0.02 g/dL (5). As

BAC levels in drivers increase, the use of seat belts decreases and speed increases (6). As drivers' BACs approach 0.08, their risk of being involved in a crash increases significantly. From an epidemiological standpoint, drivers ages 35 years or older are 11 times more likely to be involved in a fatal single-vehicle crash at 0.08 BAC than drivers of the same age who have had nothing to drink (7). The BAC dose-response curve rises more sharply among younger drivers, making alcohol-impaired driving for young drivers even more hazardous (Fig. 1).

#### 0.08 BAC Policy Considerations and Decisions in the 1990s

The aforementioned facts led NHTSA as early as 1992 to propose that all states should adopt 0.08 BAC laws. Five years later, by 1997, only 15 states had 0.08 laws. Among the 10 states with the greatest levels of alcohol-related fatalities, two had 0.08 BAC *per-se* laws, seven had 0.10 BAC *per-se* laws, and one had no BAC *per-se* law (8). Thirty-one states had 0.10 BAC laws as late as 2000, leaving the United States with among the highest and most lenient legal limits for BAC in the world—two or more times the level in Australia, Austria, Belgium, Canada, the Czech Republic, Denmark, Finland, France, Germany, Greece, Japan, the Netherlands, Norway, Portugal, Russia, and Sweden (9).

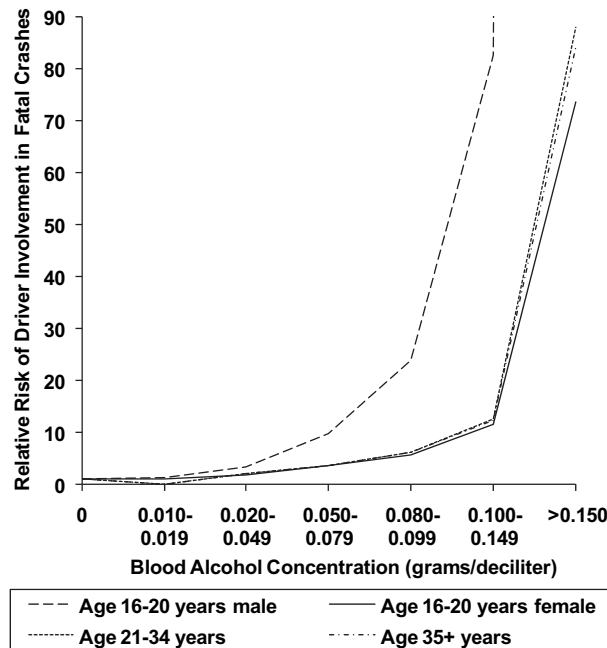
As part of the 1998 Transportation reauthorization legislation (known as The Transportation Equity Act for the 21st Century [TEA-21]), the Clinton Administration endorsed Senate bill S 1173, which included a new section (154) to title 23, U.S. Code that would have made 0.08 BAC the national standard for driving while intoxicated and would have provided for sanctions (i.e., a diversion of highway construction funds to safety programs) for states that failed to adopt 0.08 BAC laws. This Senate bill also provided that 0.08 BAC be included as a requirement for basic grants under a revised Section 410 Alcohol Impaired Driving Countermeasures Program. The Clinton Administration endorsed this legislation (S. 412 and H.R. 981). However, the Conference Committee removed both requirements and replaced them with a new incentive grant program to encourage the states to enact 0.08 BAC *per-se* laws. This incentive program provided \$500 million in grants over 6 years to states that had enacted and enforced 0.08 BAC laws.

At the time the TEA-21 Authorization Bill was considered, only four published studies, considering five states, had examined the effectiveness of 0.08 BAC laws. NHTSA had characterized the studies as "conclusively establishing that 0.08 BAC was effective" (8). In April 1999, three additional studies were released that showed promising results. Nonetheless, in a report issued in June 1999, the General

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\* Previously, NHTSA monitored alcohol-related fatal crashes and fatalities. In these more comprehensive groups, an alcohol-related fatal crash or fatality was defined as one that involved at least one driver, pedestrian, pedalcyclist, or motorcyclist with a BAC of 0.01 or greater.

† *Per-se* laws enable police to stop motorists to check BAC solely on suspicion of impaired driving rather than only being able to check BAC subsequent to the motorist being stopped for another traffic violation such as speeding.



**FIGURE 1.** Blood alcohol concentration dose-response fatal crash risk by age. \*Risk of driver involvement in a fatal crash relative to sober drivers of the same age and sex. Source: Zador et al. (7).

Accounting Office (GAO) raised methodological concerns about the studies—specifically noting that they were subject to potential biases such as the influence of historical events concurrent with changes in a state’s BAC limit. The GAO therefore concluded that “overall the evidence did not conclusively establish that 0.08 laws, by themselves, result in reductions in the number and severity of alcohol-related crashes” (8). This position is consistent with the fact that, when various bills are under consideration, there is the potential for opponents to challenge the views of the regulatory agencies (in this case NHTSA) as not being impartial.

## BUILDING A BRIDGE BETWEEN EVIDENCE AND POLICY

The Motor Vehicle Injury Prevention Team in the Division of Unintentional Injury Prevention (DUIP) of the Centers for Disease Control and Prevention’s (CDC’s) Injury Center worked in the late 1990s to initiate a process that would: (i) be seen as impartial; (ii) use state-of-the-science methods to carefully assess existing evidence on the effectiveness of 0.08 BAC laws and other selected interventions in reducing morbidity and mortality from motor vehicle crashes; and (iii) produce and disseminate resulting policy-related recommendations. The process chosen was that of the Community Guide, which involves conducting systematic reviews of the effectiveness of community-based public

health interventions (10). These systematic review findings then form the basis for evidence-based policy and practice recommendations made by the Task Force on Community Preventive Services (Task Force). The Task Force is a nonfederal, independent body of nationally renowned experts in public health research, practice, and policy. Task Force members are nominated through a process that includes broad input from stakeholders throughout public health and health care and they are appointed by the CDC Director to serve for limited terms. CDC staff provides technical and administrative support to the Task Force. The Community Guide places equal weight on assuring the quality of two aspects of its systematic review processes: (i) its group processes and (ii) its synthesis methods.

## The Community Guide’s Essential Group Processes

The Community Guide’s processes are founded on the principle that active participation by intended users in both the conduct and dissemination of systematic reviews increases the relevance and accessibility of the findings and recommendations to those users (11). Each systematic review is therefore conducted by a Coordination Team of 6-15 subject matter and methodological experts who are involved in all decision making. The Motor Vehicle Systematic Review Coordination Team was led by subject matter scientists in DUIP and NHTSA—experts in the design, evaluation, or practical implementation of alcohol-impaired driving programs. Support was provided by systematic

review methodologists in CDC’s Community Guide Branch and a Task Force member. The Coordination Team ensured that the research questions were relevant to practice, the information was complete and accurate, and the review and recommendation were conceptually and methodologically sound.

A Community Guide Coordination Team is supplemented by a Consultation Team of subject matter experts that provide consultation at key points in the review. The Motor Vehicle Consultation Team included representatives of federal, state, and local governmental agencies; professional organizations; and academic, policy, and practice-based partners (Table 1). The Consultation Team’s roles were to ensure that diverse viewpoints were reflected, the review was conducted and communicated consistently, rigorous methods were applied, and the results could be understood by generalist audiences. Together the two teams provided complementary contributions to enhance the quality of the review and the credibility, usefulness, and practicality of the findings.

### The Community Guide’s Synthesis Methods

Consistent with the methods for all Community Guide reviews, the Motor Vehicle Team’s systematic review of the effectiveness of state laws that lower BAC for motor vehicle drivers from 0.10 g/dL to 0.08 g/dL involved the following: (i) developing a clear intervention definition, research questions, and logic model showing how interventions are presumed to be related to intermediate and ultimate outcomes; (ii) searching for and screening all available studies; (iii) evaluating the quality of all candidate studies; (iv) undertaking detailed abstraction of all qualifying articles and reports; generating evidence tables; and (v) summarizing and synthesizing the results. The team also assessed other benefits and harms of the intervention, potential barriers to implementation, economic efficiency, and applicability of the intervention to multiple settings and situations.

A key difference between the Community Guide review and the preceding GAO report (8) was that the Community Guide review considered the body of empirical evidence on 0.08 BAC laws as a whole rather than as a series of discrete studies. The effect estimates from each study were treated as individual data points that were subject to systematic and random sources of measurement error. These individual data points were synthesized graphically and with the use of descriptive statistics to get a more reliable and valid estimate of the true effects of a change in BAC limits than would have been possible from any individual study. From this perspective, potential threats to the internal validity of individual studies—e.g., the effects of historical events in a given state—that would not be expected to be pervasive

**TABLE 1.** Members of the Community Guide Motor Vehicle Consultation Team

Federal Agencies
Centers for Disease Control and Prevention
Health Resources Services Administration
Substance Abuse and Mental Health Services Administration
National Institute for Alcohol Abuse and Alcoholism, National Institutes of Health
National Highway Traffic Safety Administration
Indian Health Service
National Professional and Non-Governmental Organizations
National Public Service Research Institute
National SAFE KIDS Campaign
Insurance Institute for Highway Safety
National Safety Council
Other Members
SMEs from state, county, and city departments of health
SMEs from numerous academic institutions and institutes

SMEs = subject matter experts.

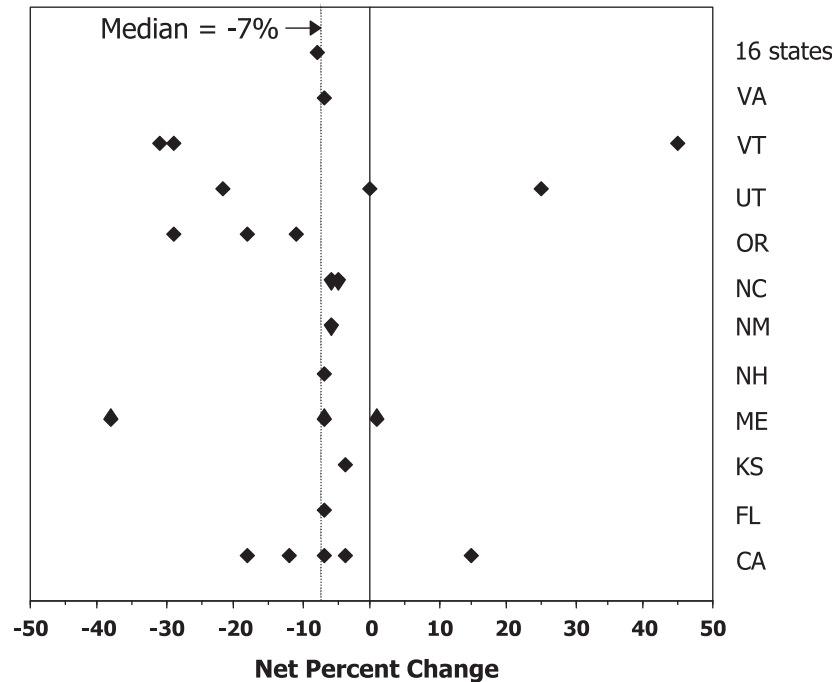
throughout the entire body of evidence simply become “noise” in the overall pattern of results and would not be expected to be a systematic source of error in the effect estimates.

The primary outcome evaluated in the review was fatal injuries from alcohol-related crashes (or proxies for alcohol-related crashes). The body of literature consisted of 12 studies, 10 of which included concurrent comparisons to control for threats to validity that did have the potential to be pervasive throughout the body of literature (e.g., secular trends in alcohol-related crash fatalities). When plotted graphically, a clear pattern of results emerged indicating that lowering the BAC limit to 0.08 g/dL was effective in reducing fatalities (Fig. 2). The median effect estimate from these studies was a 7% decrease in fatalities, with an interquartile interval of –15% to –4% (12).

The review and synthesis process found that 0.08 BAC laws were effective in reducing fatalities from alcohol-related motor vehicle crashes, with the potential to save 500 lives a year if implemented in all states. The Task Force considered the evidence and issued a recommendation that 0.08 BAC laws be implemented on the basis of the strong evidence of their effectiveness (13).

### After the Task Force Recommendation: Moving from Evidence to Policy Action

Shortly after the Task Force’s 2000 recommendation, and while the Community Guide review was on its way to publication, Congressional hearings were taking place on the Department of Transportation’s 2001 Appropriations legislation. No states had adopted 0.08 BAC laws in 1998, and only three states had done so in 1999, the two years immediately after enactment of the TEA-21 incentive program.



**FIGURE 2.** Percent change in measures of alcohol-related motor vehicle fatalities attributable to .08 BAC laws, by state. The figure was first published in: Shults et al. (12). References for the studies represented in the figure are available there. Number of data points per row corresponds to the number of studies conducted using data from that state. Median percent change calculated by using the median value for the state. Median percent change: -7%; interquartile range: -15%, -4%.

Again, there was consideration of a provision of a Senate provision (Section 342) that would encourage states to adopt 0.08 BAC laws by withholding a portion of a state's federal highway funds, beginning in October 2003 (the start of fiscal year 2004), for states that did not adopt such laws. The House-passed bill (H.R. 4475) did not contain such a provision, however.

During their deliberations, members of the Subcommittee requested information about the effectiveness of 0.08 BAC laws in saving lives. An influential non-federal member of the Community Guide Motor Vehicle Consultation Team was aware of this request and of the need to respond quickly. Because he knew firsthand the credibility and quality of the Community Guide processes, he asked the Motor Vehicle Coordination Team for the systematic review findings. He then expeditiously arranged for the Chair of the Transportation Subcommittee to receive a letter from the lead (non-federal, independent) Task Force member on the Motor Vehicle Coordination team and an accompanying graphic (Fig. 2) that together summarized the scientific findings and Task Force recommendation. These items were introduced into the debate. Both the House and Senate subsequently approved the Transportation Appropriations bill (Section 342), as a result of testimony including the Community Guide systematic review evidence. The bill was sent to the

White House and signed into law by President Clinton on October 23, 2000.

### Facilitating Evidence-Informed Decision Making by Stakeholders of Policy Action

The new bill included a provision in the fiscal year 2001 Department of Transportation and Related Agencies Appropriations Act that required states to enact 0.08 BAC laws by October 2003 or face losing some funding for federal highway construction. To assist states, DUIP developed and, with NHTSA's assistance, implemented a formal dissemination plan for the 0.08 BAC and related Community Guide motor vehicle reviews aimed at: (i) increasing awareness of the systematic review results and Task Force recommendations among motor vehicle safety experts, law enforcement, public health professionals, and policy makers; (ii) fostering wider, third-party distribution of review findings and Task Force recommendations through emails, listservs, newsletters, trade publications, the popular media, etc.; and (iii) facilitating evidence-informed decision making among stakeholders of legislative and policy action at state and local levels.

In determining who should communicate with different partners and stakeholders, DUIP identified sources that would be most credible with key audiences and built on



existing relationships. DUIP and Community Guide staff delivered more than 40 presentations about the 0.08 BAC and related reviews at national and international conferences. Various Coordination Team members met in person with leaders of NHTSA, Advocates for Highway Safety, Society for Public Health Education, Insurance Institute for Highway Safety, Mothers Against Drunk Driving (MADD), and others. DUIP created and sent via direct mail and email more than 600 packets of information that people could use to share the findings with colleagues, partners, decision-makers, and local media. The packets included cover letters, copies of the systematic review publications, information about the Community Guide, news releases and sample articles that could be dropped into newsletters, a one-page overview of the recommendations, fact sheets, and questions and answers. All of the materials included a link to the Community Guide website, whose motor vehicle section was accessed by nearly 5000 readers between June and December, 2001. DUIP, the Community Guide, and NHTSA also distributed more than 1000 flyers and 4600 copies of the systematic review publications at key national and international public health and motor vehicle safety conferences and meetings. Finally, DUIP provided information to organizations such as the Governors Highway Safety Association, who then mailed letters about the systematic review findings and recommendations to its membership.

### Impact of the Policy Actions

Before the enactment of the 2001 Appropriations bill that included sanctions for states without a 0.08 BAC law, only 19 states had passed 0.08 BAC laws (4). By July 12, 2004, all 50 states had enacted these laws (14). The Community Guide findings and related Task Force recommendation appear to have influenced the federal Appropriations process, which resulted in the sanction for states. The sanction, in turn, was likely the main ingredient in the legislative process at the state level, with the wide dissemination of the Community Guide findings and recommendations likely helping to facilitate the state legislative process in the post-appropriation period.

Through ongoing interactions with its partners, DUIP learned of additional impacts of the Community Guide findings and Task Force recommendation resulting from their adoption by other key government agencies, constituents, advocates, and voluntary and not-for-profit groups that helped diffuse and apply the results on a wider scale. For example, the National Association of County and City Health Officials cited the reviews in formal policy resolutions endorsing 0.08 BAC laws and suggested how local health departments and traffic safety programs could implement and promote them. New York State used the evidence

to support a 2009 bill passed by the State Assembly that makes it a felony to drive while intoxicated with a child in the vehicle. The U.S. Department of Transportation, American Automobile Association Foundation, NHTSA, and CDC incorporated the findings of the 0.08 BAC and other Community Guide motor vehicle reviews into requests for funding proposals. Influential organizations, including the Insurance Institute for Highway Safety (15); International Council on Alcohol, Drugs, and Traffic Safety (16); United Kingdom's Health Development Agency (17); World Health Organization and World Bank (18); and the Global Road Safety Partnership program (19), highlighted the review in their publications and encouraged uptake of 0.08 BAC laws and other interventions that were recommended by the Task Force to reduce alcohol-impaired driving. Finally, NHTSA continues to highlight the Community Guide 0.08 BAC laws and related reviews on its website and in its national training for enforcement officials.

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### LESSONS LEARNED

Important lessons have been learned from this case study. Specifically, the successful translation of evidence into policy was related to the: (i) salience of the health problem and policy intervention, in addition to the compelling relationships between the health problem, policy intervention, and health outcomes; (ii) use of systematic review methods to synthesize the full body of evidence; (iii) use of a recognized, credible, and impartial process for assessing the evidence; (iv) development of evidence-based policy recommendations by an independent, impartial body; (v) ability to capitalize on readiness and teachable moments; (vi) active participation of key partners and intended users throughout all stages of the process; (vii) use of personalized channels, targeted formats, and compelling graphics to disseminate the evidence; (viii) capacity to involve multiple stakeholders in encouraging uptake and adherence; and (ix) attention paid to addressing sustainability. Each of these will be briefly described.

#### The Salience of the Health Problem and Policy Intervention and the Compelling Relationships between the Health Problem, Policy Intervention, and Health Outcomes

The translation of evidence into policy action was facilitated by both the health problem and the intervention (lowering the legal BAC limit to 0.08 g/dL) being readily understandable by policy makers. In addition, the intervention addresses an important and salient public health problem and can play a key role in its reduction. Moreover, the ultimate intended health outcome (i.e., reduction in fatalities) was measured in the studies and could be extrapolated to nation-wide implementation.

### **The Use of Systematic Review Methods to Synthesize the Full Body of Evidence**

The 0.08 BAC law intervention had a strong evidentiary basis in terms of the number of studies. The use of systematic review methods to synthesize the available evidence helped to control for differential threats to validity across the studies and revealed the consistency of the intervention effect across the studies. Therefore, this synthesized evidence foundation led to the formulation of a stronger, more defensible policy recommendation.

### **The Use of a Recognized, Credible, and Impartial Process for Assessing the Evidence**

When NHTSA initially reviewed the literature, there may have been some discounting of NHTSA's neutrality. A number of components of the Community Guide process were critical to the credibility it was accorded by policy-makers and others involved in facilitating legislative processes. The Community Guide reviews were staffed by CDC, which has a reputation for scientific integrity. Additionally, the Community Guide was known for employing rigorous, standardized, and transparent processes and using strong scientific methods.

### **The Development of Evidence-Based Policy Recommendations by an Independent, Impartial Body**

Translating evidence into policy was further facilitated by the production of policy recommendations by an independent and impartial body. Thus, not only did the Community Guide process produce scientific findings, but it also produced associated, actionable, evidence-based policy recommendations made by a reputable, impartial, nonfederal, independent, and generalist Task Force.

### **The Ability to Capitalize on Readiness and Teachable Moments**

DUIP and the Coordination Team recognized the need to develop and maintain readiness, or “prime the pump.” Different agencies had undertaken activities over a number of years to increase and maintain awareness of the problem, develop or document evidence, and identify policy actions. Also recognized was the importance of capitalizing on a teachable moment, or a briefly opening policy window (20). Partners promptly took action when they learned that transportation legislation and issues of alcohol-impaired driving were being debated. Moreover, by being aware that policy makers were at the contemplation stage (21), partners could match their messages to the appropriate stage of change. Additionally, it is possible that providing information just before the legislative vote did not give opponents time to cast doubt on the findings and recommendations.

### **The Active Participation of Key Partners and Intended Users throughout All Stages of the Process**

Engaging key partners and intended users in all stages of the process, rather than only at the dissemination stage, helps to ensure relevance of Community Guide reviews to real world issues, early understanding and buy-in, and readiness of dissemination channels and supports (11, 22). From the outset of the review, the Community Guide process engages individuals and groups that work with the health problems and have credibility with intended users, including recognized “champions” (23). The Motor Vehicle Coordination Team was particularly adept at nurturing pre-existing relationships and fostering new connections. Team members strived to develop and maintain effective group processes and collaborative relationships; communicate well; rise above turf issues; and build consensus. They were deliberate and outcomes-oriented. They also nurtured their relationships with their Consultation Team and other partners so that these extended networks were ready to disseminate the findings and recommendations to their constituents who, in turn, were informed when decision makers considered policy action.

### **The Use of Personalized Channels, Targeted Formats, and Compelling Graphics to Disseminate the Evidence**

Communications to all audiences referred to both the scientific findings and the recommendations while being brief and to the point. The Coordination Team also developed a compelling graphic (Fig. 2) of the summarized data that clearly demonstrated for policy makers and other audiences how the data supported the conclusions. Specific dissemination channels and formats were focused on who would have the most credibility with, and what would be most helpful for each intended audience. The dissemination strategy capitalized on personal connections with, members of the Coordination and Consultation Teams making in-person visits to key partners and stakeholders whenever possible and attending critical meetings and conferences. Information on the review findings and Task Force recommendations was delivered by an influential non-federal member of the Consultation Team to the Chair of the Transportation Subcommittee of the House Appropriations Committee by use of a personal letter from the nonfederal Task Force member on the Motor Vehicle Coordination Team, supplemented by the aforementioned graphic.

### **The Capacity to Involve Multiple Stakeholders in Encouraging Uptake and Adherence**

Stakeholders at multiple levels were able to act meaningfully to bring about support for policy action. Federal policy makers established meaningful incentives (budgetary sanctions) to encourage policy action at the state level. Various public health and traffic safety groups and advocates such as

MADD worked to support laws at the state level. Multiple constituents at local levels—police, public health and traffic safety professionals, and advocates (including local MADD affiliates)—later worked to encourage adherence.

### The Attention Paid to Addressing Sustainability

Because a policy can often be readily changed, there has been specific commitment to addressing sustainability. Most important in this case has been the ongoing personal commitment of several influential “champions” (i.e., D. Sleet and J. Nichols). They continue to look for opportunities to feature the systematic review findings and Task Force recommendations. The NHTSA Team member has worked to keep information about the Community Guide process, review findings, and Task Force recommendations in mandatory NHTSA training for federal and state employees. Additionally, governmental agencies, external researchers, and local jurisdictions have continued surveillance to maintain current data. A sustainability challenge will be to secure institutional memory when the Champions eventually move on. The use of Community Guide processes to re-engage influential partners in updating the systematic review may help in this regard.

### CONCLUSIONS

This case study suggests the value of preparing from the outset for, and moving in a deliberate progression from clearly outlining the relationships among health problems, interventions, and outcomes; to systematically assessing and synthesizing the evidence; to using a credible group and rigorous process to assess the evidence; to having an impartial body make specific policy recommendations on the basis of the evidence; to being ready to capitalize on briefly opening policy windows; to undertaking personalized, targeted, and compelling dissemination of the evidence and recommendations. The case study also underscores the importance of engaging key partners and stakeholders throughout both the production and dissemination of the evidence and recommendations, to ensure adequate conceptualization and interpretation of the evidence as well as readiness of channels for targeted dissemination. Finally, it highlights the value of involving multiple stakeholders in encouraging uptake and adherence of policy recommendations and of addressing sustainability.

The important lessons learned through this case study are actively being used by the Community Guide to enhance dissemination and translation into action of evidence on the effectiveness of other policy interventions. These lessons may also help others working to translate epidemiologic and other forms of evidence into policy.

The authors would like to thank Charles A. Hurley, BA, Stephanie Zaza, MD, MPH, Peter A. Briss, MD, MPH, and Brad A. Myers, MPH, for their recollection of key incidents and for their participation in presenting an earlier version of this case study. The authors would also like to thank Richard A. Schieber, MD, MPH, for his helpful comments subsequent to that presentation.

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