NATIONAL ASSOCIATION OF
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What's Working in Chronic Disease Prevention and Control?

Success Stories from States and Territories

A MESSAGE FROM DAVID HOFFMAN

Chair, NACDD Legislative & Policy Committee

What's Working in Chronic Disease Prevention and Control? Promoting State Success highlights successful approaches developed in state and territorial chronic disease programs for cancer; diabetes; heart disease and stroke; nutrition, physical activity and obesity; osteoporosis; school health; oral health; women's health; aging; and arthritis.

Chronic disease is the most prevalent and costly health problem in the nation, with an annual price tag of $7 billion. Much is known about how to prevent and control chronic disease to preserve well-being and promote longevity for all Americans. These success stories illustrate state action to establish public/private partnerships and maximize available resources to expand the reach of chronic disease programs, improve quality of life for many and save scarce health care dollars. A stronger commitment of resources to a system-wide chronic disease approach emphasizing prevention, health equity and sustainability will help states achieve even greater health and economic benefits not only for state residents but for the country as a whole.

NACDD leaders, members and partners, especially the Centers for Disease Control and Prevention, deserve thanks for their many contributions to state success in chronic disease and for actions that are paving the way for future accomplishment.

David P. Hoffman

David P. Hoffman, MEd
Director of Chronic Disease Prevention and Control
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A MESSAGE FROM THE EDITOR

What's Working in Chronic Disease Prevention and Control? is the second set of success stories published by NACDD from our online collection aimed at partners, policymakers and public health leaders. These stories describe the positive impact of chronic disease programs on the health, quality of life, and longevity of people in our nation's states and territories.

Stories are added to the collection regularly, are searchable and can be printed for sharing with stakeholders, the public and others. We hope you'll learn from these success stories and contribute your own stories to this collection of current public health practice in chronic disease.

Read all the success stories in the collection and submit your own at: www.chronicdisease.org.

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ARKANSAS WORKERS SQUARE OFF TO GET FIT

The Arkansas Fitness Challenge becomes a nation-wide event to benefit a wider audience

Public Health Problem

- Many Arkansas adults get little daily physical activity and over half are obese or overweight.
- Most adults spend a large percentage of their day at work and their fitness affects productivity, absenteeism, employee satisfaction and employer health care costs.
- Programs to increase worker's physical activity can help prevent the onset of chronic diseases that result from obesity and lack of activity.

Program

- The Arkansas Department of Health and Arkansas Blue Cross created the Arkansas Fitness Challenge as a competition for employee teams from the two agencies who participated in specific exercises along a virtual route through 92 checkpoints. Participants must satisfy a daily exercise requirement in order to advance one checkpoint and must advance at least three times a week for most of the weeks in the three month challenge to meet the program goal of 30 checkpoints. The winning team is the one with the most accumulated points.
- The Challenge encourages employees to work toward the public health recommendation of thirty minutes of physical activity, most days of the week.
- Over four years of Challenges, thousands of employees from the two originators were joined by many thousands more from companies and groups starting their own challenge teams using a free kit.

Impact

- Arkansas Fitness Challenge participants report that due to the contest:
  - they increased the number of days they exercised
  - their health had somewhat or greatly improved
  - they lowered their blood pressure, blood cholesterol, and weight
- Arkansas Blue Cross employees won the contest more often than health department teams, but all participants were winners in improved health and fitness.
- Paul Halverson, DrPH, director of the Arkansas Department of Health says, "The Fitness Challenge provides a great opportunity for our employees to become healthier individuals by implementing regular physical activity into their daily lives."
- The success of the Challenge led to its expansion as the national Blue and You Fitness Challenge.

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BUILDING PROGRAM PARTNERS WITH AN ARTHRITIS COMMUNICATIONS CAMPAIGN

California increases arthritis awareness to promote participation in evidence-based physical activity programs

Public Health Problem

- Arthritis is the leading cause of disability in the United States.
- Preventing activity limitations due to arthritis in adults with chronic joint symptoms is a Healthy People 2010 Objective for the nation.
- Early diagnosis and appropriate management of arthritis, including self management, can help people with arthritis decrease pain, improve function, and lower health care costs.

Program

- The California Arthritis Partnership Program, California Department of Public Health implemented evidence-based physical activity programs with a statewide perspective rather than a separate approach to each individual Arthritis Foundation Chapter.
- The Arthritis Foundation, Northern California took the lead to implement *Physical Activity. The Arthritis Pain Reliever,* a tested campaign to raise awareness of physical activity as a way to manage arthritis pain and increase function and to increase the trial of physical activity behaviors. Lead responsibilities included educating the other Chapters on how the campaign was previously implemented, offering suggestions for current year implementation, and coordinating the graphics production
- The campaign used radio spots and posters and brochures customized for each Chapter's target populations, generating goodwill with Chapter partners.

Impact

- Consistent messages are disseminated statewide and there is increased statewide collaboration among Chapters.
- Provision of needed physical activity programs is greatly expanded in the Long Beach area from an initial single program offering.
- Campaign implementation targeted areas where evidence-based Arthritis Foundation programs were slated for expansion as a way of ensuring that the expected increase in demand for programs would be accommodated.

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COMBINING TOBACCO CESSATION AND DIABETES AWARENESS EFFORTS TO INCREASE BENEFITS

Promoting tobacco quit lines to providers extends reach to people with diabetes

Public Health Problem

- Almost one fifth of the two million people with diabetes in California are smokers.
- Smoking raises blood sugar and reduces the body's ability to use insulin, making it more difficult to control diabetes.
- Controlling diabetes through tobacco cessation and other lifestyle changes can reduce the costly complications of the disease such as heart attack, amputations and blindness.
- Tobacco quit lines are a proven strategy for reducing tobacco use.

Program

- The *Do you cAARd?* campaign is part of the "Be Proactive" Collaborative Diabetes and Tobacco Cessation Project of the California Diabetes Program, the California Smokers' Helpline and the California Tobacco Control Section at the California Department of Health Services. Funding for this project comes from the State-Based Tobacco Cessation Quitlines supplemental tobacco control award from the Centers for Disease Control and Prevention.
- The campaign is designed to increase the frequency with which diabetes educators and other health care providers ask about the smoking status of people with diabetes, advise them to quit and refer them to the free Smokers' Helpline (**A**sk–**A**dvise–**R**efer)
- Campaign strategies include: helping providers incorporate the Ask–Advise–Refer method into regular practice; incorporating a diabetes-specific screening question in the Helpline caller intake; providing tobacco cessation education for American Association of Diabetes Educators chapters in California; training Helpline counselors and diabetes program staff; and supplying free campaign materials. Outreach information includes announcements, articles, newsletters, and a pocket guide for providers. Information at www.caldiabetes.org.

Impact

- The campaign resulted in a twenty percent increase in referrals to the Helpline and increased distribution of cessation and campaign materials.
- Awareness of the toll free Helpline number increased by forty percent among health care providers.
- The number of quit line callers with diabetes increased 165% over a one year period.
- When surveyed, almost two-thirds of California's diabetes educators were aware of the campaign.
- The campaign is being considered by the Centers for Disease Control and Prevention Office of Smoking and Health and Division of Diabetes Translation and the California Department of Health Services Tobacco Control Program as a model to use with other chronic diseases.

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COLORADO PARTNERS PROVIDE EASY ACCESS TO PHYSICAL ACTIVITY

Corporate fitness challenge and exercise classes held in natural settings promote physical activity to Pueblo County residents.

Public Health Problem

- Half of all Colorado adults are overweight or obese, increasing the risk of chronic diseases such as heart disease, diabetes, and stroke.
- Only one-fourth of the state's adults meet the Surgeon General's recommendation of 30 minutes of moderate physical activity most days of the week.
- Twenty percent of adults report no physical activity.

Program

- The YMCA of Pueblo and Steps to a Healthier Pueblo sponsored two community programs promoting physical activity:
  - The *YMCA Corporate Cup* challenged teams from local organizations and businesses to compete in events such as volleyball, golf, bowling and bike relays. Awards were presented for sportsmanship, participation, team T-shirt design, and event winners. Financial sponsors included Colorado State University-Pueblo and Parkview Medical Center.
  - *YMCA Fitness on the Riverwalk*, a three-month physical activity campaign, offered Pueblo residents the opportunity to participate in free fitness classes held at the beautiful Historic Arkansas Riverwalk. This project received additional funding from the Pueblo Board of Water Works and in-kind media sponsorship from a local radio station.

Impact

- Over fifteen years, the Corporate Cup has grown from six participating businesses to 25 companies and 1,650 team members. Several companies have made policy changes to promote nutrition and organized physical activity.
- Many of the more than 800 Pueblo residents who participated in *Fitness on the Riverwalk* noted that it was their first experience with group exercise classes.
- Programs such as these provide easy access to fitness programs and no- or low-cost opportunities for community members to try healthy behaviors.
- The partners planned activities that maximized the strengths of each organization, teaching the value of regular physical activity not only to their members but to the community as a whole.

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A REGIONAL APPROACH TO SUPPORT FOR STATE DIABETES PROGRAMS

Partnership across New England promotes networking and supports better program efforts

Public Health Problem

- Public health issues related to diabetes are similar across the New England states and collaborating on shared solutions extends the reach and impact of individual programs.
- The high turnover rate among diabetes program managers/coordinators in New England, one-third in a recent year, slows program progress in preventing and controlling diabetes.
- Management theory supports the value of networking with peers, professional development and teamwork as significant aspects of job satisfaction and retention of trained, competent workers.

Program

- To increase collaboration among diabetes program managers/coordinators six states, Massachusetts, Connecticut, Rhode Island, Maine, New Hampshire and Vermont, established a regional partnership to work on regional initiatives, share ideas and materials and provide networking opportunities and support to state program staff.
- In addition to planned meetings at conferences outside the region, an annual, regional meeting promotes work on state specific programs and projects of benefit to all states, such as the Management Information System and the Performance Improvement Plan.

Impact

As a result of the partnership, state diabetes programs in the New England region have:

- Decreased planning time for each individual state through the exchange of ideas for training of professional, lay health and para-professional program and partner staff
- Increased opportunities to extend the reach of the Stanford Chronic Disease Self Management Program, an evidence-based program shown to enhance quality of life for people with chronic diseases such as diabetes and improve the management of their condition
- Implemented the Move More Program to promote physical activity in additional states in the region following its development in Maine
- Increased the public's exposure to diabetes public service announcements by sharing ideas within the region on the use of cable television to broadcast information on diabetes
- Improved cooperation among programs which resulted in anecdotal reports of increased job satisfaction for program coordinators that may promote retention of experienced staff.
- Improved program effectiveness through wider sharing of program knowledge among the region's diabetes programs, such as use of performance measures and ways to engage partners.

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COALITION ASSESSMENT AND ACTION TO REDUCE ASTHMA BURDEN

Members and leadership highly regarded; recommended changes will improve capacity

Public Health Problem

- Asthma is estimated to affect over a half million children and adults in Indiana.
- The Indiana State Department of Health Asthma Program seeks to reduce the burden of asthma in the state and works closely with the Indiana Joint Asthma Coalition to develop and implement interventions that improve the health and quality of life for residents with asthma.

Program

- The Indiana Joint Asthma Coalition is a voluntary, statewide network of people and public and private organizations which helped develop *A Strategic Plan for Addressing Asthma in Indiana*, the State Asthma Plan. The Coalition helps identify resources, create collaborative relationships with internal and external partners, implement activities of the State Asthma Plan including specific interventions, and support a comprehensive asthma data and surveillance system.
- With funds from the Centers for Disease Control and Prevention the Indiana State Department of Health Asthma Program assessed Coalition leadership, resources, decision-making, internal communications, perceived value and sustainability in order to identify strengths and areas for improvement.
- Overall, the assessment revealed positive regard for leadership, resources, functions and value of the coalition and identified state staff and coalition leaders as knowledgeable, capable, and effective. Coalition members described the benefits of membership as staying informed in a rapidly changing environment, better professional skills and knowledge, and development of collaborative relationships with other agencies.

Impact

Assessment of the state asthma coalition revealed positive regard for the leadership and identified member benefits. Areas for change were identified that will improve the coalition's capacity to reduce the burden of asthma in Indiana. These include:

- Consideration of multi-year terms for leadership to improve continuity
- Systematic assessment of coalition membership to maintain strengths
- Provision of regular updates on activities to members and partners to maintain interest
- Regular assessment of progress towards reaching objectives and development of action strategies
- Maintenance of momentum to accomplish objectives through encouragement of a more regular schedule of workgroup meetings
- Examination of the benefits and drawbacks of attaining 501(c)3 status before taking this step

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EXPANDING PARTNERSHIPS TO REACH HEALTH OBJECTIVES FOR DIABETES

Improving the diabetes care system for women reduces barriers and improves outcomes

Public Health Problem

- With obesity rates for Indiana women increasing it is likely that, without intervention, the diabetes rate for women in Indiana will continue to rise.
- Women with diabetes must navigate a complex system of health care services in order to obtain needed screenings, education, and support to manage their disease effectively.
- Encountering barriers and having limited assistance to overcome these barriers makes it harder for women to follow diabetes management recommendations.
- Unique strategies that focus on the needs and concerns of women with diabetes can improve outcomes and reduce complications of diabetes such as blindness, amputations and heart disease.

Program

- The Indiana Diabetes Prevention and Control Program is partnering with the Indiana Office of Women's Health to implement the *Indiana Women's Diabetes Initiative,* funded by an Advancing System Improvements to Support Targets for Healthy People 2010 grant and guided by a Women's Health Committee of the Indiana Diabetes Advisory Council.
- The Initiative goal is improving performance on ten selected health objectives related to women's health in the area of diabetes, overweight, nutrition and physical activity.
- A pilot patient navigation system developed by the Initiative helps women with diabetes successfully manage their disease and overcome barriers to accessing health care services and community resources.
- The Indiana University Department of Family Medicine Bowen Research Center is also a partner along with three community partners who are implementing the pilot, Elkhart County Health Department, Partners for a Healthier Community in Howard County, and Hoosier Uplands in Lawrence County.

Impact

- The *Indiana Women's Diabetes Initiative* is reducing the barriers to services and resources, such as access to care and medications, to promote better diabetes management for women.
- The patient navigation system is providing access to diabetes education classes, diabetes meters and strips, and a support system.
- Several in-kind services that address the Indiana Consensus Guidelines for Diabetes Care are now available in each county.
- A sustainability plan ensures continued assistance for women, even when grant funding ends.
- This Initiative is increasing the number and strength of partnerships with the state health department, garnering attention for the serious issue of diabetes care for women and increasing the likelihood of future expansion of the pilot services to meet health objectives.

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SUPPORTING HEALTH CARE COLLABORATIVES TO IMPROVE DIABETES CARE

Annual educational sessions promote successful practices and disseminate resources

Public Health Problem

- Healthcare collaboratives track quality measures over time to help practitioners assess and improve the care they give to people with chronic diseases such as diabetes and to increase the adoption of self-care measures by the people in their care.
- By taking steps to impact the most vulnerable populations, healthcare collaboratives can reduce health disparities and enhance health outcomes.
- Keeping health care practitioners up-to-date on accepted disease management guidelines and effective methods for working in collaborative settings can improve their clinical practice.

Program

- The Kentucky Diabetes Prevention and Control Program, Heart Disease and Stroke Program, Immunization Program, along with the Kentucky Primary Care Association, Diabetes Network Health Plan Partners, National Diabetes Education Program, and the Association of American Medical Colleges Academic Chronic Care Collaboratives partnered to develop and conduct annual educational sessions for Kentucky healthcare collaborative members.
- The educational sessions review successes and challenges in translating evidenced-based guidelines into practice as well as provide new information that health care practitioners need. The most recent sessions reached participants from all but three of the sixteen Kentucky collaborative sites.
- Funding to cover the facility and materials expenses for the sessions comes from several state chronic disease programs and food costs are covered by exhibitor fees paid by for-profit companies.

Impact

- More of the high risk population is getting improved diabetes care and reducing their risk of death and serious complications. Trends tracked by the collaboratives show that rates of dilated eye exams, patient self monitoring of blood sugar, foot exams, influenza and pneumonia vaccinations and visits to a health care professional for diabetes care all *improved* since the establishment of the collaboratives and the training sessions.
- Most respondents to a follow-up survey state they intend to apply a concept, idea, or strategy in their own setting that they learned from the sessions.
- Successful collaborative sites now mentor other sites on important client service topics and successful approaches are shared for easier adoption by other sites. Opportunity is also provided for Medicare, Medicaid, Kentucky Department for the Blind, the Kidney Foundation, and others to provide their resources to the collaborative members.

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NETWORK TAKES STEPS TO REDUCE THE BURDEN OF DIABETES

Establishing a statewide coalition in Kentucky extends the reach of diabetes programs

Public Health Problem

- Diabetes is a growing and serious problem in Kentucky but much of the sickness and death associated with it could be prevented by applying evidence-based treatment and disease-management guidelines, such as monitoring and normalization of blood sugar levels, routine doctor visits, self-management training, and routine eye and foot exams.
- Coalitions focused on a single topic, such as diabetes, can unite diverse groups behind a common goal, foster cooperation and combine each group's resources to promote needed change, achieving results surpassing those of each organization working individually.
- Groups providing services to people with diabetes can benefit from joint efforts to promote prevention and may provide greater credibility on this important issue.

Program

- The Kentucky Diabetes Prevention and Control Program identified the need for a statewide partnership to prevent diabetes and improve treatment and outcomes for Kentuckians who have the condition and facilitated a steering committee of key public and private entities to create the Kentucky Diabetes Network.
- The Kentucky Diabetes Network established by-laws, a strategic plan, workgroups and advisory committees, and secured federal 501c-3 non-profit status. The Kentucky Diabetes Prevention and Control Program staff serves as liaison to the Board of Directors and as administrative coordinator for the network as well as assisting with strategic goal-setting and advising work groups.
- Funding for the Network comes primarily from pharmaceutical partners and donations.

Impact

- Examples of the many accomplishments related to Kentucky Diabetes Network activities are:
  - Appropriation of $2.4 million in state funds for the state Diabetes Prevention and Control Program resulting from educating policymakers about the diabetes burden in the state.
  - Creation and annual funding by state legislature of $200,000 for a Diabetes Research Board
  - Development and dissemination of large numbers of a variety of educational materials to health care providers, patients and the public, some in English and in Spanish.
  - Development of a professional lending library, the Kentucky Diabetes Connection newsletter, three diabetes conferences with the Kentucky School Nurses Association, publicity materials for National Diabetes Month and Diabetes Alert Day, billboards across the state, and a Kentucky Diabetes Network Web site.
  - Advancing cultural competence and sensitivity at network meetings and through a training scholarship opportunity for an individual serving a minority population.

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PARTNERSHIP FOR A TOBACCO-FREE MAINE

A successful comprehensive statewide tobacco prevention and control program

Public Health Problem

- One-third of tobacco users age eighteen years or younger will die early of a tobacco-related disease.
- Maine had one of the highest rates of smoking in the nation among young adults in 1996 at 34%.
- Aggressive and comprehensive tobacco control programs produce substantial declines in rate of cigarette use.

Program

- The Partnership For a Tobacco-Free Maine is the state program developed using CDC's best practice recommendations for comprehensive state tobacco prevention and control programs.
- The program, established by the Maine legislature, includes these components: funding for thirty-one Healthy Maine Partnerships which are community and school initiatives to reduce tobacco use and tobacco related disease; a statewide counter-marketing initiative; statewide tobacco treatment services including the Maine Tobacco HelpLine; enforcement of tobacco laws that reduce youth access to tobacco products and protect the public from secondhand smoke; and a statewide network of youth advocacy programs, partnerships with other state-level chronic disease programs, surveillance and evaluation.
- Thirty-one local Healthy Maine Partnership grantees are using policy and environmental change strategies to reduce tobacco use, while also increasing physical activity and improving nutrition at local schools, work sites, hospitals, recreation facilities and community sites.

Impact

Partnership results for the first eight years are:

- Smoking rates of high school students dropped by more than half.
- Consumption of cigarettes dropped from 101 packs to 72 packs per capita.
- State cigarette excise tax increased from 74 cents to $2 per pack.
- Maine smoking rates have declined and are now in line with the national average rather than above it.
- Maine has had more adults reporting they are former smokers than any other state.
- Maine is smoke-free in all public places and indoor workplaces including workplace vehicles.

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LOVING SUPPORT BUILDS BREASTFEEDING-FRIENDLY COMMUNITIES

Montana partners change policies to encourage recommended breastfeeding

Public Health Problem

- Longer breastfeeding duration makes it less likely a child will be overweight or develop diabetes.
- Many women in Montana initiate breastfeeding but only about half of them continue to breast-feed for at least six months.
- Recommended strategies for increasing initiation and duration of breastfeeding include implementing "baby-friendly" maternity practices, education, support for breastfeeding in the workplace, and peer and professional support for breastfeeding.

Program

- The Montana Department of Public Health and Human Services Nutrition and Physical Activity Program and its partners such as the Montana Dietetic Association were trained on evidence-based interventions to create breastfeeding-friendly communities by the Centers for Disease Control and Prevention, the Nutrition and Physical Activity program funder.
- The state and its partners developed the first Montana Breastfeeding Coalition which is implementing policy and environmental changes statewide to promote breastfeeding.
- Activities include publication of a document supporting breastfeeding as a cost-effective health practice, influencing policies on breastfeeding in the workplace, implementation of a survey on existing hospital practices related to breastfeeding, support for expanding the WIC breastfeeding peer counseling program, training health professionals, establishing communication mechanisms, implementing a media campaign, and promotion of a breastfeeding hotline.
- Hospital surveys revealed that most facilities were interested in initiating tracking of breastfeeding duration.

Impact

- Coalition partners advocated for successful passage of Montana Senate Bill 89 requiring break time and privacy to support breastfeeding mothers in public employee workplaces. Web-based materials were developed to help employers comply with the law.
- For the first time, breastfeeding advocates across the state are working together to support and promote breastfeeding for all Montana mothers and infants, a key obesity-prevention strategy.
- Based on a need identified by hospital surveys, the Nutrition and Physical Activity Program is developing a breastfeeding data collection system for maternity facilities that will be applied statewide after a pilot in two sites.
- Criteria are developed and available for worksites to use in identifying themselves as Breastfeeding Friendly, including policies, privacy issues, and education of employees.

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SCHOOL HEALTH: ACHIEVEMENT THROUGH PARTNERSHIP

Three national organizations collaborate to advance coordinated school health programs

Public Health Problem

- Recent surveys reveal that most school-age youth don't eat recommended amounts of daily fruits and vegetables or attend daily physical education classes; about a fourth of them are smoking and over thirteen percent are overweight.
- These risk behaviors lead to diseases such as cardiovascular disease and cancer which by themselves account for well over half of all deaths among people over age twenty-five.
- Students benefit most from their education when they are healthy – and are not absent because of chronic conditions such as asthma or diabetes or hungry and tired from a lack of activity and healthful food.
- Every day state health and education agencies are working together to prevent these risk behaviors among youth through coordinated school health programs.

Program

- The National Association of Chronic Disease Directors, Directors of Health Promotion and Education, and the Society of State Directors of Health, Physical Education and Recreation formed a unique partnership to support school health efforts.
- With funding and support from the Centers for Disease Control and Prevention's Division of Adolescent and School Health these three national, non-governmental organizations held workshops with a total of fifteen state teams to enhance state-level collaborative efforts between health and education agencies.
- The organizations worked intensively with the state teams during the workshops and provided individualized technical assistance with teams for up to year afterward.
- *School Health Programs: Achievement through Partnerships* workshops provided a forum for open dialogue on challenges of and best practices for implementation of state and local school health programs.

Impact

Evaluation results show the substantial workshop benefits to states:

- The partner-sponsored workshops stimulated inter-agency team planning and strengthened team relationships.
- Nearly all participating states achieved one or more of the three intended outcomes – thirteen reported engaging in joint planning, eight worked on coordinated school health policies, and six shared resources in support of coordinated school health-related activities.
- Participants credit the workshops with the initiation of new collaborative actions in their state that improved the pace and quality of collaboration and created conditions that support it.

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PROMOTING BETTER DIABETES CARE FOR RESIDENTS OF NORTH DAKOTA

Support for health professional education, outreach to Native Americans, and patient initiatives

Public Health Problem

- North Dakota has limited resources, is home to health systems that are cutting staff and services for economic reasons, and is sparsely populated by an increasingly aging population as younger people leave for better paying jobs and a kinder climate.
- These factors create a huge challenge to public and private health interests to employ and retain the qualified staff needed to solve the state's health problems such as the increase in the number of state residents with diabetes, particularly among the American Indian population.

Program

- The Dakota Diabetes Coalition began as a loose network of practitioners that now has wide outreach to diabetes care providers in the state, many of whom have reduced opportunities for ongoing education and travel due to personal and workplace financial considerations.
- The Diabetes Prevention and Control Program conducted a provider needs assessment and funds salaries for a part time director and part time administrative and web support staff for the coalition. The non-profit status the coalition is seeking in order to be eligible to receive grants will allow them to offer more programs and services for Coalition members and for the people with diabetes they serve.

Impact

The Dakota Diabetes Coalition is...

- Meeting the need for tailored continuing education identified by diabetes care providers by offering regular updates on diabetes topics provided by a North Dakota physician who is an expert in diabetes prevention and control, distributing a free diabetes team guide that offers free continuing medical education hours and providing guest speakers on timely topics
- Providing scholarships and arranging mentors for people taking the Certified Diabetes Educator exam to increase the number of trained practitioners available to help people control their diabetes
- Supporting the North Dakota Pharmacy Association pilot to expand diabetes patient education and MediQHome, an advanced medical home project using technology to track patient-centered care, a first-of-its-kind undertaking
- Increasing outreach to American Indians by moving an annual in-person meeting to the United Tribes Technical College, a more convenient venue and by including tribal managers in regular conference calls
- Continuing to recruit members who cite the coalition's strengths as clear communication, opportunities for leadership, and conflict resolution

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IMPLEMENTING THE STATE PLAN TO PROMOTE HEALTHIER WEIGHT

New Mexico plan guides partners to prevent and control obesity and other chronic diseases

Public Health Problem

- Almost two-thirds of New Mexico adults are obese or overweight as well as a quarter of high school students and one fourth of the young children who participate in federal food programs.
- Preventing overweight and obesity reduces the chance that children will develop chronic diseases such as diabetes at an early age and delays or prevents the onset of these diseases for many adults.

Program

- The New Mexico Department of Health Physical Activity & Nutrition Program for Healthier Weight partnered with key stakeholders to develop the New Mexico Plan to Promote Healthier Weight (www.HealthierWeightNM.org).
- The New Mexico Healthier Weight Council, formed from the state plan stakeholder group, leads the effort to implement the plan objectives, has established a leadership structure, operational guidelines, and an annual action plan and is increasing awareness around the issue of healthy weight through brochures, postcard mailings, and an on-line resource directory.

Impact

- Examples of Healthier Weight Council partner implementation activities include:
  - Implementation of a new policy for all public schools in New Mexico eliminating sugar-sweetened and caffeinated soft drinks and vending machines in elementary schools, requiring middle and high school vending machines to stock only low fat and low sugar foods, and to provide healthier choices when selling food as a fundraiser
  - Addition of a mandatory physical fitness program for corrections officers in Bernalillo County and implementation of a pilot wellness program in county government departments
  - *Prescription Trails*, a pilot physical activity prescription program to provide health care professionals with prescription pads and walking trail guides to use to increase walking and wheelchair rolling by their patients in Albuquerque
  - Leveraging of funding from the National Governor's Association Center for Best Practices for *Healthy Las Cruces, Healthy Kids* and from the National Association of Chronic Disease Directors for the ACHIEVE initiative in Albuquerque, which includes the YMCA
  - Participation by three elementary schools from the Las Cruces Public School District in the Walk and Roll to School Day with a substantial increase in walking and rolling to school on the event day in at least one school
  - Creation of a Senior Advisor position in the NM Department of Health's Office of the Secretary to provide guidance to the New Mexico Interagency for the Prevention of Obesity, a collaborative effort of eight state government departments and more than 40 programs
  - The Centers for Disease Control and Prevention presented the New Mexico Healthier Weight Council with a "Partner in Advancing Public Health Award" recognizing them as the state's first comprehensive network of partners working together to prevent and control obesity.

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CAMPAIGN INCREASES CANCER SCREENING FOR ELIGIBLE MEN AND WOMEN

Active recruitment more effective at reaching priority population of underserved people

Public Health Problem

- Timely cancer screening can prevent deaths from colon and breast cancer and even prevent cervical cancer altogether when precancerous lesions are found and treated in a timely manner.
- Community-based partnerships in New needed creative ways to reach the priority population of low-income, uninsured, and underserved people.
- Active recruitment more effectively reaches priority populations and puts them in contact with service providers than passive outreach which simply provides information.

Program

- The New York State Department of Health Cancer Services Program oversees statewide, comprehensive cancer screening for breast, cervical and colorectal cancer for uninsured and underinsured women and men using funding from the state and the National Breast and Cervical Cancer Early Detection Program. These funds support partnerships that coordinate screening.
- Cancer Services Program staff developed the ASK ME campaign to enable local partners to shift recruitment efforts from public information to active person-to-person recruitment. Evaluation is done through semi-annual reporting by partnerships.
- Recruitment volunteers at five thousand participating community locations such as libraries and beauty salons wear buttons, available in eleven languages, and/or aprons with the message "*Uninsured? ASK ME how to get a FREE cancer screening*". These volunteers provide program eligibility criteria, the phone numbers to call for services, and often encourage and assist potential clients to contact the program. ASK ME messages are displayed on windows and doors at thousands of locations. Campaign materials are free of charge.

Impact

- This active recruitment campaign generated three thousand new screenings for breast, cervical or colorectal cancer.
- New tools developed for the campaign are now available to all screening programs.
- Community outreach training for Cancer Services Program partners to increase the use of effective active recruitment skills was developed and delivered to extend the reach of active recruitment.

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REDUCING HEALTH DISPARITIES FOR LATINOS AND AFRICAN AMERICANS

East Harlem Diabetes Center of Excellence expands reach to support better care

Public Health Problem

- East Harlem has a predominantly Latino and African-American population and the highest rates of obesity and diabetes in New York City, both of which are increasing at an alarming rate.
- People with diabetes can manage their disease by eating healthy foods, being physically active, taking diabetes medicine as prescribed, and testing blood sugar levels regularly.
- Community education and support programs can help people with diabetes and their families manage their diabetes.

Program

- The New York State Department of Health funds diabetes coalitions throughout the state to implement steps to prevent and control this condition.
- The East Harlem Diabetes Center of Excellence, one of these coalitions, was awarded a Racial and Ethnic Approaches to Community Health grant from the Centers for Disease Control and Prevention to build upon its efforts in diabetes prevention and control. They are using the grant to create a Center of Excellence in Eliminating Disparities called the Inspired and Motivated to Prevent & Control Diabetes (IMPACT) Center which will serve as a national resource for evidence-based, innovative approaches to diabetes.
- Using community-based participatory approaches, the Center strives to improve diabetes prevention and control in East Harlem with a focus on diabetes disparities among Blacks and Latinos, award over $350,000 in local and regional grants.

Impact

- The Center leveraged significant funding to develop a conceptual model to describe the forces at work in East Harlem contributing to diabetes disparities and to intervene in those areas.
- Fifty Coalition members from thirty-five grassroots, multi-service, faith-based, tenant, educational, and public health organizations helped develop planning meetings or offered their ideas on a logic model to guide program planning, implementation, and evaluation.
- Partners developed specific objectives for the first two years of operation including selecting a small neighborhood for intensive intervention, conducting an assessment of the neighborhood's physical environment to identify areas for intervention, and releasing a request for proposals for local community groups.
- This work expands the reach of the East Harlem Diabetes Center of Excellence and serves as the foundation for activities to reduce health disparities for Latinos and African-Americans.

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REACHING HIGH RISK INDIVIDUALS WITH DIABETES SCREENING AND EDUCATION

Pinnacle Coalition for Diabetes Prevention and Management outreach at targeted event

Public Health Problem

- Over seven percent of adults living in Westchester, Rockland, and Putnam counties as well as the rest of the state of New York have diabetes and the numbers are increasing, especially among African Americans and Hispanics.
- Many people with diabetes don't know they have it or have never received education on how to successfully manage their disease.
- People with diabetes can manage their condition and reduce complications such as heart disease and blindness through healthy eating, physically activity, taking diabetes medicine as prescribed, and testing blood sugar levels regularly.

Program

- The New York State Department of Health funds diabetes coalitions throughout the state to implement steps to prevent and control this condition.
- The Pinnacle Coalition for Diabetes Prevention partnered with the Mount Vernon Hospital in West Chester County to attend the Black and Puerto Rican Legislative Caucus held in Albany.
- Ten thousand people braved eighteen degree temperatures and icy roads to attend this event where coalition members reached a significant number of high risk individuals from the region with screening for diabetes risk and education on diabetes prevention, healthy eating and physical activity.
- Education sessions focused on preventing long term complications, medication management, eating healthy, heart disease & diabetes and signs and symptoms of stroke. Hundreds of pieces of diabetes education literature were distributed.

Impact

- Well over two hundred people and many in the high risk group of Latinos and African Americans received one-on-one and group education about diabetes, some of them traveling long distances to attend.
- A significant number of attendees who reported that they had not taken their diabetes medication that day because they thought skipping it would not be too harmful received direct counseling advice on appropriate management of diet and medications when traveling.

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MEDIA BROADCASTS THE MESSAGE OF STEPS TO A HEALTHIER PENNSYLVANIA

Increasing awareness and educating county residents about preventing chronic disease

Public Health Problem

- Obesity has increased by ten percent in Pennsylvania's Luzerne County over ten years.
- Risk factors associated with overweight and obesity are also on the rise – for example, one fourth of Luzerne County residents get no regular physical activity.
- The numbers of adults diagnosed with asthma has increased by a third since 2000. Asthma is one of the top three causes of preventable hospitalization.
- Steps to a Healthier Pennsylvania–Luzerne County educates residents to increase awareness about changes in nutrition, physical activity and smoking habits that will prevent asthma, obesity and other chronic diseases.

Program

- Steps to a Healthier Pennsylvania – Luzerne County established a partnership with the local ABC affiliate to create public service announcements promoting healthy lifestyles.
- The station donated booth space during their Home and Backyard Show reaching over 5000 residents; highlighted the Steps program in a major newscast; and featured a Steps intervention school in a major news story.
- Over six months, Steps to a Healthier Pennsylvania was mentioned in an additional 45 newscasts or print articles in thirteen different media venues. To date, 255 television public service announcements ("spots") have aired on WNEP in Luzerne County.
- Steps to a Healthier Pennsylvania holds is an active member of the stations regional advisory board, and a WNEP staffer works with the Steps Community Consortium.

Impact

- Up to two free television spots have been provided by the television affiliate for every paid spot that airs, at least doubling viewer exposure at no additional cost to the program. The station continues to air the educational spots even without additional Steps funding.
- Government funding was leveraged by six hundred percent to $145,000 through sponsor donations covering production and airtime costs. Additional money was contributed as in-kind services by the television station.
- Media coverage keeps the county's healthy lifestyle initiatives and messages in the public eye to boost local prevention activities.
- Survey results suggest this is an effective approach – over a third of respondents have heard of Steps to a Healthier Pennsylvania.

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UNITING STAKEHOLDERS FOR ACTION ON ORAL HEALTH

Two existing groups come together to plan and act more effectively

Public Health Problem

- One of the hardest tasks in public health is bringing all stakeholders to the same table, identifying common goals and maintaining forward progress to achieve objectives.
- Two existing oral health stakeholder groups, the South Carolina Oral Health Advisory Council and the South Carolina Oral Health Coalition, were working in South Carolina with support from the Division of Oral Health of the South Carolina Department of Health and Environmental Control.
- Focus group results with members of these two groups revealed a lack of effective communication and coordination which affected their ability to achieve oral health objectives.

Program

- The South Carolina Department of Health and Environmental Control Division of Oral Health used funding received through a cooperative agreement with the Centers for Disease Control and Prevention to bring these groups together.
- An evaluation consultant conducted a series of focus groups with Council and Coalition members whose practice locations differ widely and include private practice, public health, health care, academia, and community organizations. The Council is comprised of mainly executive level individuals who influence policy while the Coalition is comprised of individuals more familiar with practice issues.
- The focus groups revealed a need to explicitly define the roles of each as well as improve communication and coordination between the two groups.
- As a result of the assessment, a unified structure was introduced that maintains the strengths of each group while enabling them to work toward a common goal.

Impact

- Unifying two groups into one oral health coalition, the South Carolina Oral Health Advisory Council and Coalition has resolved many turf-related issues and created a single vision and strong lines of communication that are contributing to successful revision and implementation of the South Carolina State Oral Health Plan.
- Advocacy training offered to stakeholders keeps coalition members interested and active in coalition activities and moving toward achievement of better oral health outcomes for South Carolina citizens.

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PARTNERSHIP IMPROVES CARE FOR PEOPLE WITH DIABETES

Increasing awareness and implementation of recommended standards gets results

Public Health Problem

- People with diabetes may be unaware of recommended management standards for their disease and health provider systems may lack accountability measures for meeting these recommendations within their care system.
- When the medical care of people with diabetes meets recommended standards, such those set by HEDIS, the Health Employer Data Information Set, serious and costly disease complications are reduced and people with diabetes have a better quality of life.

Program

- The Utah Diabetes Prevention and Control Program formed the Utah Health Plan Partnership with the state's major health plans to increase diabetes awareness among clients and providers and to implement and improve systems-based care.
- Using the Health Employer Data Information Set (HEDIS), the Partnership identified areas for improvement in diabetes awareness and care. For example, a low percentage of people with diabetes met the criteria for having a regular eye exam – important for reducing blindness and other serious eye-related complications of diabetes.
- Projects developed and implemented by the Partnership health plans include:
  - Increasing client and provider awareness of key clinical indicators for diabetes, such as desirable A1C levels, a measure of blood sugar control.
  - Increasing system supports for the delivery of diabetes care and the measurement, tracking, and reporting of important indicators related to this care
  - Implementing health plan member reminder/call back systems focused on the indicators and on medication compliance
  - Providing feedback to members and providers related to their performance
  - Implementing comprehensive, standardized data collection, evaluation, and reporting

Impact

- The Partnership interventions:
  - Improved eye exam rates and the documentation of these exams for clients
  - Improved rates of blood sugar and blood lipid measurement and control. Good control of blood sugar and blood lipids can reduce complications such as blindness, kidney failure and heart attack for people with diabetes.
  - Increased the rate of recommended nephropathy screening. Early detection of nephropathy and taking preventive measures can delay progression to more advanced kidney disease.

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GO LOCAL HEALTHY FOODS PROMOTION IN POHNPEI, MICRONESIA

Program has potential to reduce the economic and health effects of a shift to imported food

Public Health Problem

- Eating habits, particularly diets lacking in fruits and vegetables, are a major lifestyle factor related to obesity and type 2 diabetes.
- Obesity and diabetes are serious problems in the Federated States of Micronesia but a large survey of Micronesians identified no cases of diabetes before residents shifted their food intake to more expensive, imported foods such as rice and refined flour and away from eating local bananas, taro, breadfruit, panadanus, and other local staple foods, fruits and vegetables.
- Attitudes of residents about local foods hindered consumption. For example, some said that taro, a nutrient-rich native food, is "just starch" implying that it had no value and perhaps contributing to their adopted preference for imported white rice and refined flour products.

Program

- The Go *Local* program initiated by the non-profit, non-governmental organization, Island Food Community of Pohnpei, one of the four states of the Federated States of Micronesia, promotes growing and use of local foods and heightened awareness of their "CHEEF" benefits: **C**ulture, **H**ealth, **E**nvironment, **E**conomics, and **F**ood security.
- Involvement by many groups and agencies including agriculture, health and education agencies; church, youth, community and women's groups; and local media and business facilitates the promotion of local foods. Some funding was provided by the Centers for Disease Control and Prevention through their IMMPaCt program supporting global nutrition interventions and to the island's diabetes prevention and control program.
- Communication and educational methods include workshops, radio, newspapers, email, posters, billboards, newsletters, recipes, postage stamps, post cards, bumper stickers, and a proclamation by the Governor proclaiming locally grown Karat as the State Banana of Pohnpei. A *Going Yellow* video with the "Let's Go Local" theme song promotes this native fruit. Efforts to encourage small-scale processing of local foods were also initiated.

Impact

- After two years of promotion of local foods which contain health-promoting fiber, vitamins and minerals, imported rice consumption decreased and local banana and taro consumption increased in this population.
- Growing, harvesting and preparing local food provides physical activity benefits and promotes self reliance.
- Buying locally-grown food strengthens the local economy, supports family farming, safeguards health, and protects the environment – as well as providing exceptionally fresh and tasty food.
- One community resident says, "I tell you it is a very effective program, when we have our special gatherings, we now have local food dishes and we say "Go local!"

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CHUUK WOMEN "PADDLE THE CANOE" TOGETHER TO PROMOTE HEALTH

Local community women teach and act for diabetes prevention through healthy lifestyle

Public Health Problem

- Chuuk, one the four Federated States of Micronesia, has many lifestyle-related health problems, such as diabetes.
- Because many of the island communities are isolated and can be reached only by plane or ship, public health capacity to reach communities with health messages is very limited.

Program

- The Chuuk Women's Council is a community-based organization with about forty active groups of diverse women working within island communities.
- In partnership with the Federated States of Micronesia Diabetes Prevention and Control Program, the Council extends health promotion and diabetes prevention efforts across the main island, the remote lagoon islands, and the outer islands.
- Council members attend diabetes workshops on preparing healthy meals using local foods, increasing physical activity, diabetes management and prevention. The training increases awareness, helping to remind women and their families and friends to be screened for diabetes and hypertension and to take preventive steps. The women also receive training in effective ways to promote health by tailoring health messages to fit the community environment, language, culture, and social customs which is critical for understanding and acceptance by people living in the community.

Impact

The teamwork of the Chuuk Women's Council with public health professionals helps increase resources for health promotion and diabetes prevention as follows:

- Council members launched education sessions for primary schools on healthy lifestyles and organized community diabetes seminars in separate sessions for women and men according to cultural custom that allows participants to talk freely with one another.
- Learning of the danger to people with diabetes of cuts to their feet the Council worked to clear village footpaths and maintain them free of objects that cause injury.
- The Council and the diabetes program coordinator distributed diabetes education materials translated into native languages and sponsored family fun walks with over 120 participants.
- Membership is growing about ten percent every year indicating a real interest in better health.
- The Chuuk Women's Council health chair says, "…it's truly serving local women. We are paddling the canoe together in living healthier lives and making better choices. Local public health programs cannot do it alone."

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COLLABORATION FOR BETTER PEDESTRIAN SAFETY IN GUAM

Educating high risk pedestrian populations to prevent pedestrian-related accidents

Public Health Problem

- Many Guam residents are at risk for a pedestrian/motor vehicle accident because they cross at unmarked road crossings, roads are poorly lighted or unlighted, their clothing doesn't promote visibility at night, or they are crossing while intoxicated.
- The rate of pedestrian fatalities from accidents occurring while drivers were "driving under the influence" are five to nine times higher on Guam than the Healthy People 2010 objective for the nation for pedestrian deaths.

Program

- With funding from the Preventive Health and Health Service Block Grant, the Bureau of Professional Support Services Pedestrian Safety Program conducted two pedestrian safety training sessions for parents of the Guam Head Start Program and produced a pedestrian safety public service announcement in collaboration with partners such as the Unified Courts of Guam, the Office of the Attorney General, the Offices of the Governor and Lt. Governor, the Guam Police Department, and the Department of Public Works. Key community leaders from these public agencies appear in a television commercial to offer safety tips.
- The public service announcement aired during primetime hours on a local television station over several weeks and will continue to air as funds are made available and in conjunction with other Guam Department of Public Health and Social Services programs.
- Written educational materials in common local languages such as Chamorro, Chuukese and Tagalog are planned as a way to educate pedestrians and posters in these languages will be placed near high risk crossings to alert pedestrians to safe ways to navigate road crossings. (This is something we are planning to implement as soon as funding is available.)

Impact

This program has achieved these results:

- Reached over five thousand general community residents and over a thousand residents in higher risk communities with information on crossing streets more safely with each airing of the public service announcement.
- Provided safety messages at road crossings to alert pedestrians to cross more safely.
- Educated parent trainers from Head Start schools and other safety information providers on how to safely cross Guam roadways.

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TARGETING ADULTS AND CHILDREN TO INCREASE PHYSICAL ACTIVITY

Implementing research-tested interventions helps ensure behavior change for good health

Public Health Problem

- Obesity costs Kentucky taxpayers more than a billion dollars a year in extra health care costs.
- Two-thirds of residents of rural Grant County are overweight, a higher percentage than Kentucky adults overall. Another quarter of the county population is obese.
- Few Kentucky adults get recommended amounts of physical activity, an important factor in controlling weight.
- Head Start teachers and staff in Grant County observed that a growing number of students were too big for the small bikes used in the program or were having difficulty running and jumping. Many of their parents are also overweight or obese.

Program

- A Grant County coalition, Fitness for Life Around Grant County, and the Grant County Health Department partnered to launch a physical activity challenge called "Get Up, Get Out, Get Fit Grant County."
- Based on proven interventions from CDC's Guide to Community Preventive Services the campaign used multiple media channels and leveraged local health department dollars to support the campaign which includes physical activity scorecards distributed at many community locations, worksite and school activities; and newspaper inserts, radio spots, and billboard messages.

Impact

- About half of follow-up respondents had changed their intent to become physically active as a result of the campaign.
- Almost half of the county's students tracked their daily physical activity using the Physical Activity Scorecards promoted by the program.
- Program success led the coalition to seek additional funding from Safe Routes to School and to raise money to become a permanent, non-profit organization that can take action on sustaining physical activity promotion in the community.

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BARBERSHOPS FIGHT KIDNEY DISEASE IN AFRICAN AMERICAN COMMUNITIES

Providing prevention information and social support for health behavior change

Public Health Problem

- African Americans are at high risk for chronic kidney disease partly due to high rates of diabetes and high blood pressure.
- Chronic kidney disease can lead to complete kidney failure, requiring dialysis or a kidney transplant to maintain life. About 45% of the dialysis population in Michigan is African American.
- Almost three-fourths of chronic kidney failure cases can be delayed or prevented with proper treatment, saving up to $60,000 a year on each case.
- Barbers in the African American community often have established relationships with their clients making them trusted providers of important prevention information.

Program

- The Dodge the Punch: Live Right™ program trains barbers as lay health advisors to talk with clients about the impact of uncontrolled high blood pressure and diabetes on their kidneys and promote preventive steps on nutrition, activity, smoking cessation and medical care.
- The Michigan Department of Community Health and the National Kidney Foundation of Michigan partnered on this project which has reached about 100 barbers over two years using funding from the Centers for Disease Control & Prevention, PHHS Block Grant.
- Barbers receive six hours of training to develop skills in educating clients to make health behavior changes and to keep track of changes clients make. Clients receive ongoing support and education from their barber.

Impact

- This program implements an important recommendation from the Michigan Strategic Plan to Prevent Chronic Kidney Disease "to expand educational outreach efforts to high risk populations in Michigan, using the lay health advisor model ...to provide education on diabetes, hypertension and CKD prevention."
- Almost half the clients tested by doctors as a result of this program have been diagnosed with high blood pressure, diabetes, and/or kidney disease allowing them to take steps to control their condition before it leads to complete kidney failure or possibly a heart attack or stroke.
- Over half of the more than 2,800 clients reached have made healthy behavior changes, such as increasing their physical activity, their fruit and vegetable intake, limiting their salt intake, or taking steps to see a doctor.
- A barber and a client explain the value of the program: "The barbers I work with are truly committed to helping their clients stay healthy. It's not always easy to get people to make a lifestyle change but when the advice is given by someone just like themselves they take it to heart" says Detroit barber Oliver Milton. And a client – "I never would have known I have high blood pressure without this program. Now I can deal with my blood pressure and get it under control."

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BUILDING HEALTHY COMMUNITIES IN MICHIGAN

Funding, training, and technical assistance jump-start the community process

Public Health Problem

- Michigan has higher rates of chronic disease than the country as a whole.
- Unhealthy eating, physical inactivity, and tobacco exposure are three risk factors that contribute significantly to the development of many chronic diseases.
- Influencing the environment in the many places where people live, work, and play makes it easier for them to buy and eat healthy food, be physically active, and not smoke – vital steps for preventing chronic disease.

Program

- The Building Healthy Communities Project developed from an initial state-funded competitive grant program to a wider partnership that leveraged funding from the US Department of Agriculture Food Stamp Nutrition Education Program in a one-to-one match with state and local dollars. Local agencies are funded, trained and provided with technical assistance to apply a strategic process to planning and implementing evidence-based policy and environmental changes. Examples of these changes are establishing farmers markets, building walking and biking trails and health promotion and education.
- Partnership with Michigan State University Extension now enables funding of seven local health departments and eight county extension agencies covering twenty-five counties and reaching more than 283,000 residents, to enable them to assess their communities and implement nutrition, physical activity, and tobacco education and policy change.

Impact

- This project helped local coalitions leverage close to a million and a half dollars in additional funding to support their work. Joining two funding streams, state and federal, led to a more comprehensive community project.
- Policy, built-environment, and educational results for the project communities include:
  - Eleven trails covering almost sixty miles and seven parks were created or enhanced with benches, lighting, and signage and equipment. Walking maps and community fitness classes were provided to residents
  - Five new farmers market locations opened with access to Electronic Benefits Transfer transactions for food stamp recipients.
  - Six counties passed new, clean indoor air ordinances.
  - Seven new school or community gardens were created.
  - Many healthy food taste tests, nutrition education classes, and healthy lifestyle booklets were provided to individuals, families, and day care centers
  - Several counties designated workplaces, trails, and beaches as smoke-free.

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FRONTIER TOWN FIGHTS OBESITY

Montana mayor helps his town get healthier food choices in stores and restaurants

Public Health Problem

- Combating the growing problem of obesity in Montana means implementing strategies to improve the food, nutrition and physical activity habits of residents.
- Shelby, Montana, like many frontier towns, doesn't have an extensive public health system or a large budget for health projects.
- Residents also depend on food available locally since the next-nearest stores and restaurants are eighty miles away.

Program

- The City of Shelby used a small grant to conduct focus groups on nutrition and physical activity topics. This grant came from the Montana Nutrition and Physical Activity Program under a contract from the Montana Department of Public Health and Human Services to Montana State University. Funds for the Program are supplied by the Centers for Disease Control and Prevention, Division of Nutrition and Physical Activity.
- A Columbia University graduate student did formative research on local food choices, a walking trail, and support for breastfeeding, key elements of obesity prevention efforts.
- Results of a Nutrition Environment Measurements Survey in Shelby showed that healthful foods were seldom available at restaurants and convenience stores.
- Responses to a survey of residents initiated by the town's mayor showed that residents wanted more healthy options in restaurants, particularly on children's menus.

Impact

- The engagement of Shelby's mayor is driving the development of strategies to work with restaurant managers and food distributors serving the Shelby area on incentives for increasing availability of competitively priced, healthy food in this community.
- A baseline town assessment is providing comprehensive information on the eating and physical activity habits and physical measurements of a large percentage of the town's children and adults.
- A repeat assessment will give local officials valuable feedback on the steps they're taking to make the town environment healthier, including changes in the food system and increasing access to opportunities for physical activity.
- A promotional campaign using bartered radio time and newspaper space, if necessary, will encourage residents to patronize restaurants and stores offering healthy foods and to use the local trail.

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EAT SMART, MOVE MORE…MAINTAIN, DON'T GAIN HOLIDAY CHALLENGE

Taking steps to prevent holiday weight gain that can lead to overweight and obesity

Public Health Problem

- Gradual, unnoticed weight gain over several years can result in overweight and obesity.
- Busy schedules and unhealthy eating habits along with less time spent being active adds pounds over the winter holidays for many people.
- Maintaining weight by preventing weight gain is a healthy step toward long-term prevention of obesity and overweight

Program

- The Physical Activity and Nutrition Branch of the North Carolina Division of Public Health and their partners created the *Eat Smart*, *Move More* – Maintain, don't gain! Holiday Challenge to help residents stem the weight gain that often occurs over the holidays.
- The Challenge supports the Eat Smart, Move More NC movement – and gives the many *Eat Smart, Move More* Leadership Team member organizations a way to actively participate in creating policy and environmental change statewide.
- Local health departments and other partners implement the campaign each year in worksites and community sites with the help of local businesses and organizations.
- This free, six-week challenge provides weekly emailed newsletters containing tips for managing holiday stress, ideas for fitting in physical activity during the busy season, and resources for cooking quick and easy meals when time is short. A calorie counter, food log and activity log are also available to help people track their progress and radio commercials promote the challenge.

Impact

- Eighty-four percent of participants reported maintaining their weight. Of those who did not maintain their weight, many actually lost excess weight.
- The second year participation rate increased fifty percent over the first year's rate.
- The Holiday Challenge is now an annual event with a goal of 6,000 participants.
- A follow-up campaign, Revisit Your Resolutions was created for use in July, to remind people of their resolutions to eat smarter, be more physically active and lose weight at times other than the holidays and encourage them to recommit to achieving and maintaining a healthy weight.

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NEW HAMPSHIRE STUDENTS WALK, BIKE TO INCREASE PHYSICAL ACTIVITY

KidPower! uses pedometers, newsletters and more to increase physical activity

Public Health Problem

- More than a third of all children don't participate in daily physical activity.
- Most schools don't have daily physical education classes and many are eliminating recess.
- Almost all elementary school students arrive at school by bus or private car rather than walking or biking, missing an opportunity for physical activity.
- Increasing children's physical activity will help reduce today's high rates of childhood obesity and provides other significant health benefits.

Program

- The New Hampshire Department of Health and Human Services developed *KidPower*!, a program to increase physical activity for children and their families. The program has several components:
  - *KidPower! Newsletter*: Provides children and families seasonal ideas for being more physically active, reducing sedentary time, and simple healthy recipes. To date more than 80,000 NH families receive this newsletter four times a year.
  - *KidPower! Pedometer Program*: Students receive a pedometer to record their daily steps, and other physical activity, in a logbook that includes messages about safety, healthy eating, and ideas for increasing physical activity. To date, more than 2,500 students in 17 New Hampshire schools have participated in the program.
  - *KidPower! Seasonal Activity Trackers*: Designed for preschool through grade 3 students, trackers remind families that their children need to stay active each season, to reduce TV time and the importance of daily physical activity.
  - *KidPower! Walk and Wheel Safely*: Children are encouraged to walk or bike to and from school in groups accompanied by adults. Students living too far from school to walk or bike, or in neighborhoods without safe routes, walk at school before or after classes or during recess.

Impact

- Students increased their physical activity an average of 25 percent over the weeks that they used pedometers, according to two years of evaluation.
- Utilization of the *KidPower! Newsletter* by pediatric practices and community health agencies provides patient education and outreach that extends the program beyond the original school-based audience.

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NEW JERSEY BLUEPRINT FOR HEALTHY AGING INFORMS DECISION MAKERS

Planned actions can lessen impact of chronic disease and improve quality of life for older adults

Public Health Problem

- Much of the physical decline associated with aging is due to lifestyle; for example, lack of physical activity and unhealthy diet.
- A third of older people get no leisure-time physical activity and about two thirds are either overweight or obese.
- Health care spending is expected to increase twenty-five percent by 2030, due in large part to the anticipated increased health care needs of older adults.
- Even into advanced old age, people who make healthy lifestyle choices can reap wellness benefits, improve quality of life and prevent disease.

Program

- With a one-year Senior Planning Grant from the National Association of Chronic Disease Directors, the New Jersey Department of Health and Senior Services developed the Blueprint for *Healthy Aging in New Jersey*, a guide to effective, low-cost senior wellness programs.
- The *Blueprint* document (www.nj.gov/health/senior/blueprint/) includes:
  - Cost-effective programs to implement locally to support older adult healthy behaviors
  - County-specific data on older adults and their health status
  - Strategies for containing health care costs and public policy recommendations
  - Personal success stories from older adults in every New Jersey county
- A feedback form tracks community agencies use of the document to plan, implement or expand older adult health promotion programs and policies.

Impact

- For the first time, county-specific data on older adults is available to direct local action on preventive lifestyle changes for older adults to lessen the impact of chronic disease.
- The *Blueprint* is reaching local, county, state and federal government leaders, local health departments, health and aging service organizations and local foundations. For example:
  - The Grotta Foundation for Senior Care used the Blueprint to set priorities for its current grant funding cycle
  - Local agencies report they'll use the *Blueprint* to increase support for older adult programs
  - Workshops for health and aging service professionals are providing technical assistance on using the Blueprint to expand health promotion to older adults
  - Benjamin Mount, Atlantic County Division of Public Health says of the *Blueprint*, "Great job...I see the Blueprint playing a supporting role in the implementation of the Community Health Improvement Plan action cycle as we address this issue."

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PREVENTING DIABETES WITH GOOD EATING AND PHYSICAL ACTIVITY HABITS

New York's Southern Tier Diabetes Coalition offers a tested weight loss program

Public Health Problem

- Almost two thirds of New York adults are overweight or obese putting them at greater risk for developing chronic diseases such as diabetes.
- Changing eating and activity habits helps people achieve a healthy weight. Weight loss of as little as seven percent of body weight and an increase in physical activity can prevent or delay a diagnosis of diabetes.
- Many New York adults don't get recommended amounts of daily physical activity and most don't eat the recommended daily servings of fruit and vegetables – steps that are keys to a healthy weight.

Program

- The Southern Tier Diabetes Coalition introduced the Mission Meltaway program to a new region of the state.
- This free, eight-week healthy lifestyle program created by the Broome County Office for Aging uses a group approach to weight loss and maintenance building on the concepts of the National Diabetes Education Program called "Small Steps, Big Rewards."
- Health professionals from the Delaware County Public Health Department using resources provided through the Southern Tier Diabetes Coalition, educated participants, reinforced healthy eating and physical activity habits, and tracked weekly weight-loss progress.
- Ballroom dancing was offered as a way to get recommended amounts of physical activity.

Impact

- Group weight loss was over a hundred pounds. Two thirds of the thirty participants in the group were at high risk for diabetes.
- Some participants continued exercising together on their lunch breaks after the program had ended and many of them commented on the value of ballroom dancing as a unique way to be more active and the on the fun they had learning it.
- The success of the program will lead to expansion to other county sites by the coalition.

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DIABETES SUNDAY PROMOTES AWARENESS AND EDUCATION

Coalition joins with clergy to reach African Americans with important health information

Public Health Problem

- Diabetes is a serious problem for African Americans who have higher rates of this disease and three of its major complications: blindness, amputation and kidney failure.
- About one third of African Americans with this disease are not aware they have it and are therefore not getting recommended care.

Program

- The New York State Department of Health funds diabetes coalitions throughout the state to implement steps to prevent and control this condition.
- The Dutchess Coalition for the Prevention of Diabetes partnered with the African American Clergy of Dutchess County to promote diabetes awareness on a designated "Diabetes Sunday."
- Five churches with large congregations offered diabetes-related sessions presented during church services.
- Members of each congregation received the American Diabetes Association risk assessment, a simple test which helps people determine their risk of having diabetes or pre-diabetes.
- Members also received copies of information describing the signs and symptoms of diabetes and how this condition affects African Americans in their community.

Impact

Results of these awareness sessions include:

- Reaching over a thousand community residents with important information to help them determine their risk for diabetes and how to take steps to prevent and control it. For example, a participant from one of the churches told her doctor she had symptoms similar to those she learned about in one of the Sunday diabetes messages. Her doctor was able to diagnose pre-diabetes and refer her to the diabetes program at a local hospital for preventive care.
- Additional requests for presentations and participation in church health fairs, extending the reach of this education
- Opportunities for ongoing health education of church members through requests to participate in the church health ministry and a church nursing guild.

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COMMUNITY GARDENS PROVIDE FAMILIES WITH FRESH, HEALTHY PRODUCE

More gardens mean more people eating vegetables and fruit and enjoying physical activity

Public Health Problem

- Eating generous amounts of vegetables and fruit is associated with lower rates of chronic diseases such as high blood pressure, heart disease and diabetes.
- Most New York adults don't eat the recommended number of servings of vegetables and fruit daily.
- Community gardens help lower food costs and increase access to produce for low income families, as well as providing an enjoyable opportunity for physical activity and improving neighborhood relations.

Program

- Capital District Community Gardens, a non-profit community service organization, reached out to low income neighborhoods in Rensselaer County to increase the number of garden plots and the number of gardeners, using funding from the New York Department of Health Healthy Heart program.
- A single community garden plot can yield over $1000 worth of fresh produce in a season, but new gardens require access to water, fencing, storage sheds and gardening equipment.
- Each new community garden provides thirty to fifty additional families with access to garden plots. Community gardens allowed low income families to learn about growing vegetables from experienced gardeners.
- This effort increased the number of garden plots by almost twenty percent.

Impact

- The almost twenty percent increase in the number of garden plots supplies many more families with fresh, healthy food not available in most inner city convenience stores.
- Community buy-in and participation is strong – local communities have donated almost two hundred thousand dollars in land and in kind services to support this effort due to the recognized benefits.
- This community gardening effort transforms vacant lots or other empty land into spaces that provide fresh produce and stress-reducing recreation and physical activity contributing to good mental and physical health.

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FAMILIES EATING HEALTHIER AT LONG ISLAND RESTAURANTS

New menu offerings teach patrons about healthy choices for preventing chronic disease

Public Health Problem

- Diets high in calories, saturated fat, and sodium raise the risk of developing chronic diseases such as heart disease and diabetes.
- When adults and children eat out they tend to eat more fat, calories and sodium, drink less milk, and eat fewer fruits and vegetables than when eating at home.
- Americans spend almost half their food dollars on food eaten away from home

Program

- The Just Ask Us! Restaurant program, funded by the New York State Healthy Heart Program, promotes healthier choices at Long Island restaurants.
- Participating restaurants offer healthier options on adult and children's menus
- The restaurant program is promoted by a Web site directed at parents and by local schools. Suffolk County Libraries supply Just Ask Us! restaurant brochures to the community.
- During the first annual "Eating Well Restaurant Week" restaurants promoted at least one healthier meal special and received beneficial local publicity while a number of political leaders supported the effort.
- Forty-seven restaurants participate in the program which reaches an estimated 4700 residents a day.

Impact

- Restaurants report:
  - An eighteen percent increase in customers ordering healthier choices
  - Customers requesting healthy changes to regular menu items
  - More parents asking for healthy choices for their children's meals;
  - More restaurants offering juice or low-fat milk on kids menus instead of soda "Our kids' meals come with …apple juice or low-fat chocolate milk. We don't even ask if they want soda," says Drew Streeff from Hartlin Inn.
- Restaurateurs have learned that healthy items will sell and patrons are now aware that they can ask for healthier changes at any restaurant

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LOCAL CONVENIENCE STORES LABEL AND SELL HEALTHIER FOODS

Community residents learn to make better choices, too

Public Health Problem

- Eating a healthy diet low in saturated fat and higher in fruits, vegetable and whole grains helps prevent heart disease, the cause of about forty percent of all deaths in New York each year.
- If you can't buy it, you can't eat it – so increasing access to healthy foods is a recommended strategy for reducing the risk of chronic diseases including heart disease and diabetes.
- Stewart's Stores is often the only local source of groceries in rural New York communities making residents dependant on their product choices.
- Retail grocer priorities are compatible with public health goals but coordination is needed.

Program

- The Warren/Washington Healthy Heart Program, funded by the New York State Health Department Healthy Heart Program, worked with a local retailer called Stewart's to promote low-fat milk consumption using the retailer's line of milk products. This heart disease risk-reduction strategy for shoppers was promoted in worksites, schools, malls, senior centers and WIC program offices.
- Stewart's management also supports "community scavenger hunts" developed by the Healthy Heart Program to inspire community residents to discover their community by foot and to focus on healthy food options and other aspects of the health environment in their community.
- Scavenger Hunts, conducted in twelve communities, a school, a park and a mall, are free and geared for people of all ages and abilities. Local Stewart's stores label healthy items to be "found" during the hunts.

Impact

- Grocery stores realized a ten percent increase in the quantity of healthy items sold and a thirty-five percent increase in total register sales, a benefit to the stores and an indication that the Health Heart Program message about healthy eating was communicated effectively.
- Participating stores now carry more than fifteen fresh fruit or vegetable items and whole grain breads, available for the first time in these stores.
- Store shelves and individual foods continue to carry the "Good for You" label to guide shoppers to healthier choices. This labeling concept has also been duplicated and patented by a larger New York grocery chain as a way of promoting healthy items to its customers.

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COMMUNITY PARTNER ADOPTS AFTER SCHOOL PHYSICAL ACTIVITY PROGRAM

State works with university and community center to help make it happen

Public Health Problem

- In Pennsylvania over a third of eight graders are either overweight or at risk for overweight.
- Students in certain Fayette County public elementary schools are receiving about half the recommended amount of physical education class time, on average.
- Increasing physical activity at school or after school helps children achieve and maintain a healthy weight, an important factor in their current and future health and academic performance.
- The director of East End United Community Center in Fayette County identified an important need to include increased physical activity in his after school program which serves a large minority population.

Program

- Steps to a Healthier Pennsylvania-Fayette County partnered with faculty at Penn State Fayette to offer a service learning opportunity for university students at the East End United Community Center.
- Steps to a Healthier Pennsylvania-Fayette County trained university students to implement the *Take 10!* physical activity curriculum and initiate walking programs at the center. They also provided tools and curriculum materials.
- To sustain the benefit to local children, the community center applied for and received grant funds for paid staff to run the program.

Impact

- The first phase of the program demonstrated important benefits to elementary students, provided college students with a service learning opportunity, and leveraged over a hundred hours of free service to community children.
- Federal funds leveraged $22,000 in additional grant funds for paid staff to continue the project and integrate physical activity more regularly into the after-school environment.
- Now three hundred students in Uniontown's East End community have an after school physical activity program adopted by a local organization committed to sustaining it.

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PALAU COMMUNITY GROUP SUPPORTS HEALTHY LIFESTYLE CHOICES

Small group of dedicated members is growing in scope by spreading the word of success

Public Health Problem

- Making positive lifestyle changes can improve health and quality of life as well as prevent chronic diseases such as diabetes and heart disease.
- Changing lifestyle habits, such as food and physical activity choices, can be a difficult task without support and education.

Program

- Belau National Hospital, operated by the Palau Ministry of Health, organized a community group that members named *Di-reng*, a Palau word meaning "only will power of the heart."
- Two representatives of the Palau Ministry of Health officially witnessed the establishment of *Di-reng*.
- Members of this group are committed to making small, steady changes to achieve healthy weight and develop healthy lifestyle habits. They help each other interpret food labels and learn to cook healthy meals and make healthy choices on a limited household budget. Testimonies based on the many members' successes are shared for motivation and encouragement.
- The membership fee is five dollars which members feel encourages continued participation, important for "staying on course." The fee for missing a meeting is one dollar and collected fees are used to provide monetary incentives for certain healthful changes or for other purposes decided by the by group.

Impact

- Over three-quarters of the *Di-reng* members report making lifestyle changes to improve their health.
- Di-reng members highlighted their group at Palau's Public Health Convention and have appeared on local talk shows. As a result, interest in Di-reng is growing in other communities and a *Di-reng* group is being developed for state workers.
- An active member of *Di-reng* says, "knowledge gained from this group empowered me to make wise choices."

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SHAPE UP TIOGA COUNTY HELPS RESIDENTS INCREASE PHYSICAL ACTIVITY

Increasing knowledge and motivating change helps prevent chronic disease

Public Health Problem

- Less than a third of Tioga County residents are at a healthy weight and the obesity rate in Tioga County has increased by eight percent over ten years.
- About a third of county residents get no physical activity.
- Overweight and obesity raise the risk of developing serious chronic diseases such as type 2 diabetes, heart disease and arthritis.
- Increasing physical activity helps people achieve and maintain a healthy weight.

Program

- *ShapeUp Tioga* is a ten-week program that encourages people of all ages to set goals to be more active on a regular basis and track points earned for every minute of daily activity.
- Program funding is provided by the Steps to a HealthierPA initiative in the Division of Adult and Community Health at the Centers for Disease Control and Prevention.
- Paid advertising in the local newspaper and on the radio encourages participants to reach physical activity goals and promotes activities and workshops to educate and motivate them to change habits.
- The program is structured to meet the needs of all people – no matter how inactive they are.

Impact

- Participation in *ShapeUp Tioga* increased one thousand percent from year one to year two.
- Participants gained knowledge about healthy eating and physical activity.
- More than half of participants were physically active for at least thirty minutes, five times a week during the program.
- All participants reported that they'll maintain or increase their physical activity over the six months following the program.

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GROCERY STORE INITIATIVE TEACHES PEOPLE TO EAT MORE FRUITS AND VEGGIES

Program's taste samples and nutrition advice add an incentive to eat more produce for good health

Public Health Problem

- In South Carolina, few youth or adults eat recommended amounts of fruits and vegetables daily.
- People who eat generous amounts of fruits and vegetables as part of a healthy diet are likely to have a reduced risk of developing serious chronic diseases, such as heart disease and diabetes.

Program

- The South Carolina Department of Health and Environmental Control, Clemson University Culinary Science Program and BI-LO grocery stores supported the launch of the Fruits and Veggies – More Matters national brand with in-store events that made it easy for consumers to taste and buy healthful produce.
- For four months, this pilot program, funded in part by the Preventive Health and Health Services Block Grant, offered samples of healthy foods prepared by professional and student chefs, recipes, nutrition tips, and displays of suggested portion sizes.
- A volunteer Department of Health and Environmental Control registered dietitian and a professional chef answered customer's questions and offer suggestions.
- Customer surveys about food and nutrition knowledge, usual produce purchasing habits, and an analysis of actual produce purchases of participating customers were conducted before and during the pilot.

Impact

- Produce purchases increased by six percent when compared to purchases made immediately before the pilot program at the Simpsonville, S.C. store.
- BI-LO stores made a commitment to support additional events throughout the state with advertising, customer incentives to take part in the program, and provision of recipe ingredients for taste sampling.
- When kale soup samples were offered, for example, customers later reported their families "ate every bite of it" and produce department staff noted that sales of kale were higher than usual that day.

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CLOSING THE HEALTH CARE GAP FOR AFRICAN AMERICANS

South Carolina partnership seeks to eliminate disparity in diabetes care and control

Public Health Problem

- Fifteen percent of African-Americans in South Carolina have diabetes, a rate significantly higher than other population groups.
- Controlling blood sugar in people with diabetes can prevent the strokes, heart attacks, amputations and other complications of diabetes that African-Americans are more likely to have.
- Healthy diet, physical activity, healthy weight and regular monitoring are key strategies for controlling blood sugar in people with diabetes.
- African-American residents of Charleston and Georgetown counties in South Carolina have more risk factors related to poor control of diabetes than other state residents.

Program

- The REACH Charleston and Georgetown Diabetes Coalition, based at the Medical University of South Carolina College of Nursing, receives CDC funding for the project. This group works in partnership with more than sixteen organizations, four health care systems, the South Carolina Department of Health and Environmental Control Diabetes Prevention and Control Program, and the Diabetes Initiative of South Carolina to improve diabetes care and control for more than 12,000 African-Americans with diabetes in South Carolina.
- A community action plan guides the provision of free diabetes education, support groups, health care referrals, assistance in getting diabetes medicines and supplies, learning opportunities for providers and consumers, health information resources, healthy eating and physical activity programs, as well as advocacy for policy changes to improve diabetes care.

Impact

- A greater percentage of African-American patients are controlling their diabetes, keeping their hemoglobin A1C, a measure of blood sugar control, at recommended levels.
- Diabetes care has improved and is more in line with recommendations for quality and prevention of complications. For example, four community health centers have significantly improved provision of recommended tests to assess patient blood sugar control, lipids, kidney function, and foot health (important in preventing amputations), and eliminating diabetes care disparities documented previously.
- Health fairs, family reunions, and church breakfasts in these counties have changed foods provided and serve as a model for healthier eating. Participants are now more active.
- Emergency visits to hospitals decreased by half for unfunded persons with diabetes.
- Lower extremity amputations in African-American men decreased forty percent in Charleston County.

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SPREADING THE WORD: PHYSICAL ACTIVITY. ARTHRITIS PAIN RELIEVER

Urban, rural, and minority populations across the state learn how to improve quality of life for those with arthritis

Public Health Problem

- Arthritis is a leading cause of disability and its prevalence is expected to increase.
- Close to a third of Wisconsin adults with arthritis have work limitations due to their condition. Many are also obese, a modifiable risk factor for a number of chronic diseases.
- People with arthritis may not know that physical activity is important in helping them improve physical function, reduce pain, lessen disability and maintain a healthy weight.

Program

- The Wisconsin Arthritis Program, with funding support from the Centers for Disease Control and Prevention (CDC), implemented arthritis public awareness campaigns throughout the state (final regional implementation to occur in 2008), basing campaign messages on those CDC developed: *Physical Activity. The Arthritis Pain Reliever* and *Buenos Dias Artritis*, a Spanish-language campaign.
- Using a social marketing approach in partnership with local communities these communication campaigns promote the benefits of physical activity for people with arthritis through print and radio messages, community events, seminars, and changes in the built environment to make places for physical activity more accessible.
- Reaching out to African American communities, the Latino community in urban Milwaukee and rural Oneida and Chippewa Counties and engaging local healthcare professionals, clinics, fitness and recreation facilities, parks, and others with a menu of local options allowed the adaptation of activities and messages to local community needs.

Impact

- The campaign achieved over six million media impressions, letting residents know that being physically active and creating a community environment to support physical activity helps those with arthritis and other chronic diseases. A media impression is an estimate of exposure to the messages of the campaign.
- The Wisconsin Arthritis Program, working with partners, developed systems for improving availability of evidence-based self management proven to reduce the disability of arthritis as well as access to physical activity. The Oneida County Health Department, for example, worked for city approval to create five new bike routes linking schools, the town center and paths from outlying towns, using CDC funds to purchase route markers and to create road stripping.

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RAISING AWARENESS TO IMPROVE DIABETES CARE

West Virginia program partners with local Quality Improvement Organization

Public Health Problem

- West Virginia has a much higher rate of diabetes than the rest of the nation.
- Raising awareness of the importance of preventive services and self-management among people with diabetes makes it more likely that they'll ask for and get services that can prevent costly and even life-threatening complications of their disease.
- Surveys show that significant numbers of West Virginian's with diabetes do not get needed eye and foot exams or blood sugar monitoring tests, such as the A1c test.

Program

- A series of public service announcements on diabetes were developed for radio and television broadcast in West Virginia.
- The segments focused on the importance of specific clinical tests and exams that are recommended for people with diabetes, such as flu examination, eye examination, and the A1c test for monitoring blood sugar levels. Certain announcements highlighted the importance of flu and pneumonia shots for those with diabetes and all segments included the phrase "Ask your doctor for more information."
- A contract with the West Virginia Broadcasters Association guaranteed broadcast of the messages and over thirteen thousand diabetes-related radio and television public service announcements were aired in selected markets in West Virginia over six months.
- West Virginia Medical Institute, the state's Medicare Quality Improvement Organization, coordinated diabetes materials with the broadcast messages for its physician and beneficiary newsletters and weekly television program.

Impact

- Nearly all residents surveyed in an evaluation of the message broadcasts said they had seen or heard the diabetes announcements.
- Medicare beneficiaries with diabetes who had higher exposure to the announcements were more likely to say that they took action based on the messages than those with less exposure.
- An American Journal of Preventive Medicine article documents the effectiveness of the mass media campaign in raising awareness.

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WEST VIRGINIA MEDIA CAMPAIGN INCREASES CALLS TO TOBACCO QUIT LINE

Personal testimonial is an effective tool as part of a tobacco control program

Public Health Problem

- West Virginia is one of the top four states in rates of tobacco use.
- Tobacco use is estimated to cost the state over two billion dollars a year in direct health care costs and mortality-related productivity losses.
- Promoting quitting among young people and adults is part of a comprehensive, broad-based approach to reducing tobacco use.
- Mass media campaigns directing viewers to a telephone based quit line are an effective method to improve quit rates.

Program

- The West Virginia Quit Line includes a toll free number, tailored information, pre-authorized nicotine replacement therapy, pro-active telephone coaching and web-based support for helping callers quit smoking or using spit tobacco. The quit line was (at the time these ads ran) sponsored by the Public Employees Insurance Agency, West Virginia Medicaid, and the West Virginia Bureau for Public Health.
- A twelve week media campaign was aired by three television stations with complete or partial coverage in twenty-three counties highlighting a woman who had successfully quit smoking after twenty-seven years. Her message was that smokers need to quit now and not put off making the quit line call until it's too late.
- Evaluation included comparing enrollment data for thirteen weeks to the same thirteen weeks in the prior year, calculating a one year return on investment, and measuring changes in referral sources resulting from the Campaign.

Impact

- Increasing calls to a tobacco quit line which offers effective methods such as proactive telephone coaching and free or low cost nicotine replacement therapy is a proven way to increase the number of smokers who successfully quit smoking or using spit tobacco.
- Counties with full exposure to the quit line campaign experienced a net quit line enrollment more than thirty percent higher than if there had been no campaign. Counties with partial exposure to the campaign had a twenty-three percent increase.
- Referrals averaged three times those in the prior year.
- The one year project return on investment was over four dollars for each dollar invested.

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IMPROVING ORAL HEALTH ASSESSMENT CAPACITY TO ENABLE ACTION

Building infrastructure helps Alaska develop policy, address disparities, monitor trends, and develop strategies

Public Health Problem

- Building a statewide oral health surveillance system is a Healthy People 2010 Oral Health objective for states.
- Good oral health is an important goal for states and has the potential to improve the early identification and prevention of complications related to certain chronic diseases.
- When Alaska prepared the state's Healthy People 2000 plan only limited information was available on community water systems fluoride levels and the state had virtually no capacity to monitor the oral health status of its citizens.

Program

- With funding from the Division of Oral Health at the Centers for Disease Control and Prevention, the Alaska Oral Health Program set up a system for collecting and analyzing oral health data from existing data sets such as the Behavioral Risk Factor Surveillance System and Medicaid, and for conducting open-mouthed assessments of children enrolled in Head Start, kindergarten, and third grade.

Impact

- The Alaska Oral Health Program has now met or nearly met 6 of the 17 Healthy People 2010 objectives including establishment of a statewide oral health surveillance system and establishment of a cleft lip/palate registry and referral system.
- The Program now has data on the state's status in relation to 13 of the 17 national oral health objectives.
- Recent data reveals serious health concerns but has also shown that Alaska is making significant progress in improving the oral health of its citizens.
- The development of Alaska's oral health surveillance system better positions the state to develop oral health policy, address disparities, monitor trends, and develop strategies to reduce oral disease and to reach additional state (and national) health objectives.
- The availability of useful data on oral health has stimulated valuable discussions among key leaders and citizens on increasing dental access, expanding dental sealants programs for non-Native racial ethnic minorities, and encouraging earlier intervention to reduce tooth decay in young children.

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JOINT PROGRAM EFFORTS EXPAND DATA AND EDUCATION REACH

Chronic disease programs collaborate to gather needed data and engage stakeholders

Public Health Problem

- Osteoporosis is a public health threat for over half of Michigan adults age fifty and older.
- Over thirty percent of Michigan adults also have arthritis, making the state the sixth highest in the rate of arthritis of all the states.[o]
- Providing education on both diseases simultaneously makes good use of time and enables providers to give more complete information and care to patients with these chronic conditions.
- Gathering data on several chronic conditions at once and educating stakeholders about more than one chronic disease program at a time can be very efficient, reaching more stakeholders with fewer dollars and emphasizing the overlapping steps for preventing each.

Program

- To maximize resources, the Michigan Diabetes, Arthritis, and Osteoporosis Survey, a joint survey across three program areas in the Michigan Department of Health Department, gathered previously unavailable Michigan-specific information on knowledge, opinion, and behavior related to these three conditions as well as other chronic diseases. These data guide activity in three programs and two coalitions.
- Building on this successful joint work, the Michigan Arthritis and Osteoporosis Coalitions developed the free-of-charge *Taking Control of Bone and Joint Health: A Practical Perspective* conference that provided important information about healthy eating and physical activity programs to providers likely to reach the population susceptible to both conditions.

Impact

- Twenty-four new coalition members were recruited as a result of the conference, adding resources to the prevention and control effort.
- The conference attracted representatives from programs in heart disease, stroke, diabetes, asthma, arthritis and osteoporosis – engaging these practitioners from many areas of chronic disease in education can boost effectiveness of all chronic disease programs.
- Free television exposure for the important messages of osteoporosis and arthritis prevention resulted from the conference, including on-air interviews with local rheumatology experts and the chairs of each coalition.
- Almost all respondents to the conference evaluation plan to share information learned with their colleagues and many said they would talk to family and friends about osteoporosis and/or arthritis and incorporate information from the meeting into their daily activities.
- Donated funds covered costs, making the free conference available to a wider audience and introducing new stakeholders to both coalitions

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FACTS AND FIGURES TO SUPPORT THE NEW MEXICO CANCER PLAN

Up-to-date document provides a baseline for evaluation and monitoring

Public Health Problem

- Health planners rely on accurate data to develop, implement and evaluate cancer control interventions.
- State-level data is often limited in availability and data on cancer risk and protective factors, incidence, and mortality are collected and reported by different government and private entities.

Program

- The New Mexico Department of Health Comprehensive Cancer Program staff working in collaboration with partners at the University of New Mexico Cancer Center analyzed data and revised the content of a previously published document.
- *New Mexico Cancer Facts & Figures 2007* (*Facts & Figures*) was supported by funding from a cooperative agreement between the Centers for Disease Control and Prevention and the New Mexico Comprehensive Cancer Program.
- It contains the most current cancer data available on incidence and mortality rates for selected cancer sites as well as overall cancer rates by county and thirty-year trends. Data on risk factors and protective factors for the development of six cancers such as sun exposure and cancer screening rates are also included.
- *Facts & Figures* is available in print, on compact disk, and online at www.cancernm.org/cancercouncil/facts_figures.htm.

Impact

- Program planners, policymakers, and other stakeholders now have access to the most current cancer data along with narrative information that provides a context for the numbers.
- *Facts & Figures* supplies data that support the objectives of the New Mexico Cancer Plan and will help cancer stakeholders in New Mexico…..
  - …. establish baseline measures for comparison with future data
  - …. identify disparities in cancer rates among population subgroups
  - …. illustrate areas where advancements in cancer control have been made
  - …. provide information for making and evaluating changes in public policies and programs related to cancer
- The collaboration that resulted in development of *Facts & Figures* evolved into a data work group of the New Mexico Cancer Council that will assure sound data underpinnings for future comprehensive cancer control efforts.

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MEETING THE CHALLENGE OF OBESITY PREVENTION

State plan evaluation highlights great progress on infrastructure, resources & interventions

Public Health Problem

- Substantial public health actions by community organizations, businesses and government are needed to reverse the rising trend of obesity in Wisconsin.
- When many partners strive to achieve wide-ranging outcomes it helps to have a plan and assess progress regularly in order to keep partners actively moving forward.
- The Wisconsin Nutrition and Physical Activity Program and what is now called the Wisconsin Partnership for Activity and Nutrition developed a state plan in 2005 outlining strategies for obesity prevention that included over one hundred objectives in seven goal areas over a period of five years.

Program

- The Wisconsin Nutrition and Physical Activity Program, funded by the Centers for Disease Control and Prevention, assessed the status of each of the over one hundred state plan objectives by scoring them on how completely they were met or on the amount of change that had occurred from the baseline measurement at the time the plan was written.
- To arrive at a score for each of the seven goals and for the entire plan as a whole, scores for individual objectives were added and then divided by the total number of objectives.

Impact

- Wisconsin Nutrition and Physical Activity State Plan objectives are fifty percent complete as they near the halfway mark in the plan's timeframe. This is based on a calculation combining fully-completed and partially-completed objectives.
- Progress has been made on almost every state plan objective.
- Partners can now focus on meeting the remaining objectives, revising those that need it, or possibly deleting some that have become outdated based on new information.
- This helpful assessment gives partners interim markers of progress toward reaching the ultimate goal of reducing the rate of obesity in Wisconsin which will realistically take many years.

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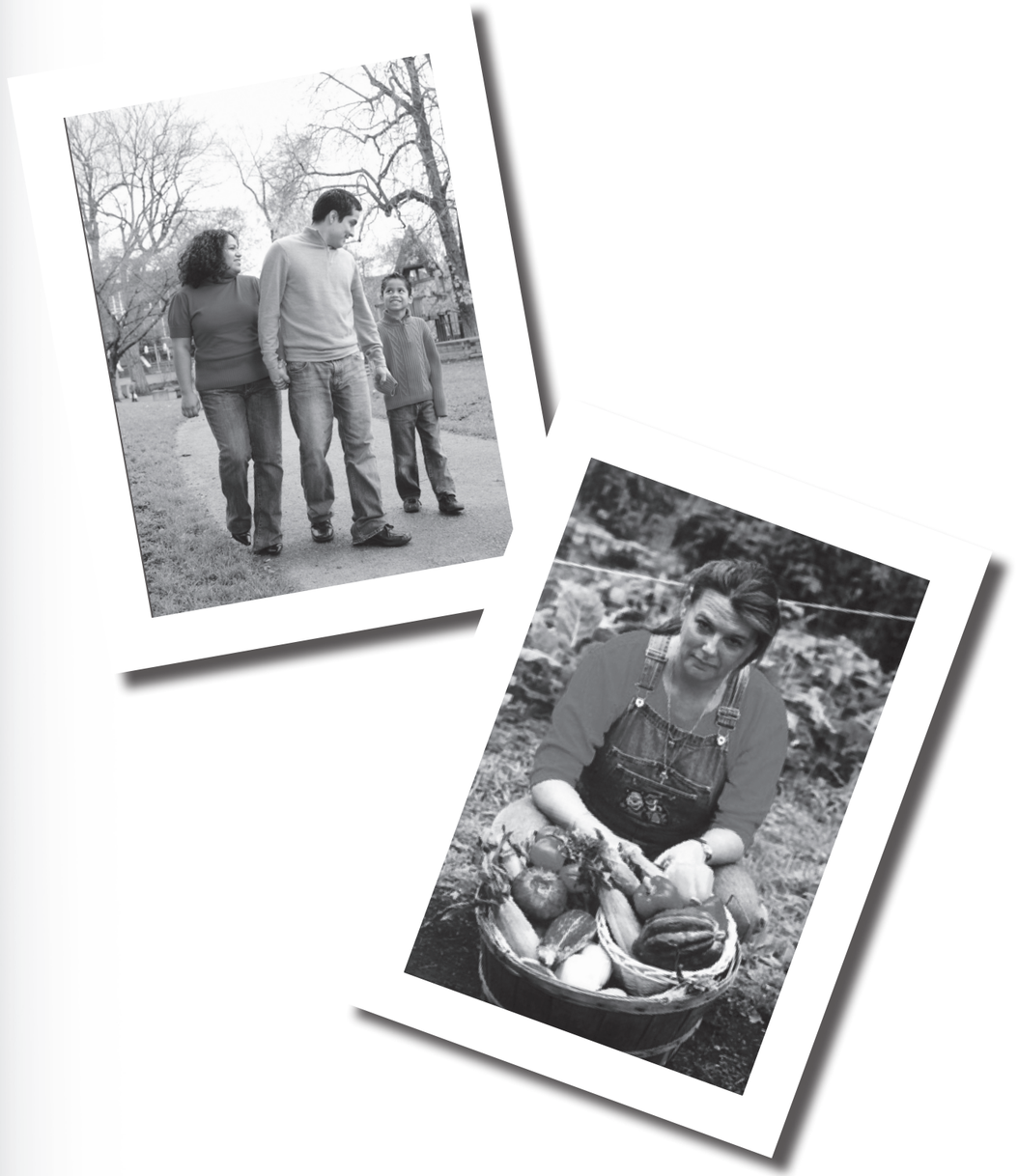

EXPANDING THE REACH OF EVIDENCE-BASED PROGRAMS FOR PEOPLE WITH ARTHRITIS

Health and aging agencies partnered to establish programs within the aging services system

Public Health Problem

- Almost two thirds of Alabama adults with arthritis are over sixty-five years old.
- Half of Alabama residents with arthritis report that the condition limits their daily activities.
- The demonstrated benefits of the Arthritis Foundation Exercise Program are improved functional ability, decreased depression and increased confidence in participants' ability to exercise.
- Finding a way to embed programs with demonstrated benefits in an existing delivery system sustains the programs and often promotes greater geographic availability.

Program

- The Alabama Arthritis Program identified adult nutrition and senior center sites as ideal for the implementation of proven arthritis control programs because they are an existing network of gathering places for older adults and provide an opportunity to reach a significant portion of the target population for arthritis programs.
- Through a partnership with the Alabama Department of Senior Services, the Arthritis Program is working with the Alabama Area Agencies on Aging to establish and sustain programs in each of their thirteen regions.
- Leader trainings were held in five locations throughout the state in order to train leaders for a wider geographic area.
- The number of trained program leaders has increased ten-fold and the number of certified trainers has doubled. Certified trainers are needed for continuous training of program leaders, both to increase the supply and to replace those retiring.

Impact

- Program leaders report that participants say they have less pain and symptoms of depression; increased flexibility, improved sleep and increased independence as a result of the arthritis exercise programs.
- In the most recent calendar year, the number of programs offered to Alabama residents and the number of participants in proven programs doubled from the prior year, significantly improving the control of arthritis symptoms for many state residents.

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OLDER ADULTS GET HELP TO MAINTAIN THEIR INDEPENDENCE

Peer Exercise Program Promotes Independence (PEPPI) engages older adults in physical activity

Public Health Problem

- Active living should be a goal for all adults – to preserve function, delay or prevent chronic diseases and maintain independent living.
- A pilot project in central Arkansas determined that the older adult population was in need of a physical activity intervention.

Program

- The University of Arkansas Medical School and the Arkansas Department of Health expanded the PEPPI pilot exercise project to other regions of the state for adults over sixty. The exercise program is based on research conducted at Tufts University which has demonstrated the benefits of this type of training for older adults.
- Older adult peer leaders receive training in flexibility, balance, strength and endurance exercises and lead exercise classes for their peers in places such as senior centers, churches, or housing complexes. There are now well over two hundred trained peer leaders in the state.
- The PEPPI program gives older Arkansans the opportunity to learn how to exercise using correct techniques in a safe environment among people of similar age and health conditions and to increase their level of physical activity.
- Specific program goals for the number of older adult centers offering the PEPPI program have been set.

Impact

- Most participants saw an improvement in endurance and lower body strength and roughly half saw improvement in four other fitness measures.
- This program is now offered statewide.
- PEPPI won the national Health Educators Institute, Special Population Health Education/Health Promotion Award and is recognized by the U.S. Department of Health and Human Services as a model program.
- Partnerships with the Division of Aging and Adult Services, Area Agency on Aging, Centers on Aging, and the Healthy Aging Coalition, leveraged additional funds for implementation from an Administration on Aging & National Council on Aging grant to offer an additional evidence-based physical activity program in two regions.

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CREATING SELF MANAGEMENT TOOL KITS FOR PEOPLE WITH DIABETES

Arizona diabetes partners identify need and legislature funds efforts to meet it

Public Health Problem

- Diabetes is a growing problem in Arizona where the rate of diabetes has more than doubled since 1990.
- Diabetes self-management education is an effective way for people with diabetes to achieve positive health-related outcomes. Reaching more people who have diabetes with this type of education is a national health objective of Healthy People 2010.
- More than a third of Arizonans with diabetes report they have never taken a course to learn the steps they can take to manage their disease.

Program

- The Arizona Diabetes Program and the Arizona Diabetes Coalition determined through a collaborative process involving multiple stakeholders that in order to significantly impact disease outcomes resources needed to be directed at multiple levels in the diabetes prevention and control system – specifically, self management tools, worksite interventions, community grants for education and a health communications campaign.
- Implementation of one of these identified levels led to development of a self management toolkit, in English and Spanish, titled "A Roadmap to Taking Charge of Your Diabetes" which includes a hand mirror for daily foot checks, a pillbox to organize diabetes medications, a Medical Alert bracelet and much more. Over 7000 kits were distributed to community health centers and organizations which used them in their educational programs, classes, and outreach activities.

Impact

- A Diabetes Legislative Appropriation of one million dollars resulted from the demonstrated need to improve diabetes care led by the Latino Caucus and Representative (now Senator) Amanda Aquirre. Part of it was used to fund this self-management initiative.
- More than three-quarters of consumers surveyed after receiving the toolkit reported making health-related changes as a result.
- Consumers who received the toolkit say:
  "*This kit is excellent; it answered all of my concerns…*"
  "*I couldn't believe that I was getting precisely all the information I needed.*"
- Toolkits were revised based on feedback from a user survey and input from the Arizona Diabetes Coalition and printed using state funds.

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LEVERAGING FUNDS TO EXPAND THE REACH OF ARTHRITIS PROGRAMS

Colorado program partners with aging agencies to serve more residents in need

Public Health Problem

- No public or private infrastructure existed in Colorado for training or program implementation to ensure that evidence-based programs for arthritis reached residents.
- The Colorado Arthritis Program works to assure delivery of quality evidence-based programs to adults with arthritis in the state to limit complications like pain and disability.
- Twenty-three percent of Colorado adults have arthritis, including more than half of those aged sixty-five and older.

Program

- A partnership formed between the Colorado Arthritis Program and the Consortium for Older Adult Wellness and their training venue The Academy for Older Adults established a needed statewide infrastructure for training arthritis program leaders and implementing programs.
- The Consortium, a statewide group committed to helping senior programs positively impact the health of older adults, now provides training to meet the needs of their community partners for implementing evidence-based arthritis programs on self-management and physical activity.
- The Colorado Arthritis Program supplies the training and technical assistance required for program fidelity and statewide data collection. The Consortium partnership also provides them with opportunities to work with others in the state's aging services network and in healthcare organizations to embed additional programs in existing delivery systems.

Impact

- The number of program sites and number of participants in evidence-based programs are expanding monthly to meet more of the need for programs that reduce disability caused by arthritis.
- The Colorado Arthritis Program leveraged additional funding for infrastructure and data from the private Colorado Health Foundation and for training and implementation from the Administration on Aging, adding to state and federal resources to expand the reach of the program.
- Leveraged funding enabled the creation of a Healthy Aging Unit in the Colorado Department of Health and Environment which will integrate aging and chronic disease efforts.
- Low-income populations are increasingly reached with needed programs as a result of the public/private partnership.

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LOCAL HEALTH DEPARTMENTS PROMOTE ARTHRITIS AWARENESS AND IMPROVE SERVICE DELIVERY

Utilizing the advantage of local agency service to the population in need to expand arthritis services

Public Health Problem

- The Illinois Department of Public Health has the capacity to assist in reducing the burden of arthritis in the state, but needs support from arthritis experts.
- The state Arthritis Foundation Chapters and branch offices have expertise, resources and materials, but need better access to local public-health systems to promote implementation of valuable programs.
- The Illinois Department of Public Health and the state Arthritis Foundation needed to work together to increase awareness and improve management of arthritis.

Program

- The Illinois Department of Public Health and the state's Arthritis Foundation chapters and branch offices educated one another about their services and program operations, such as leader training, marketing and implementation and available materials and on how to use the systems each has created for their work in arthritis prevention and management.
- The Illinois Department of Public Health contacted local health department administrators to describe Arthritis Foundation programs and services and provide contact information for Arthritis Foundation staff as well as meeting space and referrals for classes. The Arthritis Foundation Branch Directors used this information to set up meetings with local health department administrators and establish evidence-based program offerings.

Impact

- The Arthritis Foundation now has better access to the populations needing evidence-based programs since the local health department is assisting them and also serves this population.
- Many local health department staff members are now trained as leaders for evidence-based arthritis courses and ten serve on the Illinois Arthritis Initiative Partnership, expanding the expertise of this group.
- Sixty-three new leaders were trained to provide the evidence-based Arthritis Foundation self-management course.
- The number of local health departments partnering with other public health agencies to implement evidence-based classes continues to grow.

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WORKING WITH PARTNERS TO SUSTAIN AVAILABILITY OF EVIDENCE-BASED PROGRAMS FOR ARTHRITIS

Underserved communities implement programs and train leaders

Public Health Problem

- Arthritis is the leading cause of disability in the United States.
- Evidenced-based arthritis programs can reduce disability and improve quality of life for people with arthritis.
- There was minimal local availability of proven programs for arthritis management or education on prevention and care for the underserved communities of Chicago.

Program

- The Illinois Department of Public Health Arthritis Initiative worked closely with the Greater Chicago Arthritis Foundation to cultivate relationships with key constituents in underserved areas of Chicago through participation in community coalitions and health fairs and by implementing the CDC Communication Campaign.
- Illinois Department of Public Health Arthritis grant funds from the Centers for Disease Control and Prevention and in-kind support from the Greater Chicago Arthritis Foundation were used to provide training to a diverse group of leaders who could implement the evidence-based Arthritis Foundation Self-Help Program. These trained leaders represent three underserved Chicago community neighborhoods which are predominately African-American and two suburban locations, one of which is primarily Hispanic.
- Foundation staff provided technical assistance and site visits to monitor implementation.

Impact

- The reach of the Arthritis Foundation Self-Help Program has increased by fifty percent to encompass ten Chicago locations.
- The Arthritis Foundation Self-Help Program is now available in Spanish due to a partner's interest in serving this community. One Hispanic trained leader will become a Master Trainer, training other leaders and expanding the availability of both leaders and available programs.

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REACHING MARYLAND RESIDENTS TO PROMOTE ARTHRITIS AWARENESS AND PARTICIPATION IN EXERCISE PROGRAMS

Benefits include reduced disability for people with arthritis

Public Health Problem

- Twenty-seven percent of Maryland adults have arthritis.
- Arthritis is the leading cause of disability in the United States and is estimated to cost Maryland about four and a half billion dollars a year in medical care and lost productivity.
- Evidence-based exercise programs are proven to reduce pain, improve flexibility and reduce depression for people with arthritis

Program

- The Maryland Arthritis Program awarded mini-grants to local agencies such as health departments and Area Agencies on Aging to implement evidence-based intervention programs, such as the Arthritis Foundation Exercise or Aquatics Programs, by training leaders and publicizing and conducting class sessions.
- The Maryland Arthritis Program placed posters on bus shelters, on and inside buses, and at metro station platforms in the metropolitan Baltimore area. Radio spots in Spanish and English promoted physical activity to the African American and Hispanic populations.
- Educational workshops conducted across the state raised awareness of arthritis prevention and control strategies.
- Exhibits at professional conferences and health fairs were used to educate health care professionals and the public, reaching over three hundred professionals and seven hundred residents.

Impact

- Local agencies used mini-grants to increase the number of evidence-based programs offered throughout Maryland by implementing programs at over thirty sites, reaching over two thousand people with the evidence-based Arthritis Foundation Exercise and Aquatics classes.
- Over one hundred and forty evidence-based program leaders were trained over the past four years, increasing the supply of trained leaders to implement needed programs.

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THE P3 PROGRAM – PATIENTS, PHARMACISTS, PARTNERSHIPS

Preparing pharmacists to provide ongoing support and education to people with diabetes

Public Health Problem

- People with diabetes can develop costly and serious disease complications such as blindness and heart attack, greatly affecting their quality of life.
- Self-management education helps people with diabetes take steps to prevent complications but a third of people with diabetes in Maryland haven't taken a class to learn to manage their disease and about a quarter haven't had recommended tests such as a dilated eye exam, a foot check or a daily blood sugar test.
- The Asheville Project, a health care model developed in North Carolina for people with chronic conditions, demonstrated that pharmacists working with health care providers are able to educate people about their diabetes and improve delivery of recommended care.

Program

- The P-3 program, *Patients, Pharmacists, Partnerships*, sponsored by the University of Maryland School of Pharmacy and supported by a grant of state general funds from the Maryland Diabetes Prevention and Control Program, prepares pharmacists to provide ongoing support and education to people with diabetes. It is a replication of the Asheville Project.
- The Maryland Diabetes Prevention and Control Program partnered with the University to provide supplemental funds to recruit additional pharmacists to learn and improve their skills in helping patients manage their diabetes.

Impact

- This partnership engages pharmacists, often underutilized members of the health care team, to help Maryland residents with diabetes by improving access to self-management education and increasing the likelihood that they receive recommended care.
- Preliminary data show promising results in diabetes management, including increased adherence to recommended examinations, improvement in health behaviors, and reduction in health care costs.
- Three quarters of pharmacists participating in the educational session say it will improve their patient practices.
- Most pharmacists expect to use the information they learned and say the information changed their teaching style and methods, a benefit to patients they counsel.

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INCREASING ACCESS TO DIABETES SELF MANAGEMENT EDUCATION

Collaborative effort with stakeholders promotes the value and reduces the barriers

Public Health Problem

- Over seven percent of Maine adults have diabetes and another 38,000 Maine adults have diabetes but aren't aware of it.
- Maine diabetes self management programs show improved outcomes for people with diabetes a year after completing the program, such as reductions in measures of blood sugar and lipids, reduced hospitalizations, and more needed eye exams.
- Only about a third of the potential participants in state certified diabetes self management education programs are taking advantage of the education yearly.

Program

- The Maine Diabetes Prevention and Control Program, with help from partners, surveyed primary care providers, diabetes educators, and individuals with diabetes to determine barriers to accessing diabetes self management programs in the state.
- Results showed that these groups weren't aware of the programs, perceived that they didn't personally need the information, and identified many infrastructure issues such as scheduling, class format and transportation.
- The Program convened a group of stakeholders to develop an action plan to reduce these barriers and increase access to diabetes self management programs, including a strategy on planning and conducting a conference for diabetes educators to market diabetes self management programs.

Impact

- Implementing the survey raised the awareness of health professionals and individuals with diabetes about diabetes self management programs.
- The conference strategy was implemented and reinforced the value of diabetes self management programs to diabetes educators. They developed individual program marketing plans and are implementing strategies to reduce the identified barriers to diabetes self management education.
- Partner agreement on a mutual action plan enables wider implementation of useful strategies.
- The stakeholder workgroup continues to collaborate on ways to increase access to diabetes self management programs.

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INTEGRATING EFFORTS TO SUPPORT SELF MANAGEMENT OF CHRONIC DISEASES

State chronic disease programs collaborate to design strategies that reduce disease burden

Public Health Problem

- Over a third of the increase in Maine's health spending over seven years could be attributed to chronic diseases which are often preventable, such as heart disease, stroke, cancer, asthma, and diabetes.
- People with chronic diseases may have very limited contact with health care providers and need community support to self-manage their chronic condition where they live and work.
- State chronic disease programs have worked in isolation to identify community supports for disease self-management but traditionally haven't collaborated in this effort.

Program

- Healthy Maine Partnerships is a group of community health care coalitions in Maine that carries out disease prevention and control initiatives at the local level. In order to identify potential gaps in community supports for management of chronic diseases, the Care Model workgroup at the Maine Department of Health & Human Services was created. It includes representatives of these programs: Diabetes Prevention & Control, Cardiovascular Health, Asthma and Comprehensive Cancer.
- The workgroup met monthly to create a system to identify community supports and gaps, design collection tools and reporting systems, and provide training for the Healthy Maine Partnerships coalition members in conducting gap analysis and an assessment of community supports.
- The Care Model workgroup will continue to jointly plan & coordinate activities related to self-management support for health care providers and individuals with chronic disease.

Impact

- The increased communication and collaboration between chronic disease programs generated opportunities to integrate other interventions common to the programs and use resources more wisely by reducing duplication of effort.
- The Care Model workgroup activities are limiting the "silo effect" of individual chronic disease programs in planning and conducting gap analysis with local community health coalitions and increasing the potential for a more comprehensive improvement in community self-management supports for managing chronic disease.

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THE PATH TO BETTER QUALITY OF LIFE FOR PEOPLE WITH CHRONIC DISEASE

Michigan partnership broadens the reach of a proven program

Public Health Problem

- State chronic disease programs often work independently due to separate funding streams and reporting requirements.
- The Stanford Chronic Disease Self Management Program is proven to help people with many different chronic diseases, such as arthritis, heart disease or diabetes to improve their quality of life and lower the cost of their treatment.
- Implementing self-management education as a combined effort of several programs and partners increases the reach of this proven intervention, cuts the costs to each program or agency and increases the likelihood that the effort is sustained over time.

Program

- The Michigan Department of Community Health, the Office of Services to the Aging, and Michigan State University Extension partnered to coordinate and expand the reach of the Stanford Chronic Disease Self-Management Program in Michigan through a partnership called *Michigan Partners on the PATH*. PATH, Personal Action Toward Health, is Michigan's name for the Stanford Chronic Disease Self Management Program.
- Integrating health department diabetes, arthritis, and cardiovascular programs into the planning process allowed the partnership to build a sustainable system for implementing the proven PATH program to reach a broader group of those in need.
- Each agency assumed an important role, workgroups on data, evaluation, social marketing, master training were established, and additional partners were recruited, such as the Area Agency on Aging of Western Michigan, the Michigan Arthritis Foundation, the National Kidney Foundation of Michigan and Diabetes Outreach Networks.

Impact

- Expanded the reach of proven self-management education to more of the population with chronic diseases as a result of increased numbers of master trainers, trained leaders and workshops presented.
- Heightened interest and support among partners and potential partners for participation in the self-management education network by hosting regional locations for the web-cast on chronic disease self-management and reached a wider range of chronic disease practitioners including heart disease and stroke, osteoporosis, asthma, and diabetes staff.
- Integrated support activities for the self-management program into work plans for both the asthma and diabetes programs.
- Implementation of the PATH program statewide was a key part of the Office of Services to the Aging successful proposal to the Administration on Aging/National Council on Aging.
- Program practice guidelines, data, forms and registration are now centralized, facilitating sustained program implementation.

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ASSURING TRAINED LEADERS FOR CHRONIC DISEASE SELF MANAGEMENT PROGRAMS

Programs work together to expand availability of proven interventions for chronic diseases such as arthritis and diabetes

Public Health Problem

- Twenty six Missouri counties identified chronic disease as a priority in a capacity assessment of local public health agencies.
- People with chronic diseases such as arthritis and diabetes can benefit from physical activity, healthy eating and learning ways to manage their condition.
- Over thirty percent of Missouri adults have arthritis and many of them are not physically active. About seven percent of Missouri adults have diabetes.
- The evidence-based Chronic Disease Self Management Program is proven to decrease pain and depression, and improve self care behaviors for people with chronic diseases. The program teaches people about physical activity and nutrition, symptom management, use of medications and communicating effectively about their condition.

Program

- The Missouri Arthritis & Osteoporosis Program partnered with the Missouri Diabetes Prevention and Control Program in a statewide effort to train leaders for the Chronic Disease Self Management Program using funding provided by the diabetes program.
- The initial goal was to broaden the reach of the self-management program by training at least two leaders for each of seven regions.
- The state contracted with seven Regional Arthritis Centers who recruited thirty-one individuals to receive training to lead this evidence-based program.
- Partners of each regional center provides in-kind support to make the classes available in the community, including donated classroom space and paid staff time to serve as leaders. Course materials and course promotion assistance are provided through the Missouri Arthritis & Osteoporosis Program and the Regional Arthritis Centers.

Impact

- All twenty-six counties that identified chronic disease as a priority now have one or more Chronic Disease Self Management Program course offerings available to residents who need it. In the most recent program year, over three hundred participants completed the course.
- The program exceeded its initial goal and now has thirty-nine trained leaders available under the Missouri Arthritis & Osteoporosis Program.

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INCREASING OPPORTUNITIES TO MANAGE CHRONIC DISEASES

North Carolina leverages grant funds to implement programs across the state

Public Health Problem

- The number of adults over age sixty is growing rapidly in North Carolina as are associated costs for chronic disease.
- North Carolina's older population scores low on certain key measures of health.
- Chronic disease risk factors are high among the older population in the state, particularly among African Americans, people with low incomes, and those living in rural areas.

Program

- The North Carolina *Living Healthy* program currently brings the evidence-based, tested Stanford Chronic Disease Self-Management Program to forty-six counties throughout the state, including the mostly rural West, the urban Central section, and the heavily minority Eastern region.
- *Living Healthy* is a train-the-trainer program – training Master Trainers who then train workshop leaders to implement *Living Healthy* workshops for people with chronic diseases.
- Working with partners to extend and sustain *Living Healthy* across the state is the core strategy with the North Carolina Divisions of Public Health and Aging and Adult Services as the core partners in this work. Additional partners include the University of North Carolina Institute on Aging, the American Association of Retired Persons, Cooperative Extension, Community Care of North Carolina and Area Health Education Centers.
- Funding for this effort is provided by a grant from the U.S. Administration on Aging to increase implementation of evidence-based healthy aging programs, such as self-management programs, through providers serving aging adults in senior centers, faith-based organizations, senior housing and nutrition programs.

Impact

Results from over a year and of operation are:

- Twenty-four *Living Healthy* workshops have been held – greatly increasing the opportunities for participation in workshops shown to improve disability, fatigue, self-reported general health, communication with physicians and cognitive symptom management for people with chronic diseases.
- Many of the participants reached are in the priority groups of minority and low income people.
- A large number of Master Trainers are now trained and most are certified to train lay leaders, promoting sustainability.
- Almost eighty workshop leaders are trained and prepared to lead *Living Healthy* workshops for people with chronic diseases.

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EXPANDING THE REACH OF DIABETES SELF-MANAGEMENT EDUCATION

Local health departments get recognition by national organization to enable reimbursement

Public Health Problem

- Diabetes can be controlled and complications reduced when patients receive diabetes self-management education.
- Availability of quality diabetes self-management education programs is limited and the lack of insurance reimbursement for participating in them limits availability even more.

Program

- The North Carolina Division of Public Health created a program to allow local health departments to achieve recognition from the American Diabetes Association Education Recognition Program. This program is one of only two programs deemed as national accrediting programs by the Centers for Medicare and Medicaid Services.
- Financial support from the North Carolina Public Health Incubator Collaborative supplemented by the State Kidney Program allowed the program to begin with a full time nurse, registered dietitian and program assistant.
- Five local health departments participated in a pilot year, an advisory committee was established, training was held, and the application for ADA recognition was submitted.
- The Program recruited additional local health departments to participate and created expansion plans that included a grant application submitted in partnership with the North Carolina Public Health Foundation to the Kate B. Reynolds Charitable Trust.
- The resulting North Carolina Diabetes Education Recognition Program relies heavily on the support and guidance of its advisory committee.

Impact

- North Carolina now has a nationally-accredited recognition program for local health department diabetes self-management education, awarded by the American Diabetes Association, which has expanded needed diabetes education to all areas of the state and enabled health departments to receive reimbursement.
- People with diabetes are now benefiting from increased access to diabetes education resulting from this recognition program, the first in the nation designed and implemented in this innovative way.
- The program leveraged full funding for three years from a charitable foundation to sustain the local programs.
- Twelve additional local health departments have been added to the recognition program since the pilot for a total of sixteen participating and another ten or fifteen are expected in the coming year.

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EMBEDDING NEEDED PROGRAMS IN EXISTING DELIVERY SYSTEMS

Partnership with aging service agencies extends the reach of evidence-based programs for arthritis

Public Health Problem

- Evidence-based physical activity and self management education programs are proven to improve pain, function, depression, and self care behaviors for people with chronic diseases such as arthritis.
- These programs generally reach a very small proportion of the target population.
- The traditional, piecemeal approach to program delivery limits geographic availability and sustainability of intervention programs and is very resource intensive.

Program

- Working in partnership, the Nebraska Arthritis Program, the Nebraska State Unit on Aging and the Arthritis Foundation, Nebraska Chapter worked to establish the evidence-based Arthritis Foundation Exercise Program as an adopted program within the existing Area Agency on Aging delivery system. The constituents of this delivery system are likely to include large numbers of people with arthritis and reaching them with evidence-based programs serves the Agency's mission.
- The Area Agency on Aging trained several staff members from each of their eight regions to lead the Arthritis Foundation Exercise Program. Staff offers the program many times a year in senior centers in their region.
- The Nebraska Office of Women's Health refers clients to these programs.
- Fourteen leaders now provide physical activity programs throughout the state. Future plans include developing master trainers to train additional senior center staff to provide programs.

Impact

- By embedding programs within an existing delivery system, the Nebraska Arthritis Program and the Nebraska State Unit on Aging have created the capacity to provide appropriate exercise programs in all ninety-three counties in Nebraska for people with arthritis.
- Appropriate exercise programs are now routine offerings in community settings and there is a commitment of organizational resources to sustain program delivery over time.

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MANAGING ASTHMA TO DECREASE STUDENT ABSENCE FROM SCHOOL

Asthma-friendly schools improve quality of life for students

Public Health Problem

- Missed school days affect student's academic performance.
- Asthma is a leading cause of school absenteeism.
- In the Albuquerque/Bernalillo County area of New Mexico an estimated 10,000 school-aged children have asthma.
- Asthma can be controlled with appropriate management and education.
- The Albuquerque Public Schools had no coordinated asthma education program for students and no asthma education for school staff prior to initiation of the program described here.

Program

- The New Mexico Departments of Education and Health launched the Albuquerque Public Schools Asthma Program to improve student asthma management using coordinated school health funding from the Centers for Disease Control and Prevention and in cooperation with the American Lung Association and the Albuquerque Public Schools.
- Asthma Program Strategies include:
  - Implementing "Open Airways," an educational program with proven effectiveness in promoting good asthma management, for more than a thousand students in grades 3-5
  - Training elementary school nurses and providing asthma education to school staff
  - Updating school asthma procedures to include best practices and modifying policies for culturally sensitivity
  - Referring students and families without health insurance to New Mexico Department of Health Children's Medical Services
  - Equipping all school health rooms with asthma-related devices
  - Contracting with the University of New Mexico's Center for Regional Studies "Tools for Schools" program to train school staff to inspect for and identify air quality concerns, which include asthma triggers

Impact

- Absences due to asthma decreased significantly, declining by a third over four years.
- The number of schools participating in the asthma program has more than doubled.
- Students with asthma entering the absence-tracking program increased almost threefold
- Individual health care plans prepared for students, orders for medication, and asthma action plans increased, indicating better management of asthma.

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ENSURING A DELIVERY SYSTEM FOR PHYSICAL ACTIVITY PROGRAMS

EnhanceFitness reaches people with arthritis to reduce pain, improve functioning

Public Health Problem

- Arthritis is the most common cause of disability in the United States affecting many to the point where it interferes with daily activities and pain and stiffness make it difficult to walk, climb stairs, sleep or go to work.
- Evidence-based physical activity programs such as *EnhanceFitness* are proven to help people with arthritis reduce the pain caused by this condition and increase their physical and psychosocial functioning and quality of life.

Program

- The New Mexico Arthritis Program, funded by the Centers for Disease Control and Prevention, developed a partnership to create and execute a dissemination model for statewide implementation of EnhanceFitness, an evidence-based physical activity program effective for people with arthritis.
- Two partners with state-wide reach across New Mexico, Jewish Family Service of New Mexico and New Mexico Senior Olympics, were recruited to lead the implementation of *EnhanceFitness*. Each has the capacity to expand physical activity programs in senior centers, naturally-occurring retirement communities, colleges, pueblos and other private and non-profit systems across the state.
- A "Train the Trainer" workshop led by Seattle Senior Services Project Enhance, trained six staff members and volunteers from these two partner organizations and the City of Albuquerque Senior Services as Master Trainers who then trained six course instructors and will train additional instructors, as needed.

Impact

- The New Mexico Arthritis Program partners are improving the quality of life for people with arthritis by implementing new *EnhanceFitness* classes in sites such as senior centers and in the near future in senior apartments, a cardiac rehabilitation center, and a pueblo recreation center.
- Health care cost savings are expected based on a cost analysis by the University of Washington on members of a local health management organization which showed healthcare utilization costs of *EnhanceFitness* participants were over twenty percent less than non-participants' costs after one year.
- In-kind resources are leveraged and sustainability enhanced by implementing EnhanceFitness through partner organizations with access to existing program delivery sites and participants.
- The program is mapping existing physical activity and self-management programs to identify gaps and enable strategic implementation of additional programs.

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ENSURING AVAILABILITY OF THE CHRONIC DISEASE SELF MANAGEMENT PROGRAMS

Partnership increases the number of proven programs to be offered and establishes a system for maintaining them

Public Health Problem

- Arthritis is the leading cause of physical disability in the U.S. and Nevada expects a much larger estimated increase in the number of residents with arthritis than the country as a whole over the next twenty years.
- More than half of adults with diabetes or heart disease also have arthritis.
- The presence of arthritis can complicate management of these other chronic conditions by presenting barriers to healthier lifestyles, such as pain during physical activity.
- The Chronic Disease Self-Management Program, developed by Stanford University is proven effective in symptom management and reducing days spent in the hospital for people with chronic health problems, such as arthritis, diabetes, lung and heart disease.

Program

- The Nevada Arthritis Prevention and Control Program, with a grant from the Centers for Disease Control and Prevention, funded the University of Nevada Sanford Center for Aging for two people to be trained as Master Trainers for the Chronic Disease Self Management Program. These Master Trainers will train others in leader classes, then monitor the leader's activities, evaluate the self management programs that result and assist with collecting and reporting data on participants reached.
- The Sanford Center for Aging supplies in-kind dollars for office space and two staff at their Reno headquarters.

Impact

- This partnership increases the reach and sustainability of the proven Chronic Disease Self Management Program by:
  - Providing Program workshops throughout one county through a sub-grant from the local health department and through the State Comprehensive Cancer Control Program.
  - Increasing the number of Program trainers available to reach people with chronic conditions through four trainings scheduled for the Reno-Sparks Indian Colony, the Partners Allied for Community Excellence Coalition in rural Elko County, and two long term care facilities in the state.
- Additional funds for this project were leveraged through the in-kind contributions from the University of Nevada Sanford Center for Aging and the provision of in-kind health educator positions by the Washoe County District Health Department

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REACHING NORTHERN COUNTIES IN NEW YORK WITH EVIDENCED-BASED PROGRAMS FOR ARTHRITIS

Partnership leads to more trained leaders and new program offerings

Public Health Problem

- Over one fourth of the adults in the three northern-most New York counties have arthritis.
- Evidence-based programs can reduce disability and improve quality of life for people with arthritis.
- Three counties in northern New York, Clinton, Essex, and Franklin, had no evidence-based arthritis interventions available to residents with arthritis.

Program

- The New York State Department of Health Arthritis Program and the Eastern Adirondack Health Care Network serving Clinton, Essex, and Franklin counties, established a partnership to broaden the reach of evidence-based Arthritis Foundation Self Help Program to northern New York and to support the Networks desire to address this important public health problem.
- With a one year grant from the New York State Department of Health Arthritis Program, the Eastern Adirondack Health Care Network was able to provide assistance to another partner, offer monetary incentives to recruit two additional partner agencies and recruit volunteers, network staff, and others to be trained to deliver the Arthritis Foundation Self Help Program.
- After gaining experience in program delivery, the Network added the Arthritis Foundation Exercise Program, training fourteen instructors from the three counties and distributing patient education kits to motivate participants to sign-up to take the course.

Impact

- People with arthritis in northern New York are now being reached with exercise programs that improve quality of life and lessen disability. Over one hundred and fifty people have attended an arthritis evidence-based program so far.
- Arthritis interventions and information distribution have become a permanent part of the Eastern Adirondack Health Care Network annual work plan.
- A significant supply of trained leaders is now available to conduct needed programs in northern New York with the potential to sustain the supply of leaders and program offerings through the Eastern Adirondack Health Care Network.

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REACHING RURAL RESIDENTS WITH EFFECTIVE ARTHRITIS PROGRAMS

Oklahoma Arthritis Network improves availability of programs and training

Public Health Problem

- Almost a third of adult Oklahomans have arthritis, with an increase of twelve percent projected for 2030.
- About a third of adults with arthritis are inactive.
- Physical activity programs proven to lessen pain and increase flexibility and range of motion for people with arthritis as well as other effective arthritis programs are in short supply in rural areas of Oklahoma, partly due to a lack of trained program leaders.

Program

- The Oklahoma Arthritis Prevention and Education Program spearheaded the development of the Oklahoma Arthritis Network which includes health care providers, people with arthritis, third party providers, media, and others with an interest in controlling arthritis.
- The Network promotes awareness of arthritis, conducts the "Oklahoma Doesn't Sit Still for Arthritis" physical activity workshop series, and created an award-winning Oklahoma Arthritis Action Plan.
- The Network has also trained almost two hundred program leaders in workshops funded with Centers for Disease Control and Prevention arthritis program funds, resulting in implementation of eighty multi-session programs reaching over six hundred participants across a wide expanse of rural Oklahoma, a significant accomplishment.
- Two additional evidence-based programs were recently implemented in two regions of Oklahoma, EnhanceFitness and the Chronic Disease Self Management Program, expanding course offerings to include all exercise programs known to provide benefits to people with arthritis.

Impact

- There are now evidence-based programs for people with arthritis in nineteen rural communities where previously there were none (in addition to those in the metropolitan areas of Oklahoma City and Tulsa).
- Public and provider awareness and knowledge about what can be done to decrease pain and disability from arthritis has increased. The program receives increased numbers of calls and electronic requests for information and presentations. Many respondents to the Oklahoma Arthritis Network annual survey requested more information on arthritis.
- Organizations have joined the Network as partners and are recruiting and training leaders and conducting programs to extend the reach of proven interventions to reduce disability and improve quality of life for people with arthritis.

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BUILDING PARTNERSHIPS TO REACH PEOPLE IN RURAL PENNSYLVANIA

Modest beginning lays the groundwork for expanding and sustaining availability of evidence-based programs

Public Health Problem

- Pennsylvania ranks fifth highest among the states for medical care costs and lost earnings attributed to arthritis.
- Evidence-based physical activity programs are proven to improve function and decrease pain and depression for people with arthritis.
- Two contiguous rural counties in Pennsylvania, Indiana and Cambria counties, lacked evidence-based programs for people with arthritis.

Program

- The Pennsylvania Department of Health worked with the Western and Central Pennsylvania Chapters of the Arthritis Foundation to establish partnerships with local agencies such as the State Health Improvement Plan partnership in Indiana County and the Greater Johnstown YWCA in Cambria County to establish needed programs where none existed.
- Local partners developed methods to increase awareness of the benefits of exercise for people with arthritis and promote the adoption of behaviors to improve this condition.
- The Western Chapter provided basic arthritis presentations and an exercise demonstration; distributed educational materials at health fairs and to physicians, physical and occupational therapy offices and health centers; recruited new program leaders; and established new exercise program sites.
- The Central Chapter and the local YWCA held an open house to promote evidence-based exercise programs, offering hands-on experience with the exercise programs to attendees and providing specific arthritis information and discounts for attending future exercise sessions.

Impact

- Each of these counties now have trained leaders and evidence-based programs available:
  - The Indiana County partnership trained two leaders and reached over two hundred residents, recruiting sixteen participants for the inaugural Arthritis Foundation Exercise Program in that county.
  - In Cambria County, four leaders were trained in both the Arthritis Foundation Exercise Program and Aquatic Program. Over eighty participants were recruited for the initial offerings of these programs.
- Through these modest beginnings, partnerships with chapters of the Arthritis Foundation have laid the groundwork for establishing and sustaining evidence-based programs to improve quality of life for rural Pennsylvania residents with arthritis.

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EXPANDING PROGRAM OPTIONS FOR PEOPLE WITH ARTHRITIS AND OTHER CHRONIC DISEASES

Rhode Island agencies pool resources to make needed programs available across the state

Public Health Problem

- Arthritis is the leading cause of disability in the U.S.
- Over one fourth of Rhode Island adults have arthritis.
- Rhode Island had little availability of a proven self-management program for people with arthritis and other chronic diseases that can reduce pain and disability, reduce days spent in the hospital and improve quality of life.

Program

- As the result of a conference on implementing evidence based interventions for elders, an interagency group formed, including representatives from the Rhode Island Department of Elderly Affairs, Brown University, the Rhode Island Department of Health and the Rhode Island Department of Human Services Medicaid Program. This group recognized the value of collaboration to ensure wide availability of programs to improve self-management skills for those with chronic conditions.
- With funding from the Department of Human Services and the Centers for Disease Control and Prevention to the state's arthritis program and staff time contributed by each agency, this group held a Master Trainer Training session for the Stanford Chronic Disease Self Management Program and is implementing the program throughout the state.
- Seventeen master trainers, who in turn will train the program leaders, completed the training for *Living Well Rhode Island*, the state's name for the Stanford program. These master trainers are currently completing the requirements for certification, and are now embedded in agencies such as the Department of Health arthritis program, minority health program, and diabetes program, the Department of Elderly Affairs, a hospital system, and community agencies.

Impact

- An effective self-management program for people with arthritis is now offered in Rhode Island on a statewide basis, improving quality of life for many residents with arthritis and other chronic diseases.
- Master trainers are now established in many agencies reaching residents across the state, ensuring a supply of trained program leaders to sustain program offerings.
- The Department of Mental Health, Retardation and Hospitals recently joined the initial group, further expanding opportunities for program implementation.

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IMPLEMENTING ARTHRITIS PROGRAMS TO REDUCE DISABILITY

Partnerships help state expand the reach of evidence-based programs in Texas

Public Health Problem

- In Collin County, Texas, where there is a fast growing retirement community, eighteen percent of adults have arthritis.
- In general, about half the adults age sixty-five and older have arthritis.
- Evidence-based arthritis programs are proven to help participants reduce pain and disability and improve quality of life.
- Establishing a delivery system for proven arthritis programs makes them readily available to reach more of those affected.

Program

- The Texas Department of State Health Services Arthritis Program contracts with the Arthritis Foundation-Texas Chapter to train leaders to implement three evidence-based Arthritis Foundation exercise and self help programs. The goal is to increase the number of these programs offered statewide.
- The City of Allen Parks and Recreation Department also receives funding from the Department of State Health Services Arthritis Program to implement arthritis evidence-based exercise programs in the City of Allen.
- Their recognition of the need for and benefit of these programs motivated the City of Allen to take the initiative to expand arthritis exercise programs in eleven surrounding cities.
- The City of Allen partnered with the Arthritis Foundation-Texas Chapter to provide needed training resources to implement and maintain the programs for a year.

Impact

- Participants report significantly less pain and fatigue and improved flexibility as a result of arthritis exercise programs. In Collin County, over two hundred and fifty classes were conducted in eleven cities for well over thirty-five hundred participants.
- Five of the eleven surrounding cities continue to offer classes to people with arthritis, effectively increasing the availability of needed programs without the infusion of additional funds or other program resources.
- Working together, the Texas Department of State Health Services Arthritis Program, the City of Allen Parks and Recreation Department and the Arthritis Foundation-Texas Chapter combined their public and private resources to increase the availability of evidence-based exercise programs for arthritis management.

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PREVENTING TOOTH DECAY THROUGH COMMUNITY WATER PROGRAMS

Overcoming barriers to maintaining water fluoridation achieved through collaboration

Public Health Problem

- Community water fluoridation is one of the most effective strategies for preventing tooth decay.
- Fluoridation and the management of fluoridation programs is an important part of community infrastructure to improve health.
- Unfounded concern about the safety of fluoridation is often a barrier to initiating or keeping water fluoridation at the best levels for preventing tooth decay.

Program

- The Alaska Oral Health Program, funded by the Centers for Disease Control and Prevention, worked with water operators, state drinking water programs, and tribal health programs to collect data for a water fluoridation reporting system.
- Program staff educated the states' water plant operators about fluoridation guidelines and made them aware of Alaska Oral Health Program goals.
- Water fluoridation training was provided through the collaborative efforts of the Alaskan Native Tribal Health Consortium, the Alaska Rural Water Association, the Alaska Water Waste Management Association, and the Alaska Oral Health Program.
- When political leaders expressed concern about the relationship of local cancer rates to fluoride and chlorine in the water supply in Craig, Alaska, the state Dental Officer provided the local operator with information on fluoridation safety and contacted local specialists and providers to assist in providing community leaders with accurate data.

Impact

- For the first time, 24 Alaskan communities were recognized for maintaining optimal levels of fluoridation throughout the year, a significant step toward preventing dental decay for local residents.
- Members of the coalition of groups listed above worked together to allay the fears of the mayor, city council members, and citizens of Craig, Alaska about the safety of water fluoridation and saved the water fluoridation program in that community.
- This success highlights the value of both state capacity for the management of fluoridation and the collaboration between agencies in the state oral health coalition.

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SUCCESS OF HEALTHY EMPLOYEE LIFESTYLE PROGRAM BRINGS EXPANSION

Wellness program provides incentives to employees to live a healthier life

Public Health Problem

- Arkansas ranks near the bottom on a list of the healthiest states.
- Most people spend a large part of their day at work where the benefits of employee wellness programs can include reduced absenteeism, greater employee satisfaction, higher levels of productivity, and lower health care costs.
- Arkansas' largest employer, state government, has a vital interest in the health of its workers.
- When state agencies set the example for employee wellness, it can lead to commercial business promotion of employee health in other workplaces around the state.

Program

- The Arkansas Department of Health developed the pilot worksite wellness program, Healthy Employee Lifestyle Program, for employees in the Arkansas Department of Health and the Department of Human Services. It offered health risk appraisals, incentives, education, healthy eating and activity challenges, walking groups and changes to vending snacks.
- The state legislature created an attractive incentive by approving leave time for continuous participation in the program. Employees track healthy behavior changes using a point system and electronic database to become eligible for leave time.
- Approximately one fourth of employees in the two agencies registered as participants in the incentive component.

Impact

- Employee participants who registered in the incentive part of the program have improved personal health-related behaviors such as being more active, eating less fat, and eating more fruits and vegetables.
- All employees are benefiting from the health-related improvements in the work environment.
- Program success led Governor Mike Beebe to expand the program to all state agencies: "This effort means not only that our workforce will be healthier—they'll be more productive, too," Governor Mike Beebe said. "This is a truly progressive program, and will pay us benefits for years to come in our state."
- The Department of Health is working with the state's Employee Benefits Division to create a system for continuous documentation of the benefits to employee health and to state government as well as changes in employee-related health care expenditures by the state. They are also providing technical assistance to agencies in establishing the program.

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MAKING THE SMART CHOICE IN ARIZONA RESTAURANTS

Healthy menu options give residents a choice when eating out

Public Health Problem

- Obesity in Arizona has more than doubled since 1990.
- The nutrition environment, including widespread availability of fast food, vending machine and convenience store food and lack of access to fruits and vegetables is a contributing factor to the overweight and obesity epidemic.
- When an important nutritional labeling bill was not enacted by the Arizona legislature, concerned state Senator Amanda Aguirre convened a working group of community, health and restaurant leaders to develop an alternative initiative to support restaurants in offering healthier food choices and to help consumers identify these healthier options.

Program

- The Nutrition, Physical Activity and Obesity Program at the Arizona Department of Health Services developed and launched *Arizona Smart Choice*, a restaurant initiative featuring menu items that contain whole grains, beans, fruits or vegetables and reduced levels of calories, fat and sodium. Details at: www.azsmartchoice.com.
- Any restaurant can participate in this voluntary initiative just by paying the cost of nutrition analysis of their submitted recipes by a qualified company and meeting initiative guidelines.
- Window decals identify participating restaurants and menu stickers mark the items meeting initiative guidelines. A participation packet provides guidance and marketing materials such as a brochure, decals and stickers and an implementation guide.
- Quality assurance and technical assistance is provided by health department staff.
- Participating restaurants include McDonald's, the Carlos O'Brien's restaurants and Tom's Tavern and Restaurant. There is currently a pilot program in one cafeteria in the Capitol area and plans for a pilot testing of vending machines featuring healthier choices in two government agency buildings.

Impact

Arizona Smart choice is helping to create a healthier food environment in the state by:

- Enrolling restaurants serving residents across the state, including fast food restaurants
- Increasing the number of participating restaurants in this health-promoting initiative including some that are now initiating the process to join.
- Expanding the initiative, via pilot projects, into additional state agency cafeterias and vending machine outlets.

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WORK PLACES USE RESOURCES TO IMPROVE EMPLOYEE HEALTH

Arizona initiative modeled on an existing program, is a cost-effective way to reach businesses

Public Health Problem

- A healthy, productive workforce is essential to a robust Arizona economy.
- Worksite health programs have been shown to yield up to a six dollar return for each dollar invested, from results such as higher productivity, fewer missed days of work and happier, healthier employees.
- Emphasizing change in policies and organizational practices helps employers create a workplace environment to support individual healthy behavior choices that many employees are making.

Program

- The Arizona Department of Health Services Bureau of Chronic Disease Prevention and Control in a collaborative effort with the Arizona Diabetes Program, Nutrition, Physical Activity and Obesity Program, and Steps To A Healthier Arizona, developed a worksite initiative. The Arizona legislature supplied funding through the Arizona Diabetes Prevention Program.
- An online assessment and resource guide developed in collaboration with partners and modeled after Michigan's *Designing Healthy Environments* at Work, was piloted at worksites and then offered to interested businesses at a program launch in conjunction with the Arizona Small Business Association and at: www.azhealthyworksites.com
- Technical assistance provided by health department staff helps businesses use the initiative resources to conduct a needs assessment and then plan, implement and evaluate their program.
- Efforts to reach Arizona businesses to increase enrollment in this initiative include presentations to the Arizona Small Business Association, the Laveen Chamber of Commerce and the Pinal County *Building Healthy Communities* conference, email blasts, distribution of brochures at meetings and conferences, and a mass mailing to ten thousand companies employing more than twenty-five people.

Impact

- An increasing number of sites have registered, completed the online assessment, and are implementing healthier work place programming. Preliminary evaluation indicates Web site users would recommend the site to others and the Resource Guide is providing needed strategies.
- As Harold Gribow of the Arizona Small Business Association says, "With this online assessment tool, the Arizona Department of Health Services provides employers with a convenient way to assess their environments and to find ways they can help their employees while improving their companies' bottom lines."

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IMPROVING HEALTH HABITS THROUGH COORDINATED SCHOOL HEALTH

Changing health behaviors can improve academic performance and reduce health disparities

Public Health Problem

- Many health-related behaviors are established during childhood and adolescence.
- Addressing health risk behaviors among youth can improve academic performance and reduce health disparities.
- Effective coordinated school health programs can increase the adoption of health-enhancing behaviors, improve student and staff health, and use resources wisely.
- Gadsden County Florida suffers disproportionately from health and academic disparities, ranking in the lower half of Florida school districts in percent of students meeting standards in reading, math and writing.

Program

- The Florida Coordinated School Health Program, funded by the Centers for Disease Control and Prevention, provided funding, training and intensive technical assistance to Gadsden County to implement a district-wide coordinated school health program.
- The Gadsden County school district formed a planning and advisory committee, Gadsden County Wellness Approach to Community Health and used the results of participating schools' *School Health Index* assessments to develop a coordinated school health strategic plan.
- The plan, approved by the district school board, has forty-five goals and covers all eight components of the coordinated school health model, emphasizing nutrition and physical activity.
- Each of twelve schools in Gadsden County receive two thousand dollars yearly for a Healthy School Team to implement activities consistent with the district strategic plan.

Impact

After just one year of implementation, the school district:

- Required a daily fifteen-minute recess for all students up to grade six and for some sixth grades
- Adopted a policy that encourages physical fitness for students and discourages the use of physical activity as punishment
- Prohibited sales of carbonated beverages during meal periods
- Required compliance with the Florida state guideline of a 20-minute seated eating time
- Required each school to include a wellness goal in its School Improvement Plan
- Partnered with the Coordinated School Health Program to provide professional development to promote lifelong healthy nutrition, tobacco avoidance, and physical activity.

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COORDINATED SCHOOL HEALTH MAKES A DIFFERENCE IN HAWAII

Schools apply nutrition and physical activity interventions in unique wellness efforts

Public Health Problem

- Poor health habits established in youth, such as eating an unhealthy diet, using tobacco and not being physically active, contribute to the development of serious chronic diseases.
- More than two thirds of Hawaii youth in ninth through twelfth grade don't eat the recommended number of servings of fruits and vegetables every day, fourteen percent are overweight, and over two-thirds are not physically active at recommended levels. Also, every day, nearly 5,000 young people in the United States try their first cigarette.
- Coordinated school health programs integrate education, health, and social services to provide a comprehensive set of programs and services to reduce risk factors and improve health habits among young people.

Program

- The Hawaii Departments of Health and Education, funded by the Centers for Disease Control and Prevention and Tobacco Settlement Funds, meet quarterly to jointly develop programming and workgroup opportunities related to the eight components of coordinated school health: health services; health education; healthy physical and social environments; nutrition services; physical education and other physical activity; counseling, psychological, and social services; health programs for faculty and staff; and collaborative efforts of schools, families, and communities.
- A Safety and Wellbeing Survey is being developed to monitor wellness policy implementation in all schools and provide information related to the annual trend report for each school which is required by state law (pending approval by the Board of Education).

Impact

Results of coordinated school health efforts in selected schools throughout the state include:

- The Hana School Building Program partnership collaborated with Career and Technology Education students to build a cottage to house needed substance abuse counseling services and an enclosure with an exercise room that will be open to families.
- Waiakeawaena Elementary incorporated "Take 10" into daily lessons, linking learning activities with ten-minute physical activities to help children meet physical activity recommendations.
- Most students voluntarily take an important cancer prevention step by using sunscreen during physical education classes at Kalama Middle School since the school started providing sunscreen for student use.
- Giving YMCA youth memberships to students at Makawao Elementary increased participation in before and after school physical activity programs
- New snack policies were implemented at King Kaumualii School where now students may only bring fresh fruits and vegetables as snacks during the school day.
- Creation of a traverse climbing wall using donated supplies and labor to reduce costs

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STATES JOIN FORCES TO EXPAND COORDINATED SCHOOL HEALTH

Michigan and Indiana promote school health leadership for the benefit of students

Public Health Problem

- High school students in Indiana and Michigan engage in high rates of risk behaviors that compromise their health and academic performance, including smoking, eating unhealthy diets and getting too little physical activity.
- Coordinated school health programs give schools a framework to support students in adopting healthy behaviors.

Program

- The Indiana and Michigan Departments of Education and Health, and the Great Lakes American Cancer Society with support from the Division of Adolescent and School Health at the Centers for Disease Control and Prevention, worked together to develop the MICHIANA School Health Leadership Institute. Districts representing almost 150,000 students from about three hundred schools in the two states participated.
- District teams participated in trainings over three years, gaining knowledge and skills for successful implementation and sustainability of coordinated school health programs.
- Ongoing support and technical assistance is provided by the Indiana and Michigan Departments of Education and Health and the Great Lakes American Cancer Society.
- A second Institute will reach approximately twenty new school districts.

Partnership enabled a greater impact in each state than partners could have accomplished by themselves:

Impact in Indiana

- Receipt of over $10 million in grant funding
- Implementation of policies limiting the sale of unhealthy foods in cafeterias and vending machines in ten districts
- Passage of tobacco-free campus policies in ten districts
- Creation of dedicated staff positions dedicated in four districts
- Initiation of a school breakfast program in ten districts
- Requiring the integration of physical activity throughout every school day in kindergarten through fifth grades in ten districts

Impact in Michigan

- Receipt of over $1.6 million in grant funding
- Implementation of policies offering healthy vending choices and improving options in the cafeteria in five districts
- Passage of tobacco-free campus policies in eight districts
- Formation of eight district-wide coordinated school health councils and twenty-six building level teams
- Opening of three school-based health centers
- Implementation of the *Michigan Model for Health®* comprehensive school health education curriculum in eight districts

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CHANGING MIDDLE SCHOOL ENVIRONMENTS TO REDUCE OBESITY

Massachusetts students eat healthier, watch less television, and are more active

Public Health Problem

- Many Massachusetts middle school students are either overweight or at risk of overweight.
- Students often don't meet recommended guidelines for physical activity, many spend three to six hours a day watching television, and few eat recommended amounts of fruits and vegetables daily.
- Poor diet and being inactive and overweight can affect academic performance and contribute to early development of chronic disease such as diabetes.

Program

- The Massachusetts Department of Public Health and Blue Cross Blue Shield partnered to develop *Healthy Choices*, a nutrition and physical activity program for middle schools.
- Schools receiving a *Healthy Choices* grant are required to: (a) implement *Plant Health*, an evidence-based nutrition and physical activity curriculum aligned with the Massachusetts Department of Education Curriculum Framework; (b) implement the CDC School Health Index, a tool that helps schools improve nutrition and physical activity policies, (c) offer a before- or after-school program that provides opportunities for physical activity and hands-on nutrition education; and (d) promote the 5-2-1-0 message throughout the school (eat five or more servings of fruits and vegetables, watch no more than two hours of television, get at least one hour of physical activity every day and use no tobacco).
- *Healthy Choices* coordinators based in the Department of Public Health's regional offices provide training, resources and ongoing support to teams of parents, community members and school staff who plan the program for each school.

Impact

- Individual students in *Healthy Choices* schools report eating more fruits and vegetables, participating in more physical activity and watching less television every day – important steps for achieving and maintaining a healthy weight.
- Over one hundred public middle schools provide the *Healthy Choices* program to more than 75,000 students with school changes such as adding healthier items to school lunches, improving the snacks and beverages in school vending machines, and implementing before- or after-school programs that increase opportunities for students to be active and to develop healthy eating habits.
- Tobacco messages were added in collaboration with the health department's tobacco program in ten pilot sites and will be evaluated as the program progresses.
- Program sustainability is enhanced through funds and training supplied by partners such as the Massachusetts Department of Education, by engaging decision-makers in schools as part of an advisory group, and by expanding to upper elementary grades.

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MARYLAND WORKS: WELLNESS PROGRAMS MOTIVATE CHANGE

Mini-grants to local health departments jump-start employee physical activity and healthy eating

Public Health Problem

- Active adults who eat a healthy diet and maintain a healthy weight derive many benefits for themselves and their employers, including lower health care costs, less absenteeism, better quality of life and higher productivity.
- Adults spend a large part of their day at work making this an important site for reaching them with tested wellness programs that promote healthy lifestyle behaviors.
- With healthy eating and regular physical activity people are more likely to achieve and maintain a healthy weight.

Program

- The Maryland Department of Health and Mental Hygiene Obesity Prevention Program, funded by the Centers for Disease Control and Prevention, awarded small grants to seven local health departments to implement workplace wellness programs with the goal of increasing fruit & vegetable intake and daily physical activity of employees.
- Tested wellness programs were implemented, including *Active for Life, Take Action*, the *America on the Move* walking challenge, an on-site *Weight Watchers* class and others. Programs included various activities, for example physical activity or fruit & vegetable team challenges, incentives for participation, educational sessions, personal goal-setting, promotional email messages, changes in vending machine items, policies for foods served at meetings and often an administrative directive to allow physical activity breaks during the workday.

Impact

- Positive results of the seven wellness programs include:
  - Participants increased their physical activity, are eating more fruits and vegetables or are achieving a healthier weight because of the interventions at a number of sites.
  - A permanent walking group formed at one site.
  - More than a third of participants in another site maintained changes in diet even three months after the nutrition phase of the program.
  - An existing wellness committee has developed a renewed focus & more members.
- Individual workers reported:
  - A weight loss of twenty-four pounds which helped this worker lower her blood sugar level. She continues to work at losing her excess weight with support from co-workers and the daily walk break encouraged by her employer.
  - Another worker says "she can't wait until its time for her afternoon walk" each day.

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SCHOOL HEALTH COORDINATORS MAKE AN IMPACT

Evaluation shows schools have improved nutrition, physical activity, and tobacco policies

Public Health Problem

- Many Maine students don't eat recommended amounts of fruits and vegetables daily or reach recommended levels for physical activity. About a quarter of high school students are obese or overweight and over twenty percent of them use tobacco.
- Promoting healthy eating, physical activity, and tobacco cessation through better school health policies and practices improves the outlook for prevention of chronic diseases caused by poor health habits.

Program

- Forty-two school health coordinators have been funded in Maine schools as part of a statewide network of community and schools coalitions known as Healthy Maine Partnerships. Coordinators are responsible for implementing the Maine Coordinated School Health Programs (CSHP) initiative, a joint collaboration between the Maine Departments of Education and Health and Human Services to improve school health programs, policies, and services.
- Researchers from the Maine-Harvard Prevention Research Center evaluated the changes in policies and individual health behaviors occurring in local education agencies comparing those with funded school health coordinators to those without coordinators.
- The evaluation was made possible through funding from the Centers for Disease Control and Prevention Division of Adolescent and School Health and from Maine's Tobacco Settlement monies as part of CSHP collaboration with the Healthy Maine Partnerships.

Impact

Results from local education agencies *with* school health coordinators:

- Increased time for regular physical activity for K-8 students in more than seventy-five percent of local education agencies
- Increased walking and fitness programs for school staff and community members
- Implementation of policy changes that improved more than one aspect of school nutrition, such as eliminating soft drinks and other foods of minimal nutritional value from vending machines in all districts
- Passage of tobacco-free school campus policies in all districts
- Leveraging of additional resources for improving school health, including more than five million dollars for physical activity and nutrition programs
- Greater likelihood of having physical activity intramural offerings, improved nutrition offerings, and tobacco cessation programs
- Decreased soda consumption, decreased tobacco use, and less inactivity.

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MAKING STATE EMPLOYEE WELLNESS A PRIORITY

North Carolina creates low-cost wellness programs that reduce chronic disease risk factors

Public Health Problem

- Employee wellness programs can reduce sick leave, increase productivity and cut health care costs for employers.
- North Carolina is experiencing an alarming increase in the number of state employees treated for chronic diseases and a decrease in the number of healthy members of the North Carolina State Health Plan.
- Plan members with a chronic disease average more than nine times the health care costs per year as healthy members.

Program

- North Carolina Department of Health and Human Services partnered with the North Carolina State Health Plan to create a worksite wellness program for all 18,700 employees in the department to serve as a model for all state government agencies.
- The model wellness infrastructure developed includes a department-level wellness director position providing oversight, designated Wellness Representatives serving as the main agency contacts for the initiative, a department level wellness council to advise senior leadership on wellness policy a department level wellness council to advise senior leadership on wellness policy, and wellness committees and wellness plans within each agency.
- Funding for the project was jointly provided by the State Health Plan for State Employees and Teachers and the Division of Public Health through its Public Health and Health Services Block Grant appropriation.

Impact

After one year of minimal-cost operation, these improvements were reported:

- Sites with healthy vending options doubled and state Services for the Blind vending contracts now require healthier snack options
- Tobacco cessation programs greatly increased
- Worksites with indoor fitness areas increased
- Stress management programs more than doubled
- Over half of all employees report participating in one or more worksite wellness activities
- Employees reported exercising more often, choosing healthier foods, eating more fruits and vegetables, moving closer to a healthier weight, and reducing or eliminating tobacco use.
- More employees participating in worksite wellness activities reported positive behavior changes than non-participants.
- The Department of Health and Human Services' identification of state laws and regulations that prohibited some essential components of effective wellness programs played a key role in the development of a new Office of State Personnel worksite wellness policy that will be implemented in all state agencies and universities.

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NORTH DAKOTA'S SCHOOL GREENHOUSE/ GARDEN PROJECT

Fresh fruits and vegetables for the school lunch program and the community

Public Health Problem

- Students in North Dakota are not eating recommended amounts of vegetables and fruits or getting recommended amounts of physical activity for good health.
- Unhealthy diet and inadequate physical activity contribute to death and disability from obesity, high blood pressure, diabetes and other chronic diseases.
- Establishing good health habits in youth can prevent health problems now and in the future.
- Making fruits and vegetables available to students in ways that encourage consumption is a good strategy for increasing the intake of these foods in student's diets. Gardening also provides a physical activity opportunity that encourages participation.

Program

- The North Dakota Green and Growing Collaborative includes the North Dakota Departments of Public Instruction, Agriculture and Health, North Dakota Career and Technical Education, North Dakota State University Extension Service, and 5 + 5 Communities.
- North Dakota Department of Public Instruction, Coordinated School Health program funded by the Centers for Disease Control and Prevention, Division of Adolescent and School Health, supports many programs in schools that emphasize healthy eating and physical activity. They partially funded the Collaborative effort to pilot garden projects in two North Dakota schools, adding healthy eating and physical activity opportunities to the school day. Additional funds were leveraged from Department of Agriculture farmer's market funds, community grants, and donations.
- Students, staff, and community members work cooperatively at school to prepare the garden site, tend the crops, harvest, and serve the produce. Existing greenhouses at school are used to start plants for the garden, extending the project through most of the school year.

Impact

- Garden produce such as tomatoes, cucumbers, peppers, and radishes appear on the school salad bar and pride in their product encourages student consumption. Produce is also frozen for use in school meals or is donated to the community food pantry.
- Schools use the garden project to teach science and math skills enhancing academics, and allow students to give back to their community through the food pantry, making healthy eating and physical activity appealing behaviors that are more likely to be adopted.
- The garden project will expand to at least three additional schools next year and participating schools will find ways to increase consumption and market their products.

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GET UP AND GET MOVING! WITH PRESCRIPTION TRAILS

Encouraging physical activity with health care provider "prescriptions" and trail guides

Public Health Problem

- Rates of obesity and related chronic diseases such as diabetes are high in New Mexico.
- Physical activity helps people stay at a healthy weight or lose weight slowly, if needed. It also helps people with diabetes keep their blood sugar in a normal range.
- People comply more readily with a physical activity recommendation if it comes from their health care provider; mapping trail and walking routes is also likely to increase their use.

Program

- A group of partners developed the Albuquerque Prescription Trails Pilot Program which provides a prescription tool on walking and wheelchair rolling for health care practitioners to give to patients along with a guide to suggested routes in the local community. Partners include the Albuquerque Alliance for Active Living, New Mexico Health Care Takes On Diabetes, New Mexico Diabetes Prevention and Control Program, City of Albuquerque, National Park Service, PRISM Evaluation, and a number of health plans.
- The program is partially funded by the Centers for Disease Control and Prevention as well as substantial in-kind support from the partners. Information about existing trails can be found at: http://www.cabq.gov/parks/prescription-trails
- Several Albuquerque clinics piloted the program. An evaluation of the providers in the pilot showed they needed more information on risk factors and physical activity guidelines and motivational techniques to use with patients. Patients wanted more trails to easily access, bad weather activity options, safety information and a Spanish language version of the trail guide.

Impact

- Providers are now able to give specific recommendations about the benefits of walking and can guide patients to available walking routes, making it more likely that "prescriptions" will be followed.
- The partners are seeking funding to expand the program to the City of Santa Fe, continue the program in the Albuquerque area, do a comprehensive evaluation of both the provider and patient outcomes and revise Prescription Trails based on pilot evaluation results.
- As one provider describes the benefit, "I can give you medicine that will treat one condition and cost money or I can give you a prescription for physical activity that will help prevent a whole range of diseases, is free, and will last a lifetime."

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SYRACUSE SCHOOLS DELIVER HEALTH TO STUDENTS, STAFF AND FACULTY

Assessment of school environments leads district schools to take steps toward wellness

Public Health Problem

- Onondaga County is the site of the Syracuse City School District which is the largest district in central New York. About two thirds of county residents are overweight or obese.
- Like other parts of the country, many students here have poor eating and activity habits contributing to the risk of becoming obese and developing chronic conditions such as high blood pressure and diabetes.
- Good eating and activity habits supported by a healthy school environment help students stay healthy now and in the future and prepare them to reach their academic potential.

Program

- A district-wide Wellness Advisory Committee met to plan improvements in the schools of the Syracuse City School District which has a population of over 22,000 students.
- This committee of school leaders, administrators, teachers, students, parents and community representatives planned an assessment of district school environments using the School Health Index developed by the Centers for Disease Control and Prevention and recommended policy changes.
- An outside consultant compiled a district-side analysis of the assessment results.

Impact

- This initiative leveraged $100,000 in additional funding from The Buffalo Community Health Foundation to support a wellness facilitator position to coordinate implementation of comprehensive school district wellness policies, to provide individual assistance to schools and to buy Fitnessgram software and a server for district-wide availability of student fitness tracking.
- Almost all district schools completed the School Health Assessment and have taken steps toward wellness, including:
  - Implementation of the Take 10! classroom-based physical activity program, bringing movement into the academic setting as a part of language arts, math, social studies, science, and health classes
  - Formation of individual school wellness committees in all schools
  - Display of nutrition information in school cafeterias and other areas of district schools
  - Development and district-wide distribution of a Wellness Toolkit and guidelines for healthy classroom snacks
  - Development of a wellness newsletter highlighting individual school accomplishments

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CITY OFFICIALS ADOPT 'SAFE ROUTES FOR SENIORS' AS PRIORITY

Making design changes in city streets supports walking for health and transportation

Public Health Problem

- Walking is an easy, low cost way for seniors and others to get daily physical activity.
- Seniors are a vulnerable pedestrian group, representing about a third of New York City's pedestrian injuries and fatalities although they are only thirteen percent of the city's population.
- Over the next twenty years the city will experience a large increase in the population of older adult residents.
- Creating safer streets makes it possible for city-dwelling seniors and others to be physically active, important for promoting a healthy heart, reducing the risk of obesity, and improving quality of life.

Program

- Transportation Alternatives, an advocacy group, started the Safe Routes for Seniors campaign with a grant from the New York State Department of Health to achieve two goals: encouraging older adults to walk more by improving their neighborhood pedestrian environment and reducing senior pedestrian injuries and fatalities.
- Meetings with local partners in nine city communities elicited ideas from seniors on improving their streets and guiding senior residents in documenting dangerous conditions using maps, measuring wheels, stop watches and disposable cameras.
- Four neighborhoods held design workshops where senior citizens had the opportunity to collaborate with urban planners to draft short and long term proposals to enhance safety and "walkability" at priority locations.
- Transportation Alternatives works with local elected officials, coalitions and senior residents to bolster community support for these proposals.

Impact

- This program has taken a major, unaddressed quality of life issue for senior citizens and made it a priority for the Mayor, City Council Chairman and Department of Transportation Commissioner. Results include:
  - Improved infrastructure including new curb-cut ramps, stop bars, a pedestrian park, signal timing changes, as well as lighting at a dangerous corner and one street closure
  - Development of the "Age Friendly New York" Initiative which will create a blueprint for transportation and pedestrian safety for senior citizens, announced by the City Council Speaker and New York Academy of Medicine
  - Creation of the mayor's "All Ages Project" to bring street improvements to twenty-five areas where seniors have been involved in a large number of pedestrian accidents.
  - Development of the Elder District Policy to educate legislators on improving streets for seniors and funding these improvements on a citywide scale

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WORKSITE WELLNESS – A WORTHWHILE INVESTMENT

Workplace programs improve blood pressure, diet and weight profiles of employees

Public Health Problem

- Four of the top ten most expensive health conditions to U.S. employers are related to heart disease and stroke.
- Adults spend many waking hours at work which makes the workplace environment integral to achieving a healthy lifestyle to prevent heart disease and stroke.
- Supportive environments that help workers control weight, eat a healthy diet and become more physically active can reduce absenteeism and health care costs and improve quality of life.

Program

- St. Vincent's Hospital Healthy Heart Program, with funding from the New York State Healthy Heart Program, worked with employers in New York, Kings, Queens and Richmond counties to create worksite wellness programs and increase opportunities for physical activity and access to healthy food at worksites for twenty-four thousand employees.
- Worksites formed wellness committees or chose a wellness coordinator before initiating programs. Programs were selected based on employee interest and worksite capabilities and included such innovative activities as on-site physical activity, blood pressure self-monitoring, subsidized intramural sports, and access to fresh produce through community-supported agriculture groups.

Impact

- Results from a sample of worksites shows:
  - Two companies negotiated discounts from insurance providers as a direct result of participation in this program.
  - A worksite weight management program resulted in almost all participants losing weight and most reporting they were eating more fruits and vegetables.
  - One site reported a significant ten-point decrease in average blood pressure of participants after one year of a self-monitoring program.
  - Most workers buying a share in community-supported agriculture for the first time reported an increase in fruit and vegetable intake as a result.
  - Two sites credit their worksite wellness program with sparing an employee serious injury because of their immediate action to seek emergency care when extremely high blood pressure was detected as part of their blood pressure monitoring program.
- Wellness coordinators shared: "Many participants lost weight, are feeling better about themselves, developed friendships, starting eating healthy …and are drinking more water and sharing fruit instead of cake in the lunch room…."

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ROCK ON CAFÉ PROVIDES HEALTHIER SCHOOL MENU CHOICES

Students test menu items for acceptability and nurses answer questions from parents

Public Health Problem

- Rates of overweight and obesity among New York children are rising.
- About one fourth of overweight children already have at least one risk factor for heart disease such as high blood pressure or high blood cholesterol.
- Eating healthier can help reduce children's risk factors but the choices offered at school may not support their efforts to eat a better diet.

Program

- The New York State Department of Health, Healthy Heart Program, funds the Health Education Awareness Resource Team, which formed a coalition of food service directors from twelve school districts to develop healthy-choices menus for kindergarten through fifth grade students in thirty-nine district elementary schools in Broome and Tioga Counties.
- These menus, identified by a "Rock on Café" logo for increased recognition, provide healthier choices while supporting tastiness, quality, and good nutrition.
- Components of the Rock on Café promotion include student-testing of all recipes or products before they are introduced in the cafeteria, newspaper ads, local magazine articles, stickers with the Rock on Café logo for packaged foods, and a student reading of the day's menu on local television.
- To help parents understand the changes in school menus United Health Services provides access to Nurse Direct at the Stay Healthy Center, a nurse-staffed service which has information about the school cafeteria changes and can add families to their Stay Healthy Kids program.

Impact

- Healthier food options are reaching 15,000 students including salads, low-fat American cheese, whole grain breads and rolls, and "French fry" products that are baked and trans fat-free. New recipes and products are introduced gradually and have been well received.
- Using a consistent menu across district schools saves money by allowing schools to benefit from volume discounts on foods they buy.
- Schools experienced a three percent increase in sales, contributing to an improved financial picture for their food service operation.
- A computer-assisted Stay Healthy Kids program was developed and is available to parents.
- High schools are a planned addition to the healthier menu program.

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RESIDENTS 'HUNT' FOR MORE WALKABLE COMMUNITIES

Assessing community walking routes helps identify important improvements

Public Health Problem

- Increasing physical activity reduces the risk of developing heart disease and other serious chronic diseases and helps people achieve and maintain a healthy weight.
- People who live in communities where there are sidewalks and destinations for walking trips such as stores and libraries walk more than people in communities without these benefits.
- Walking also improves the environment when walking trips replace car trips. Walking saves gas, reduces pollution and traffic, and increases social contact – all benefits to the community.

Program

- The Warren-Washington County Healthy Heart Program is funded by the New York State Health Department Healthy Heart Program to reduce the risk factors for heart disease and stroke in their community.
- To increase awareness among community residents about the benefits and considerations of a walkable neighborhood in nine communities in two counties, the program held twelve scavenger hunts. Organizing committees in each community included public officials, business owners and walking advocates.
- Hundreds of resident participants followed a map detailing a local walking route, completed walkability checklists, and identified improvements that would make walking routes better, safer and more pleasant.
- The list of identified improvements was shared with local decision makers and the organizing committees who worked to make the changes happen.

Impact

These walking improvements occurred in Warren County and Washington County:

- Almost five hundred thousand dollars in transportation projects are improving walkability in Whitehall and Glens Falls, including correction of poorly placed school warning signs, crosswalks and curb cuts in the latter site
- A walkway was installed along the Champlain River in Whitehall
- The Carol A. Thomas walking trail was established in North Creek
- A reconstruction project in Fort Edward includes new sidewalks, curb cuts and crosswalk improvements
- Stony Creek officials requested a new four way stop with a crosswalk at town center
- A ten percent increase in walkers along mapped walking routes occurred in nine communities conducting trail counts

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COUNTY EMPLOYEES WALK ACROSS AMERICA TO GET HEALTHY

Workers choose healthier snacks, learn about healthy lifestyle and start walking

Public Health Problem

- Two major risk factors for developing heart disease and stroke are lack of physical activity and unhealthy eating habits.
- Staff at the Wyoming County, New York, Department of Social Services decided that the snacks they consumed at work and some of their other health habits were contributing to an increased risk for heart disease and stroke.

Program

- With funding from the New York State Health Department, Healthy Heart Program, the Wyoming County Health Department worked with the local Department of Social Services to organize a wellness committee, create a bulletin board exhibit featuring health information, and begin a walking program.
- Workers replaced unhealthy snacks with more fruits and vegetables, installed a water cooler to encourage less soda and high-calorie beverage consumption and began having regular "salad days" where employees brought in components for a group salad.
- Many employees also participate in "Walk Across America" teams, walking distances equivalent to the distance from the east to west coast of the U.S.A.

Impact

- Sixty-four employees participating in the walking program collectively lost over three hundred pounds, lowered their cholesterol levels and walked the equivalent of well over twenty-five hundred miles.
- Many participants lowered their blood pressure or maintained a normal blood pressure.
- Employees enjoyed health benefits and plan to make these changes a permanent part of their lives.
- There is also improvement in office morale which staff summed up as, "it's good because it gets almost the whole office involved …….we made it fun."

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ENHANCING OPPORTUNITIES TO IMPROVE STUDENT HEALTH

Making fruits and vegetables available and appealing promotes adoption of a healthy behavior

Public Health Problem

- Ten percent of teens in Jefferson County, New York are obese.
- Eating generous amounts of fruits and vegetables is related to maintaining a healthy weight and reducing the risk of developing chronic disease.
- Few Jefferson County teens eat recommended amounts of fruits and vegetables every day.
- Making fruits and vegetables appealing and available at school provides opportunities for students to practice healthy behaviors and increases the likelihood that students will continue this healthy behavior into adulthood.

Program

- Steps to a HealthierNY partners with Cornell Cooperative Extension, a program with a wide range of resources focused on agriculture, to facilitate bringing produce directly from farms to schools.
- The partners linked New York farmers with specific schools and provided training and technical assistance to farmers and food service directors on ways to work together to enhance the school food environment where now over 4500 children are exposed to fresh local grown produce in their schools. Farmers also talked to students in their classrooms about the many aspects of growing food.
- The partnership took advantage of changes in New York law which enabled direct sales of fruits and vegetables to schools.

Impact

- There was an increase in the number of Jefferson County schools providing fresh, locally grown fruits and vegetables at school; making it more likely that students can meet health recommendations for fruit and vegetable consumption. More than 6,000 pounds of local produce were purchased over nine months.
- Educational messages in the cafeteria teach students about eating more fruits and vegetables and give them a greater awareness of the sources of the food they eat and the importance of local agriculture. Several schools were helped by this partnership to meet the requirements of their wellness policy created under USDA mandate.
- Small and mid-sized farms and the local economy benefit from an assured market for local produce and students benefit from the access to fresh, local food.

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LOWERING HEALTH CARE INSURANCE COSTS FOR SCHOOL EMPLOYEES

Steps to a HealthierNY – Jefferson County promotes wellness among school staff

Public Health Problem

- Employees participating in comprehensive work site wellness programs are absent from work less often, have lower health care costs and fewer work-related injuries.
- The Health Insurance Trust which pays the heath care expenses of Jefferson County school employees and retirees was experiencing rising costs. Funding difficulties were predicted, primarily due to increasing costs related to chronic diseases.
- Few Jefferson County adults eat recommended amounts of fruits and vegetables and less than two-thirds report being physically active. Over two-thirds of them are overweight or obese. All of these factors contribute to the development of chronic diseases like diabetes and heart attack which raise health care costs and reduce quality of life.

Program

- The Steps Program in Jefferson County partnered with a rural school district to establish a School Health Advisory Committee. An assessment of district schools using the School Health Index, an effective tool for establishing needed health policies and practices, revealed staff wellness as an area in need of improvement and facilitated the development of an action plan for district school wellness program implementation.
- School employee health promotion interventions over two years included after-hours walking groups, classes on healthy eating, and a full day devoted to staff health and wellness, courtesy of the Board of Education, as well as other activities.

Impact

- The success of the school employee wellness program allowed the Board of Education to waive one month of insurance premiums for all employees, a total of almost $300,000 in savings.
- Over one hundred district employees have lost a total of 430 pounds.
- There is a documented decrease in expenditures by the district's self-funded health care plan, the Health Insurance Trust and now its funding is at its highest level ever.

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PROMOTING PHYSICAL ACTIVITY IN THE CLASSROOM

Encouraging academic achievement and reducing the likelihood of weight gain

Public Health Problem

- About one fourth of Rockland County students are overweight or at risk for overweight.
- Most Rockland County high school students do not have physical education classes daily and only a little more than a third of them get regular physical activity in recommended amounts.
- A school environment that promotes physical activity can help students prevent overweight and obesity that can lead to diabetes and high blood pressure, serious health conditions that are being diagnosed more often in U.S. youth.
- Creating and sustaining a healthy school environment is achieved when teachers support the process by promoting physical activity and other healthy behaviors in the classroom.

Program

- Steps to a HealthierNY–Rockland County launched *Learning in Motion: Physical Activity, the Brain, and Achievement*, an innovative curriculum integrating physical activity into classroom lessons on language arts, math, social studies, science, and health.
- Teachers are trained to apply tested, interactive lessons using movement to improve learning and memory, address student learning style, and add physical activity.
- The Learning in Motion curriculum helps reduce sedentary behavior during the school day, enhances students' understanding of subject matter content, and promotes development of life-long healthy behaviors.
- More than one hundred teachers in nine Rockland County school districts have been trained to incorporate physical activity into daily lessons.

Impact

- Almost all teachers in a follow-up survey say they now use physical activity in the classroom several times a week and most are including it daily or several times a day.
- Students report feeling more energized, having better self-esteem, and being more alert during classes. Learning in Motion plays a role in enhancing academic performance while promoting healthy behaviors that can reduce risk factors for student overweight and obesity.

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AFFORDABLE, ACCESSIBLE FRUITS AND VEGETABLES FOR NEIGHBORHOODS

Mobile van increases food security and healthy food choices for low income residents

Public Health Problem

- Obesity and overweight are more common among people with low income.
- Substituting fruits and vegetables for higher energy-density foods, such as those high in fat and added sugars, is a useful weight management strategy.
- People who live in neighborhoods where a long bus trip is the only way to get to the nearest grocery store often don't include fruits and vegetables in their daily diets.
- Increasing access to fruits and vegetables is a strategy supported by the Centers for Disease Control and Prevention Nutrition, Physical Activity and Obesity Program for states.

Program

- Capital District Community Gardens, with funding provided by a grant from the New York State Department of Health Hunger Prevention and Nutrition Program launched a mobile market project in a box truck with refrigerators and shelves displaying fruits and vegetables for sale. Additional funds are being raised from donors throughout the region served by this project.
- The Veggie Mobile makes regularly-scheduled, one hour stops to sell nutritious fruits and vegetables at assisted living centers, public housing projects and other densely-populated locations in Albany, Schenectady, and Troy, in underserved neighborhoods.
- Once a week the Taste & Take program provides hundreds of residents from public housing a taste of a different fruit or vegetable and a free share of selected fresh produce.
- Volunteers perform a variety of tasks necessary to keep this mobile market running smoothly.

Impact

- The Veggie Mobile provides greater food security and fills a critical gap in area cities – a lack of grocery stores selling affordable fresh produce.
- Making fruits and vegetables more affordable and accessible to low-income city residents helps achieve several state and federal health objectives:
  - a Healthy People 2010 health objective for the nation on eating more fruits & vegetables
  - an objective of the New York State Strategic Plan for Overweight and Obesity Prevention to increase fruit and vegetable consumption and increase food security among state households
  - a goal of the Hunger Prevention & Nutrition Assistance Program to increase access to safe and nutritious food and related resources
- Eating generous amounts of fruits and vegetables as part of a healthful diet is also likely to reduce the risk of developing chronic diseases such as diabetes and heart disease.

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KEYSTONE HEALTHY ZONE MAKES SCHOOLS A HEALTHY PLACE

Coalition promotes healthy eating and physical activity across the state

Public Health Problem

- The percentage of overweight youth in Pennsylvania is slightly higher than the national average and childhood overweight is increasing.
- Overweight children have higher rates of type 2 diabetes, high blood pressure, bone and joint problems and are more likely to suffer discrimination and low self-esteem.
- Changing school policies related to recess, physical education, after school programs, and meals and snacks helps students achieve and maintain a healthy weight.

Program

- The *Keystone Healthy Zone* Schools Program, supported by Pennsylvania Department of Health, recognizes and rewards schools for making a commitment to healthier food choices and physical activity.
- The free program provides training, resources, technical assistance and mini-grant funding for schools to enable positive change in school policies and the school environment. Action Kits for Change are available to all schools.
- Over 1000 schools are enrolled and have completed an online assessment of their school.
- The *Keystone* web site gives many examples of specific school activities. At Jeannette McKee Elementary/Middle School, for example, students keep track of their "walk" across the state on pedometers that track each step walked – in math class they convert steps walked to miles traveled and in social studies class they learn about the state landmarks they'll "pass" along the way. (Information at: www.panaonline.org/programs/khz/)

Impact

- Keystone activities help schools meet federally mandated school wellness policy requirements for the 2006 school year.
- Over a single year of the program:
  - The number of schools creating a School Health Council almost doubled
  - The number of schools creating policies on foods and beverages increased thirty-five percent
  - The number of schools creating encouraging students to participate in before-school and after-school physical activity programs improved by thirty percent
  - Working to correct hazardous walking conditions within a mile of the school increased by almost fifty percent, contributing to safer routes to school.

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FROM THE FARM TO THE CITY – VEGGIES AND FRUITS FOR BETTER HEALTH

Urban market brings fresh produce to office workers and retirement community

Public Health Problem

- Few South Carolina adults eat even the minimum amount of fruits and vegetables recommended for good health.
- Making healthy foods more accessible is an important strategy for helping people achieve and maintain a healthy weight and for reducing rates of chronic diseases such as cancer and heart disease.

Program

- The Centers for Disease Control and Prevention's (CDC) Preventive Health and Health Services Block Grant made it possible for the South Carolina Department of Health and Environmental Control to increase access to healthy foods through farmers markets by partnering with the Seeds of Hope Farmers Market program. This program organizes markets which offer local farm products in an urban setting.
- A weekly market was established in the parking lot of a busy office block with a retirement community nearby, giving office workers and senior citizens access to farm-fresh produce.
- Recipes featuring vegetables and fruits offered at the market were distributed free of charge, as well as information on other farmers markets in South Carolina. A weekly drawing for a free canvas tote bag bearing the "Fruits and Veggies-More Matters®" logo provided additional incentive for patronizing the market and reinforced the latest health messages related to eating vegetables and fruits.
- Every Thursday morning for seven weeks, an independent farmer rose before dawn and loaded his white pickup truck with blueberries, butter beans, honeydew melon, collard greens, zucchini, and other farm-fresh vegetables and fruits and made the trip from rural South Carolina to sell seasonal vegetables and fruits to consumers in Columbia.

Impact

- The market attracted up to two hundred people in a single morning, with the average money spent per person totaling around nine dollars, even though patrons considered prices low.
- A survey of market shoppers shows that more than half of them felt they ate more vegetables and fruits since shopping at the market.
- The market provided a place to redeem the Senior Farmers Market vouchers that many residents of the nearby retirement community had been given, complementing this Department of Agriculture program.

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BREASTFEEDING WELCOME HERE!

State employees make their workplace breastfeeding-friendly so mothers can continue to provide baby's best food

Public Health Problem

- South Carolina promotes breastfeeding as a strategy to prevent obesity and chronic diseases like diabetes.
- The longer the duration of breastfeeding the less likely a child will be overweight or develop diabetes. Benefits of breastfeeding for mothers include decreased risk of breast and ovarian cancer as well as diabetes.
- Mothers are the fastest growing segment of the US workforce and working mothers who want to breastfeed their child face many barriers.
- Establishing workplace policies and supportive workplace environments are recommended strategies for increasing breastfeeding. Other recommended strategies include "baby-friendly" maternity practices, educating mothers, and peer and professional support for breastfeeding.

Program

- Knowing that mothers who continue breastfeeding after returning to work need a "friendly environment", including the support of their coworkers, supervisors, and others, the Bureau of Community Health and Chronic Disease Prevention offered space in their building to establish a lactation room.
- A storage closet was identified as the only available space and staff from the Division of Obesity Prevention and Control led renovation efforts along with other staff from the Bureau of Community Health and Chronic Disease Prevention, all working on their own time.
- These committed employees supplied furniture and other needed items, bought a refrigerator for storing breast milk, and transformed a tiny closet into a comfortable "Mothers Lounge."

Impact

- At a ribbon-cutting ceremony celebrating the new Mother's Lounge, invited guests from the South Carolina Breastfeeding Coalition, the African-American Breastfeeding Alliance, along with the deputy health commissioner, the agency personnel director, and others observed a first-hand example of reducing the barriers related to this important obesity prevention strategy – breastfeeding promotion.
- The Mothers Lounge is strongly supported by new mothers, mothers-to-be, and co-workers in the building, who carry the message about the importance of breastfeeding to others in the community.

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PARTNERS TEAM UP FOR HEALTHIER YOUTH IN SOUTH CAROLINA

Resulting new policies and practices set students on the path to lifelong good health

Public Health Problem

- Too many South Carolina youth are overweight or at risk for becoming overweight.
- Almost two thirds of students don't get recommended amounts of physical activity or physical education time at school, and most don't eat enough fruits and vegetables.

Program

- Coordinated school health programs help students become more physically active and eat a healthier diet – important steps toward healthy weight and lifelong prevention of chronic disease.
- South Carolina Healthy Schools, the state's coordinated school health program funded by the Centers for Disease Control and Prevention Division of Adolescent and School Health, conducts training, gives grants to local schools, and provides technical support to build school capacity to promote healthy behaviors.
- In one example of successful school efforts, South Carolina Healthy Schools worked with Anderson Partners for a Healthy Community and Anderson Medical Center to establish coordinated school health teams in every school in Anderson County, a school system serving about thirty thousand students.
- Forty-seven school health teams were established, almost all teams have been trained, and teams made plans for school health improvement using the School Health Index and developing a system to document and track their efforts.
- Pilot funding for the initiative was provided by grants from South Carolina Healthy Schools, Anderson Medical Center, and the Duke Endowment Foundation. South Carolina Healthy Schools provided technical support and professional development to school health teams as well as staff of Anderson Partners for a Healthy Community.

Impact

Schools in Anderson County have adopted many new health-promoting practices, such as:

- Adopting policies to ensure that healthy items are offered in school vending machines.
- Increasing physical activity opportunities available to students, faculty, and staff, including walking tracks and nature trails, aerobics, yoga, running and walking programs.
- Implementing an evidence-based health education curriculum.
- Eliminating fried foods, offering more fruits and vegetables and providing breakfast in the classroom.
- Creating a new student reward system that offers healthy food options and non-food rewards.
- The Anderson County School District now has thirty percent more school nurses who were initially supported with Partnership funds and are now entirely sustained with district funds.

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SOUTH CAROLINA CHURCHES TAKE STEPS TO PREVENT CHRONIC DISEASE

Faith-based health initiative to reduce health disparities, death rates among African Americans

Public Health Problem

- Heart disease, stroke, and cancer are major causes of death in South Carolina.
- African Americans are more likely to die early from heart disease, stroke, and cancer and have a life expectancy ten years less than the average South Carolina resident.
- For the African American community, churches are an important partner for public health efforts directed at chronic disease prevention.

Program

- The South Carolina Department of Health and Environmental Control used PHHS Block Grant and J. Marion Sims foundation funding to implement *Healthy and Whole*, a church health initiative to reduce premature death from chronic disease.
- Education and awareness programs reach African American adults ages 25-45 with healthy eating, physical activity and tobacco cessation strategies.
- Twenty-one participating churches formed health and wellness ministries and selected a lay health promoter from the congregation to receive training and lead the program.
- The SC Cooperative Extension Service, libraries, hospitals, and other local healthcare organizations offer lifestyle change workshops.

Impact

- All 21 churches have established rules prohibiting use of tobacco products in church.
- Ten churches have formed walking clubs and other groups to increase physical activity.
- Three churches are developing informal policies prohibiting the use of tobacco products anywhere on the church grounds.
- Several churches are increasing prostate cancer awareness and have added screening to identify prostate cancer in men age 40 and older using a grant from the South Carolina Cancer Alliance.

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ENABLING AND ENCOURAGING CHILDREN TO WALK & BIKE TO SCHOOL

Parent/school committee slows traffic, promotes safety to increase physical activity

Public Health Problem

- Children in South Carolina, as in other states, are not as physically active as they need to be for good health, contributing to the growing problem of obesity.
- Safe Routes to School programs can enhance children's health and well-being and improve air quality and quality of life in communities by promoting physical activity and easing traffic congestion near schools.
- Working together, families, neighborhood groups, schools, government officials, and community leaders can identify the issues around walking and biking to school and develop solutions.

Program

- Federal Highway Administration funds are distributed to states for Safe Routes to School activities through state departments of transportation.
- Rosewood Elementary received a $200,000 grant from the South Carolina Department of Transportation, establishing a committee of parents, teachers, school administrators and a school nurse to design and implement a comprehensive Safe Routes to School program encompassing education, encouragement, engineering, enforcement and evaluation.
- Activities include: incorporating bike and pedestrian safety information into classroom activities; distribution of safety information to students and parents; a Walk to School Day event; and increased law enforcement patrols of the streets surrounding the school.
- Future plans include: bicycle workshops to teach students bicycle safety; creating a construction plan for sidewalk improvements; crosswalks striping and school zone signage; parent & student surveys to gather opinions on the implementation; and tallies of student modes of travel to school.

Impact

- Based on parent reports, the increased patrolling of the streets surrounding Rosewood Elementary has slowed traffic and parents report increased awareness of bicyclists and pedestrians by drivers.
- Activities such as Walking Fridays have increased student interest in walking to school.
- A written plan submitted to the South Carolina Department of Transportation will describe next steps in implementing the Rosewood Elementary Safe Routes to School program.
- A local television news story about Rosewood Elementary's Safe Routes to School program reached community members with a safety and health message.

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STUDENTS TRAVEL THE WELLNESS TREASURE TRAIL TO A HEALTHIER LIFE

Elementary school students design activities to promote physical activity

Public Health Problem

- Many children in Orangeburg County, South Carolina are overweight or at risk for becoming overweight.
- Being too heavy often keeps children from participating in physical activity that would help them reach a healthy weight.
- Engaging children in the design and implementation of healthy activities makes it more likely they will participate and benefit from them.

Program

- Students at Edisto Elementary School in Orangeburg County enhanced the Wellness Treasure Trail, to promote physical activity through walking and to increase student's knowledge about healthy lifestyles.
- Funds from the Preventive Health and Health Services Block Grant enabled the school to enhance the Wellness Treasure Trail and expand their program to include educational puppet shows about the health benefits of physical activity.
- Third-grade through fifth-grade students contributed to different parts of the project, including researching and developing questions and activities posted at designated mile markers, and performing puppet shows to promote physical activity.

Impact

Examples of health impact on students over a year include:

- Increased trail usage since inception; about five hundred students walked the trail during recess and one-fifth of these reached a total of five miles walked.
- Third-grade and fourth-grade students and fifth-grade physical education students gained health-related knowledge through their research and development of questions and activities.
- Many students learned the importance of physical fitness through the puppet show.
- Edisto Elementary School will enhance the program further by paving the trail to improve safety and sponsoring regular community walks.

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TEXAS FARM TO WORK PROGRAM DELIVERS

Public and private employees can buy local, fresh produce at work, once a week

Public Health Problem

- Less than a quarter of Texas adults eat even the minimum recommended daily servings of fruits and vegetables for good health and chronic disease prevention.
- Making healthy foods easier to get can lead to healthier eating habits for adults and children.
- A key public health obesity prevention strategy recommends improving access to healthy foods among all community members, including those in worksites.

Program

- The Texas Department of State Health Services Nutrition, Physical Activity and Obesity Prevention Program, funded by the Centers for Disease Control and Prevention, worked with the department's Building Healthy Texans Employee Wellness Program and the Sustainable Food Center to create Farm to Work, an employee wellness program that provides the opportunity for employees to purchase a basket of fresh, local produce delivered at their worksite every week.
- Coordination with farmers is handled by the Sustainable Food Center, a non-profit organization that promotes healthy communities through healthy eating. Orders are prepaid through a secure server so no money is handled onsite.
- To encourage additional worksites to implement Farm to Work projects, a Farm to Work Toolkit contains all the sample documents and other resources needed to successfully implement the project developed at the Texas Department of State Health Services.

Impact

- Employees at ten Austin-area worksites and their families now have a convenient, consistent way to eat healthier.
- In just one year, nearly seventeen hundred employees participated, 82,000 pounds of fresh, local produce was delivered, and Central Texas farmers saw over $160,000 in gross sales.
- Employees save money on healthy produce – an informal comparison of the cost of the Farm to Work basket to local grocery store produce showed the grocery store produce total was more expensive than the Farm to Work produce basket.
- Employees can order on their schedule – this is not a subscription program – so it's easy for them to participate and the farmer is able to supply produce almost year round.
- Farm to Work has already spread to ten total worksites including other state agencies and private worksites in the Austin area and has the potential to be extended throughout the state.

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UTAH SCHOOLS ACHIEVE MEDALS FOR HEALTHY BEHAVIORS

Awards program honors elementary schools for establishing important wellness policies

Public Health Problem

- One quarter of Utah's school-age children are overweight or at risk of becoming overweight.
- Few elementary schools have policies that promote physical activity and good nutrition.
- Students who are physically active and make healthy food choices not only get higher test scores but are also preventing future chronic disease.

Program

- The Gold Medal Schools program works by helping schools develop strong health policies and make changes to the school environment that support good nutrition, physical activity, and tobacco prevention
- The program was developed by the Utah Department of Health using the State Office of Education's core curriculum and guidelines from the Centers for Disease Control and Prevention on overweight and obesity. Four years later Intermountain HealthCare began partnering with the Gold Medal Schools program enabling the program to expand to reach more than half of the state's elementary schools, students, faculty, and staff.
- The program's mission is to create opportunities for students to eat healthy, be active and stay tobacco-free.
- Schools can complete five levels: Bronze, Silver, Gold, Platinum and Platinum Focus. Several levels include monetary incentives that can be used to purchase physical activity, nutrition, or tobacco prevention resources. Examples of the criteria for these monetary incentives include establishing a student walking program, implementing a policy requiring 90-150 minutes of structured physical activity each week, implementing a policy for all teachers and staff requiring that food not be used as a reward or a punishment for students, and establishing faculty and staff wellness programs.

Impact

- Over 5,500 policy and environmental changes have been implemented.
- Almost seventy percent of Title 1 schools have participated.
- Almost seventy percent of all public elementary schools have participated.
- All but one school district has participated.
- GMS Power- Up, a program that extends the Gold Medal Schools program to middle/junior high schools has been developed and implemented with initial participation by ten middle/junior high schools.

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CHANGING CAMPUS STORE SNACK CHOICES TO MEET NUTRITION GUIDELINES

Legislation spurs development of standards all schools can apply to improve school foods

Public Health Problem

- Establishing healthy eating habits in youth supports learning, promotes good physical and mental health, and helps prevent chronic diseases such as obesity, diabetes and cancer.
- Many young people do not eat a diet that meets recommendations for good health.
- Setting state guidelines for school foods and applying them in individual schools improves the school food environment and supports development of student's healthy eating habits.

Program

- The Vermont Departments of Education and Health and the Agency of Agriculture, Food & Markets cooperatively developed Nutrition and Fitness Policy Guidelines in response to Act 161 of the Vermont Legislature which promotes wellness in Vermont public schools.
- Stafford Technical Center, part of the Rutland Public School System, is applying the standards in the guidance document to the sale of snacks and beverages from the campus store on the campus of Rutland High School, as well as Stafford Technical Center.
- The campus store supervisor/instructor is a member of the coordinated school health team along with the school nurse, and physical education, health and consumer science faculty. Coordinated school health is funded through the Centers for Disease Control and Prevention.
- Students are involved in making product choices based on surveys and nutrition guidelines and learn marketing skills while working in the campus store. Profits are used to enhance student educational opportunities and to improve school facilities.

Impact

- The store supervisor estimates that now at least half the choices offered in the campus store meet nutrition guidelines, due to the impact of the following changes:
  - Beverage choices now include more water, 100% juice and no-sugar-added drinks, reducing the choices that offered calories but few nutrients.
  - Baked snack chips and snack bars with less fat and fewer calories were added.
  - Snacks containing fruit, more fiber, and whole grains were added.
  - Greater variety of higher fiber snack choices is now available for purchase
  - Students showed they will buy healthy snacks if they're offered at school. Sales are estimated to be at previous levels after a brief decline.
- Snacks and beverages sold at school are now more likely to meet the nutritional needs of students.

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BUILDING HEALTHIER SCHOOLS FOR WISCONSIN

Coordinated school health programs reduce smoking, increase physical activity

Public Health Problem

- Risk behaviors for the development of chronic diseases such as diabetes and heart disease are high among Wisconsin's high school students.
- Over half of high school students don't get recommended levels of physical activity, many don't eat enough fruits and vegetables, and about twenty percent are smokers.

Program

- Wisconsin's Coordinated School Health Program supported in part through the Division of Adolescent and School Health at the Centers for Disease Control and Prevention developed initiatives to improve the health of students, their families, and school staff:
- The School Tobacco Prevention Program increased the implementation of tobacco-use prevention guidelines in Wisconsin schools, introduced new educational programs, made cessation services more available, and addressed tobacco issues among disproportionately affected youth populations.
- The *Movin' and Munchin*' Schools program helped students, families, and school staff develop lifetime skills and better physical activity and eating habits.
- The Governor's School Health Award initiated by Wisconsin's governor and the state superintendent of public instruction recognizes schools with beneficial policies, programs, and the capacity to support and promote healthy lifestyles and staff wellness.

Impact

- The smoking rate among high school students decreased by over forty percent.
- Over seven years of the *Movin' and Munchin'* Schools program an average of 25,000 students, 4,000 adults, and 3,000 teachers have reported increases in physical activity and fruit and vegetable intake every year.
- Wisconsin leveraged grant funding along with the University of Wisconsin Medical School to increase the use of evidence-based fitness testing in middle schools to improve physical education programs.
- The number of schools recognized by the Wisconsin Governor's School Health award program almost doubled and includes Richmond Elementary which was selected by *Health* magazine as one of the ten healthiest schools in the nation. The magazine considered Wisconsin's awards criteria and rating process in making its selections.

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GOT DIRT? START A GARDEN!

Partnering on a gardening initiative to increase fruit and vegetable intake and physical activity

Public Health Problem

- Physical activity and healthy diet are essential for healthy weight and the prevention of many chronic diseases.
- Enjoyable activities like gardening may be a more desirable way for some adults and children to get recommended amounts of regular physical activity.
- Vegetable gardens are a source of healthy food, too, especially in urban environments where fresh produce in stores is often scarce.
- Gardening provides physical activity opportunities and is associated with higher intakes of fruits and vegetables by gardeners related to improved availability and more positive attitudes toward these foods.

Program

- The Wisconsin Department of Health and Family Services created the Got Dirt? garden toolkit and partnered with the University of Wisconsin Extension Program to provide training and evaluate the kit's use, using funding from the University of Wisconsin School of Medicine and Public Health's Wisconsin Partnership Fund.
- Providing cold frames in three locations was a strategy used to allow schools to initiate gardens as early as the end of February so vegetables could be harvested before the end of the school year rather than just during the summer growing season.
- The majority of training attendees were either childcare providers or childcare facility owners.

Impact

- Leveraged foundation funding of almost a half million dollars.
- Increased the number of gardens in school and child care sites and increased the number of cold frame gardens used to extend the growing season in Wisconsin's northern climate.
- Provided locally-grown vegetables for school and childcare center snacks and lunches and for use in lessons, for students to take home or as food pantry donations. Garden lessons helped students learn science, math and writing.
- Additional sites and training sessions will further increase the number of gardens at childcare sites and after-school programs and will include other personnel such as chefs, kitchen staff, and parents to enhance the promotion of healthy eating and physical activity.

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IMPROVING EMPLOYEE HEALTH AND THE BOTTOM LINE

Collaborating across chronic disease programs to create healthier work environments

Public Health Problem

- Adults spend many waking hours at work.
- Making workplaces healthier helps employees live longer, healthier lives, improves productivity and reduces absenteeism and is a goal of the Wisconsin Nutrition and Physical Activity State Plan.
- Enabling businesses to change the worksite environment requires education, technical assistance and the active participation of public and business partners.

Program

- The Program Integration Workgroup of the Wisconsin Department of Health and Family Services recognized the need for worksite health interventions addressing risk factors for all chronic diseases served by state programs. They developed the *Wisconsin Worksite Wellness Resource Kit* with the Nutrition and Physical Activity Program taking the lead.
- The Comprehensive Cancer program funded a pilot test of the resource kit, revisions were made and a grant from the National Governor's Association funded coalitions to create worksite wellness programs in local businesses with an emphasis on changing policies to improve the workplace environment.

Impact

- All worksites report making changes to company policy including provision of healthy food at meetings, vending machine changes that doubled or tripled the availability of healthy food and beverage choices, health insurance discounts for healthy behaviors, flexible scheduling to increase opportunities for physical activity or breastfeeding, cash or gift incentives for healthy lifestyle behaviors, health club discounts, healthy guidelines for cafeteria food, providing bike racks, and establishing walking routes.
- Many participating employees increased their physical activity and their fruit and vegetable consumption and several sites reported overweight workers lost weight.
- Coalitions are continuing and expanding worksite wellness activities even without additional grant funds.
- Training to promote the resource kit continues with state and private sponsorship as a way to increase the number of healthy worksites.
- At least nine other states have adopted the resource kit or created an adapted version of the kit for use in their own state, saving program dollars by using a tested product.

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COLLABORATING TO IMPROVE YOUTH HEALTH THROUGH PHYSICAL ACTIVITY AND HEALTHY EATING

Public-private partnership provides successful programs in West Virginia schools

Public Health Problem

- Overweight among children six to eleven years old has more than doubled in the past 20 years making it more likely that these children will be overweight or obese as adults.
- Physical activity and healthy eating are key strategies for helping children and adults achieve and maintain a healthy weight.
- Learning and practicing healthy behaviors at school can be an easier and more effective strategy than changing unhealthy behaviors during adulthood.

Program

- The West Virginia Department of Education's Office of Healthy Schools coordinated school health program, supported by the Division of Adolescent and School Health at the Centers for Disease Control and Prevention, leveraged funding to improve school health.
- Mountain State Blue Cross Blue Shield gave $60,000 for thirteen elementary school competitive grants to implement physical activity and nutrition activities such as rollerblading nights at an elementary school, which drew enthusiastic participation from students and parents.
- The Department of Education aided in development of selection criteria and provided essential technical assistance to funded schools in implementing evidence-based programs including appropriate school lunches, healthy offerings from vending machines, and opportunities for all students to participate in physical activity in a noncompetitive environment.

Impact

- Student opportunities for physical activity were increased by building a trail to connect the Ronceverte Elementary School to the Rails-to-Trails system.
- The program leveraged two years of program funding totaling $120,000 from a non-government entity for nutrition and physical activity events to increase awareness and promote health behavior change.
- The "Challenge for Healthier Schools" partnership was recognized by West Virginia Governor Joe Manchin, III in awarding the second-year grants to the schools.
- The value of public/private partnerships to accomplish state health goals was demonstrated.

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BETTER BUSINESS AND BETTER HEALTH DOWN ON MAIN STREET

Community development and health agencies identify mutual goals and work together

Public Health Problem

- Community design influences the public's health and well being.
- Good community design incorporates features that make it possible for residents to be physically active and to buy and eat healthy food, two important public health steps for preventing obesity. For example, aesthetically pleasing environments have been shown to increase walking for exercise.
- Considering health as part of community design in existing community development initiatives multiplies the good results for community residents.

Program

- The West Virginia Bureau for Public Health's Office of Epidemiology and Health Promotion invited Main Street West Virginia, a community development initiative with a successful track record, to partner on a pilot program with the Office of Healthy Lifestyles.
- The Main Street initiative promotes local empowerment and the rebuilding of traditional commercial districts based on assets such as pedestrian-friendly environments and a sense of community.
- Office of Healthy Lifestyles grants to four participating communities enabled them to hire staff to focus attention on the mutually compatible goals of good health & good development.

Impact

- The partnership generated greater resident engagement in reaching the goals of the Office of Healthy Lifestyles, increased awareness of the health benefits of good development, and provided an additional source of funds for West Virginia communities.
- A few of the many, health-promoting community changes resulting from Main Street actions:
  - Major streetscape redesign, including lighting, benches, signage, handicap access, and improved drainage making areas safer and more pleasant for pedestrians
  - New town policies making healthy refreshments part of town celebrations & 4-H camp
  - Leveraging of additional funds from the Claude Worthington Benedum Foundation and from Safe Routes to School
  - Maintenance of a city herb garden and educational seminars for school children
  - Creation of a community walking/nutrition program and "cooking healthy" program
  - Worksite changes including offering more comprehensive health benefits, allowing physical activity breaks
  - Renovations to create a circuit training program; skateboard facility and recreation center
  - Donated local newspaper space used to promote walking

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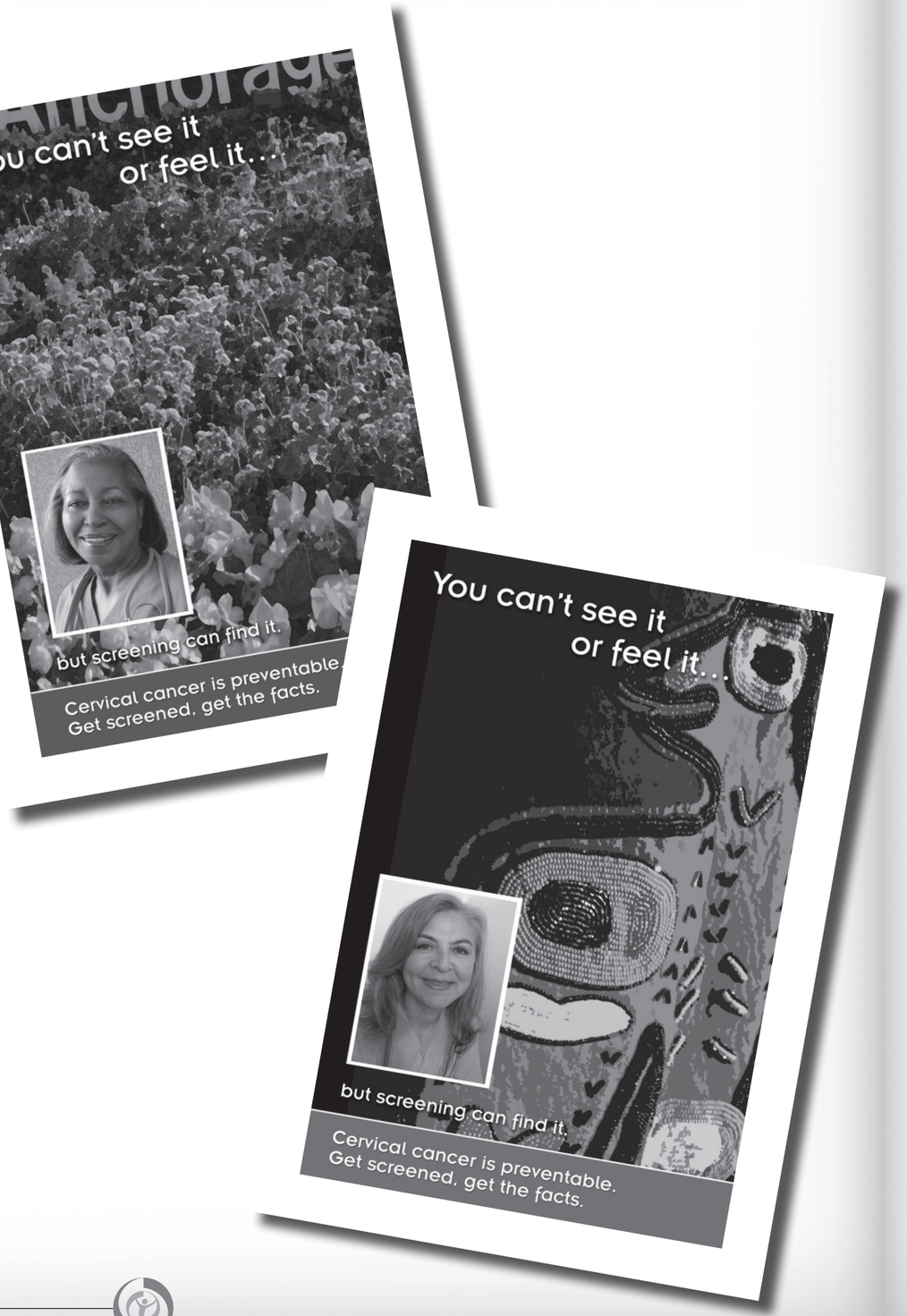

PARTNERSHIP UNITES PROGRAMS UNDER COMBINED LEADERSHIP

Better use of resources, reduced duplication, and improved service delivery are the result

Public Health Problem

- Alaska faces unique challenges in meeting the needs of its many cultural and ethnic groups for breast and cervical cancer screening, related to distance, weather, resource distribution and tribal-state relations.
- Five different grantees in Alaska receive Centers for Disease Control and Prevention funding to provide breast & cervical cancer screening services, making duplication of effort and overlapping services a serious concern.

Program

- Two of Alaska's programs drafted a Memorandum of Agreement outlining basic operating principles related to potential program overlap and eventually all five of Alaska's funded programs signed a more comprehensive version. Each of the grantees in Alaska is unique and targets different cultural and ethnic groups.
- Collective work in breast and cervical cancer screening on recruitment, professional development, surveillance and evaluation, screening/diagnosis and treatment, and quality assurance & improvement is now carried out through an annual face to face meeting, regularly scheduled conference calls and daily communications among the five grantees.

Impact

- Development, production and statewide distribution of new Breast Cancer Screening Guidelines, reflecting the work of a joint committee of clinicians representing each program.
- Decreased duplication and overlap of service areas and increased intra-program information sharing.
- Expanded referral systems assuring that eligible women are referred to the appropriate program.
- Professional development available statewide, reaching rural practitioners with videoconferencing technology who had no previous access to quality educational programs, and providing more educational programs collectively than any of the programs could provide individually.
- Joint public education messages rather than five individual sets of messages which saves program dollars by combining development, production and distribution costs.

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COLORADO PROGRAMS JOIN FORCES TO FIGHT CHRONIC DISEASE

Forming a single, unified epidemiology and evaluation branch makes programs work better

Public Health Problem

- Monitoring health status and evaluating public health interventions are essential public health services because they help public health practitioners understand patterns of disease and risk factors, plan effective programs, put services where they're needed, use resources wisely and evaluate progress toward creating a healthy state.
- When programs collaborate to perform these functions the combined capacity is enhanced, communication among programs improves, and effective public health practice follows.

Program

- Each state chronic disease program in Colorado – cancer, cardiovascular disease and stroke, diabetes, asthma, tobacco and obesity – employed staff to provide data and evaluation services. In a step toward better coordination they jointly created a comprehensive state report on all the listed chronic diseases and their health risk factors which was based on chronic disease indicators identified by the National Association of Chronic Disease Directors, the Council of State and Territorial Epidemiologists, and the Centers for Disease Control and Prevention.
- Later, the Prevention Services Division of the Colorado Department of Public Health and Environment reorganized staff into functional groups to increase program integration and enhance infrastructure and organizational capacity among chronic disease programs and other Division programs in health promotion, maternal and child health, and nutrition.
- Epidemiology and evaluation staff throughout the Division became part of a single Epidemiology, Planning and Evaluation Branch.

Impact

- Creating a single branch to provide monitoring and evaluation services for many programs enables a wider range of services and depth of expertise for individual programs while realizing greater efficiencies.
- The comprehensive chronic disease report clarifies for policymakers, residents and health care practitioners the actions that can be taken to improve the health of Colorado residents by rating state progress to date as "encouraging," "cautious" or "of concern." (www.cdphe.state.co.us/pp/chronicdisease)
- Strengths and skills of the combined staff are being assessed to assure that a full complement of data and evaluation services are available to meet program needs.

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BE SMART AND SEAL THEM!

Dental project reaches vulnerable second graders with sealants, education and treatment services

Public Health Problem

- Tooth decay is the most common chronic disease of childhood and the estimate of the time children are absent from school due to oral pain and acute infection is over seven million hours a year in Colorado.
- Dental sealants – a plastic coating applied to the chewing surfaces of the back teeth – are a safe, effective way to prevent cavities among children.
- School-based programs are successful in reaching children of racial and ethnic minority groups who are most at-risk for oral disease.

Program

- The Colorado Department of Public Health & Environment's Oral Health Unit receives funding from the Centers for Disease Control and Prevention to build key oral health infrastructure, including development of a state plan and implementation of community prevention efforts.
- The Unit supports Be Smart & Seal Them! a school-based or school-linked dental sealant project reaching low-income second grade children in Colorado with dental sealants, fluoride varnish and preventive dental care and education.
- Community partners such as Denver Health, Eastern Plains, Southwest Smilemakers, and Eagle County are helping the Unit reach children most at risk for oral disease.

Impact

- Results over a single school-year of intervention across the state include:
  Denver – Over twelve hundred second grade students in thirty-six schools received dental screening; almost one thousand received sealants. Eight hundred third grade students received additional services.
  Eastern Plains – Students in kindergarten through second grade received dental screenings and fluoride varnish and about a third of the second graders received sealants. An oral health education session reached over four hundred students.
  Southwest Smilemakers – This program of the San Juan Basin Health Department provided dental care services to more than five hundred children in Southwest Colorado; about three-fourth of the children screened received dental treatment, sealants, fluoride treatment and other preventative care.
  Eagle County – More than two hundred children now have access to dental care; the University of Colorado Smilemakers van provided free screening to almost two hundred uninsured and underinsured children, as well as education, x-rays, fluoride varnish.

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PREVENTING DIABETES AT HOME AND AT WORK

Pláticas effectively adapt prevention messages to Hispanic resident's language and culture

Public Health Problem

- The population in Weld County, Colorado is over thirty percent Hispanic, a group that is much more likely to die from diabetes than non-Hispanic whites.
- Physical activity and healthy eating can delay diabetes and help control blood sugar in people who have it, preventing costly complications such as amputations.
- To sustain changes in activity and eating habits education must be adapted to lifestyle and cultural habits.

Program

- An existing Plática Project was expanded to include diabetes prevention.
- The project brings accessible, bilingual health education to Hispanic residents at home, with their family and friends. One-on-one instruction in migrant fields is also provided.
- The *Small Changes Make a Big Difference* curriculum, developed by Colorado State University Extension and the Colorado Department of Public Health and Environment, is the source for educational messages in this project.
- A Spanish-language radio station and a weekly Spanish newspaper provide airtime and/or print space used to educate residents about diabetes and other chronic diseases.
- A mobile medical van brings needed diabetes and other health services to people in the community.

Impact

- The experience of the project's promotora, a leader from the Hispanic community who developed diabetes during the course of the project, reflects the program's benefits:
  - "Teaching others helped me learn to eat better and exercise and my diabetes is better controlled now. Several people in the Platica group told me they're taking their own small steps to change diet and activity because of my example."
- Plática Project participants show an increase in knowledge about nutrition and physical activity strategies to prevent and treat diabetes.
- Steps funding leveraged in-kind donation of Spanish-language media that directly reaches the target audience with important messages about diabetes prevention and treatment.
- Piggybacking the project onto an existing program and tailoring it to the needs of the Hispanic community lowers costs and contributes to improved health outcomes.

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HELPING RESIDENTS OF DUVAL COUNTY BREATHE EASIER

Resource guide puts county residents in touch with needed asthma services

Public Health Problem

- Hospital emergency room visits due to asthma are significantly higher for every age group in Duval County than in other Florida regions, resulting in elevated costs to the county.
- Blacks, young people and women bear a greater share of the physical and emotional burden of asthma than other county population groups.

Program

- The Healthy Jacksonville 2010 Program formed the *Healthy Jacksonville Asthma Coalition*, a group of individuals from local organizations including Wolfson Children's Hospital, Baptist Health, Shands Hospital, the Duval County Health Department Chronic Disease Prevention and Health Promotion Division, and the Duval County Medical Society. Their mission is to reduce the incidence and economic burden of asthma in Duval County through better education and management.
- Based on a survey of asthma care providers and asthma sufferers the coalition identified a need for a comprehensive list of county asthma resources. With funding from a Department of Health Community Environmental Health Advisory Board Grant and the Preventive Health and Health Services Block Grant the coalition developed an asthma resource directory and marketing plan and educated community members about available resources.
- Members of the coalition contributed information about their own organization's services and helped research other available resources. The marketing department of the county health department compiled the information into a colorful booklet for mass distribution which was provided to local hospitals, schools, clinics, and after-school programs at no charge. Local newspapers advertised community trainings and the resource guide.

Impact

- Demand for the resource guide continues to increase after distribution of the first printing of 10,000 copies. The guide includes listings of clinical services, education, professional training, support groups, community organizations and other state/national resources such as websites and hotlines.
- Many health department clinics and community education programs have reported an increase in demand for their services in response to their listing in the resource guide.

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TRAVELING RURAL ROADS TO DELIVER NEEDED HEALTH SERVICES

Mobile unit increases opportunities to reach county residents with important health messages

Public Health Problem

- Most adults in Jefferson and Madison counties in Florida have no health insurance.
- These neighboring counties also have very limited healthcare resources such as hospitals and health departments and the available facilities are often located too far away for many residents to reach.
- These availability and access problems prevent residents from receiving the blood pressure and diabetes screening, health education, and specialty care that they need to prevent and control chronic diseases such as diabetes, heart disease and stroke.

Program

- The Jefferson and Madison county health departments combined fiscal resources and purchased a mobile health unit to be used primarily to provide dental care to vulnerable groups of children.
- Equipped with two dental chairs and supplies, the mobile unit can also accommodate other healthcare services and it was soon clear that chronic disease services could also be provided. The unit is now used for blood pressure and diabetes screenings and one-on-one consultation. A retractable exterior awning allows health department staff to utilize even outdoor space to provide health screenings and education services in shaded comfort.
- The mobile unit also serves as a moving billboard promoting physical activity and tobacco messages around the state, such as *Just Move Jefferson!, Just Move Madison!*, and Florida tobacco quitline information.

Impact

- Health department staff in Jefferson and Madison counties now provides healthcare services such as blood pressure and diabetes screening and tobacco cessation information to residents of areas where these services were not available.
- Piggybacking chronic disease services with dental services uses available resources more wisely, lessens staff travel expense and increase efficiency of service delivery.
- Vulnerable Florida communities now have a healthcare access opportunity to supplement existing services and residents throughout Jefferson and Madison counties are thankful to have this new health resource.

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LOWER COSTS AND BETTER CARE ARE RESULT OF GEORGIA PROGRAM

Treating low income residents with high blood pressure reduces the expected number of adverse events such as stroke and heart attack and saves money

Public Health Problem

- High blood pressure is a major cause of heart attack, stoke, kidney and heart failure.
- Lifestyle changes, such as healthy eating and increased physical activity, combined with medication when prescribed, can control blood pressure and prevent adverse events such as heart attack and stroke.
- People with less education and low incomes are not as likely as others to have their blood pressure under control, partly because they cannot afford regular care and medications.

Program

- The Georgia Stroke and Heart Attack Prevention Program provides services to low income patients with high blood pressure.
- Patients receive intense monitoring, health assessments, and lifestyle counseling and treatment that are based on established protocols for blood pressure treatment and on the essential elements of health care described in the Chronic Care Model.
- Prescribed medicines are provided at low or no cost. Nurse case-managers monitor blood pressure, encourage regular clinic visits, and work with patients to help them take their medicine regularly.

Impact

- Program participants had better blood pressure control, lower treatment costs for those who received treatment, and lower overall costs per eligible patient according to an evaluation funded by the Centers for Disease Control and Prevention.
- The rate of expected adverse events such as heart attack or stroke was reduced by half in program participants, compared to people who received no preventive care. When compared to patients receiving usual care, the rate was cut by slightly less than half.
- For the 15,000 patients in the Stroke and Heart Attack Prevention Program costs were an average of $138 less per patient annually, compared with the cost of usual care. If these results included the costs of lost productivity and death, the program's demonstrated cost savings would likely be even higher.

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COMMUNITY COLLABORATION MEANS BETTER HEALTH FOR GUAM RESIDENTS

Identifying residents at risk for chronic disease and assuring preventive care

Public Health Problem

- Many Guam residents have difficulty accessing screening services to help them identify health problems and enable them to take preventive steps.
- Heart disease, stroke and diabetes are among the most preventable diseases in America, yet almost half the Guam adults identified through testing as having high blood pressure did not know they had it. Other data show that only about two thirds of adults on Guam have had their blood cholesterol checked in the past five years, as recommended.

Program

- The Chronic Disease Prevention and Control Program of the Guam Department of Public Health and Social Services collaborated closely with the Office of the Lieutenant Governor, public health nurses, government agencies and private organizations to expand free health screening services to additional settings including those in depressed areas of the community and in worksites.
- The screenings gave individuals access to assessments of blood pressure, blood cholesterol, blood sugar and body mass index (a measure of body fatness related to obesity assessment), as well as one-on-one health education by registered nurses to explain the results and advise participants on steps to prevent the development of heart disease, diabetes, stroke and other chronic diseases.

Impact

This program effectively met a community need and:

- Identified over a hundred adults who were unaware that they had high blood pressure
- Identified over a hundred adults who were unaware that they had high blood sugar
- Tested blood cholesterol levels of five hundred adults, identifying almost a hundred with high or borderline high levels
- Referred many participants to medical providers including ninety who are now receiving medical care for the identified conditions and forty participants who made changes in diet or began a recommended physical activity plan.

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REDUCING INFECTIONS WITH SAFE DISPOSAL OF HOME-GENERATED SHARPS

Developing and promoting guidelines to reduce the risk of needle stick injuries

Public Health Problem

- Most syringes and sharps used by people at home for injection of diabetes medication and other medical uses are discarded in everyday household trash and community solid waste, putting workers and the public at risk of needle stick injuries and possibly life threatening infections. Sharps are objects that can penetrate the skin including needles and lancets.
- Options for safe syringe and sharps disposal in the community are often limited and most people who give themselves injections have received little or poor guidance on safe disposal of used sharps. Healthcare providers may be uncertain about how to advise patients.
- The State of Indiana has no regulation or law on syringe disposal for home-generated sharps and county agencies varied in offering their own guidelines or no guidelines at all.

Program

- The Indiana Diabetes Prevention and Control Program, the Indiana State Diabetes Advisory Council, and other agencies developed recommendations on proper home disposal through a Syringe Disposal Task Force made up of representatives of public and private interests, including local health departments, solid waste management districts, and pharmaceutical companies. [www.in.gov/isdh/files/NeedleDisposal.pdf]
- The Diabetes Prevention and Control Program provided mini-grants to eight local health departments and solid waste management districts with syringe disposal programs for enhancements to or maintenance of their programs. The funds provided for outreach, education, and provision of disposal containers. The Program also distributed brochures on proper syringe disposal and provided educational materials on diabetes and proper syringe disposal of needles and lancets at solid waste management conferences.

Impact

As a result of the Syringe Disposal Task Force work and its recommendations:

- Four communities began safe-disposal programs
- One of the first county programs reported a noticeable drop in needle stick injuries to employees of the trash removal service since implementing their syringe disposal program.
- Counties have increased the number of sharps removed from the solid waste stream by increasing participation rates in county disposal programs.
- The Indiana Diabetes Prevention and Control Program is a member of the Indiana Household Hazardous Waste Task Force which advocates for safe-disposal programs.
- Trash removal companies and other Indiana counties are increasingly supportive of this effort to improve public health by removing sharps from the household waste stream.
- The Indiana Diabetes Prevention and Control Program will again offer mini-grants to continue enhancing initiatives related to safe syringe and sharps disposal.

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KANSAS IMPROVES QUALITY OF CARE FOR RESIDENTS WITH DIABETES

Diabetes registry, training and data monitoring help providers meet care recommendations

Public Health Problem

- Diabetes-related costs for Kansas are estimated at well over a billion dollars a year.
- Results of surveys in the state showed gaps in diabetes quality of care such as people with diabetes not receiving recommended eye exams, foot exams, flu vaccinations and blood sugar monitoring tests.
- Meeting recommended diabetes quality of care standards can improve quality of life and reduce the serious and costly complications of this condition such as blindness, kidney failure and nerve disease.

Program

- The Kansas Diabetes Prevention and Control Program, with funding from the Centers for Disease Control and Prevention, implemented the multiyear Kansas Diabetes Quality of Care Project.
- During over four years of implementation, more than four hundred healthcare providers from ninety sites across the state have been trained to use the Chronic Care Model to improve delivery and quality of care. The Diabetes Program provides training on implementing the Chronic Disease Electronic Management System and collects and analyzes data to help providers evaluate the systems changes they make to assure improved care for the 8500 Kansans with diagnosed diabetes currently in the diabetes registry.
- Progress is monitored through quarterly reports, site visits, and monthly conference calls with project participants.
- The Diabetes Program has developed a central repository for automatic aggregate data extraction that enables the ability to query data across all Project organizations.

Impact

- Reviews from the Chronic Disease Electronic Management System show that care has improved and that more patients…

…..receive nutrition education
…..are counseled to quit smoking
…..have set self-management goals
…..are monitoring their blood sugar
…..receive recommended flu and Pneumonia vaccinations, foot and eye exams, and blood sugar monitoring tests for hemoglobin A1c

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COMBINING TOBACCO PROGRAMS FOR EFFECTIVE RESULTS

Integrating Louisiana's Tobacco Control Program and The Louisiana Campaign for Tobacco-Free Living

Public Health Problem

- Louisiana is one of eleven states that had more than one major tobacco control program, the result of independent development of separate federal and state funding sources.
- Reducing the burden of tobacco on the health of the Louisiana population requires a well-funded effort that is comprehensive and uses limited resources wisely.

Program

- Over ten years, two tobacco programs had developed in Louisiana – the public Louisiana Tobacco Control Program in the State of Louisiana's Department of Health and Hospitals which is funded by the Center's for Disease Control and Prevention Office on Smoking and Health and the not-for profit The Louisiana Campaign for Tobacco-Free Living, part of the Louisiana Public Health Institute which is funded through the state excise tax on tobacco.
- Following hurricanes Katrina and Rita both programs faced programmatic challenges but Louisiana had reached a turning point in conducting business-as-usual in public service.
- The Louisiana Tobacco Control Program, with technical assistance from the independent Tobacco Technical Assistance Consortium, instigated a process to develop a single, integrated, comprehensive, statewide tobacco control program in Louisiana – leveraging the partnership between these two existing programs.

Impact

- Pooled resources from two overlapping tobacco programs are now being used to create more effective state and local programs aligned to reach the mutual program goals of preventing initiation of tobacco use among youth, promoting cessation among tobacco-users, eliminating tobacco-related health disparities, and reducing exposure to secondhand smoke.
- Collaboration resulted in a single, revised, comprehensive tobacco control plan for the state.
- Developing renewed infrastructure and programming and reducing duplication of effort is leading to the advance of eight major tobacco initiatives including an initiative to develop support for Louisiana's Smoke-Free Air Act through a secondhand-smoke media campaign.

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AUTOMATED REFERRAL SYSTEM STEPS UP PROGRAM ENROLLMENT

More rural Maine women are receiving screening services for breast and cervical cancer

Public Health Problem

- The Maine Breast and Cervical Health Program, funded by the Centers for Disease Control and Prevention provides quality breast cancer screening and diagnostic services to low-income, uninsured, and underserved women.
- The Maine program is able to serve only a small proportion of the women eligible to receive services partially due to the difficulty of reaching and enrolling the eligible population.
- State programs continually work with providers and community partners to identify low-cost outreach methods since screening services can help find breast and cervical cancer at the earliest stages.

Program

- As a result of a legal settlement, MaineCare, Maine's Medicaid Program began notifying potentially eligible women about breast and cervical cancer screening services through their automated client eligibility system, called ACES, and providing client's contact information to the Maine Breast and Cervical Health Program.
- Using a script developed by staff and the Cancer Information Service New England, the Portland Community Partnership Coordinator in Cumberland County initiated a pilot project to call every woman on the list residing in the county to educate her about the program and encourage enrollment.
- The successful pilot was extended to another five counties with Community Partnership Coordinators and to nine counties that have no Community Partnership. In one case, women contacted could also schedule a convenient appointment for a screening day that provided a clinical breast exam, Pap test and mammogram at the same visit.

Impact

- Almost half the women called during the pilot phase enrolled in the program.
- Over twenty-five percent of the eligible women contacted in the pilot expansion enrolled or re-enrolled in the Program because the automated client eligibility system, which previously did not include referrals to the Maine Breast and Cervical Health Program, now makes it possible for many more potentially-eligible women, especially rural women, to be contacted by the Program.
- Even women who are determined to be ineligible are benefiting from the phone contact which provides an opportunity to educate an underserved population on the importance of breast and cervical cancer screenings and on ways they can refer a family member or friend.

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REACHING WOMEN WHO ARE SELDOM SCREENED FOR CERVICAL CANCER

Cervical cancer is largely preventable if women receive regular screening tests

Public Health Problem

- The Maine Breast and Cervical Health Program, funded by the Centers for Disease Control and Prevention, provides access to critical screening services for underserved women, such as Pap tests to identify cervical cancer.
- It's important for state programs to reach out to women who never or rarely have a screening test because more than half of all cervical cancers are in women who have not received a Pap test in five years or more.
- Abnormal changes to the cervix can be detected by the Pap test and treated before cancer develops, making regular Pap tests of the most important things women can do to reduce their risk of cervical cancer.

Program

- The Maine Breast and Cervical Health Program queried program enrollees who had not had a Pap test in five years or more in order to better understand why these women are not getting regularly screened for breast and cervical cancer. Follow-up identified how many of the women went on to complete the enrollment process, see a provider for a Pap test and receive the result.
- Results of this assessment were compared to the answers to identical questions on a statewide general marketing survey of Maine women.
- Clients who have not received service within a year's time are contacted by a health educator who educates them about the program and reinforces the importance of regular Pap tests.

Impact

- Results of this initiative that are important for increasing participation in breast and cervical cancer screening:
  - The Program database now highlights enrolled women who are not regularly screened in order to aid the health educator in providing necessary assistance and encouragement to be screened.
  - Program recruitment strategies are effective. Because three-quarters of the women indicated they had not had a Pap test because it was too expensive and they had little or no insurance, program materials and advertisements continue to highlight the fact that Pap tests and mammograms are free from the Program.
  - Eligibility language was updated to show that some women with insurance still qualify for free services. The term "underinsured" previously caused confusion about eligibility.
  - Program website was updated to accommodate the increased number of women who indicate they use the internet to gather health information

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HEARTSAFE COMMUNITIES PROMOTE EARLY ACCESS TO EMERGENCY CARE

Improved emergency response and increased awareness of signs and symptoms of heart attack and stroke

Public Health Problem

- Almost half of all heart attack and stroke deaths happen before an ambulance arrives or the victim is hospitalized.
- Prompt recognition of heart attack and stroke signs and early treatment can improve outcomes such as increasing survival and promoting better quality of life for survivors.

Program

- HeartSafe Communities is an Emergency Medical Services recognition program designed to promote early access to essential components of emergency care for heart attack and stroke and serves common goals of the Maine Centers for Disease Control and Prevention Cardiovascular Health Program and Maine Emergency Medical Services. These programs worked with the state's six regional Emergency Medical Services offices to revise original program criteria to suit Maine needs and launched the initiative statewide.
- Local emergency services complete an application which is scored using established criteria in order to categorize their program in one of the HeartSafe Communities recognition levels which include Basic, Silver, Gold and Platinum. These services are required to maintain program criteria. The Maine Cardiovascular Health Program provides program coordination and collaborates with state and regional EMS offices to provide technical assistance.
- See www.healthymainepartnerships.org/mcvhp/heartsafe.aspx

Impact

- The number of designated HeartSafe services has grown to 33, covering over two hundred cities, towns, territories and one college campus and over half a million Maine residents.
- Local emergency services report that becoming a HeartSafe community has helped increase requests for community training on emergency resuscitation, a potential source of funds, and for heart disease and stroke education activities. Schools, churches, hotels, banks, camps, and daycare facilities have increased requests for devices that can restart a stopped heart in an emergency.
- Maine's Emergency Medical Services and American Heart Association affiliate initiated and achieved enactment of legislation that mandates, with funding support, the statewide implementation and evaluation of Emergency Medical Dispatch. All HeartSafe services have achieved the legislated criteria allowing one service to move from the basic HeartSafe designation level to the higher silver level.
- One service has significantly increased their capacity to identify cardiac patients in the field, raising it to the Platinum level.

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CHANGING PRIMARY CARE PRACTICES FOR BETTER HEALTH OUTCOMES

Relatively small amount of funding leverages big improvements in primary care

Public Health Problem

- Primary care in the U.S. does not effectively address chronic disease due to serious time limitations and the lack of a coordinated system.
- Disease management and systems-based approaches to clinical quality improvement such as the Chronic Care Model are effective but haven't been widely utilized in this country.
- The Chronic Care Model promotes improvements in the whole system of care, including organization, information systems, decision supports, delivery system design, self-management support, and community resources.

Program

- The North Carolina chronic disease section expanded on an existing pilot program to collaborate with important state partners, including North Carolina's Medicaid managed care program, North Carolina Area Health Education Centers, the University of North Carolina School of Medicine and the state's primary care specialty societies, in a national initiative created jointly by the American Board of Medical Specialties, American Board of Family Medicine, American Board of Pediatrics, and the American Academy of Family Physicians and designed to improve the quality performance of primary care practices.
- The initiative is based on the Chronic Care model and emphasizes methods such as the use of Quality Improvement Coordinators working with individual practices, an emphasis on data collection on common measures, collaborative learning, electronic registries, practice-wide care protocols, and strategies to support patient self-management efforts.
- The North Carolina Division of Public Health provided initial financial support and continues its support through contributions from the asthma, diabetes, kidney, comprehensive cancer, and heart disease and stroke prevention programs.

Impact

- Relatively small funding helped leverage very significant quality improvement for primary care patients.
- Patient health outcomes improved. The percent of patients meeting important goals for diabetes control increased by a third and those meeting goals for cholesterol control increased by over twenty-five percent.
- The number of participating practices increased from just sixteen in the first year to an expected 180 practices covering all regions of the state by 2009.
- This statewide initiative is also fostering linkages between state and local health departments and primary care practices to promote better care and to expand the evidenced-based Chronic Disease Self Management Program to patients in participating initiative practices.

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TEAM APPROACH TO FIGHTING THE GROWING PROBLEM OF DIABETES

North Dakota applies technology to unite a widely scattered team

Public Health Problem

- The number of North Dakotans with diabetes is growing – even children are about thirty percent more likely to develop diabetes than they were just a few years ago.
- Diabetes is a leading cause of blindness, lower limb amputation, end-stage renal disease, and coronary heart disease.
- Tackling a statewide problem such as diabetes prevention and control demands effective, coordinated effort but North Dakota's limited program resources and long travel distances between population centers present a challenge.

Program

- With only a program director and epidemiologist assigned to the North Dakota Diabetes Prevention and Control Program, a creative approach was needed to establish an effective team for this program funded by the Centers for Disease Control and Prevention.
- With no evaluation staff, limited dollars to pay full-time staff and few available evaluation consultants in the state, the Program contracted with an experienced Virginia public health evaluation consultant to guide the development and monitoring of planning and evaluation.
- Other critical expertise is provided to the team by the chair of the Dakota Diabetes Coalition and the Blue Cross/Blue Shield Disease Management Coordinator. A volunteer from the Dakota Diabetes Coalition rounds out the team.
- To work effectively with team members in many different locations, the team uses conference calls and "Click to Meet" software that links computers in virtual meetings and permits visual contact while people work together.

Impact

- Using cost effective, virtual meeting technology and conference calls is helping North Dakota build a state partnership infrastructure to coordinate the work for diabetes prevention and control. Information transmitted between people is often nonverbal making the visual component of the meeting technology useful for getting the work done.
- The improved communication system also ensures continuity of operation in times of disaster or national emergency when people with chronic disease such as diabetes need special help.
- Regular evaluation of the diabetes team process has resulted in increased accountability, better coordination of the Diabetes Prevention and Control Program and improved capacity to adapt actions based on evaluation results.
- The Diabetes Prevention and Control Program has developed consensus on program outcomes by agreeing on a logic model as an underpinning for activities. The logic model will guide the revision of the North Dakota Diabetes Health System strategic plan in 2009.

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NEW MEXICO SUPPORTS CANCER SCREENING FOR UNINSURED WOMEN

State legislature helps breast and cervical cancer program provide services to more women

Public Health Problem

- A screening mammogram is the most effective method for detecting early-stage breast cancer and a regular Pap test is the most effective method for preventing cervical cancer
- Many New Mexican women live in poverty and over one fourth of them report that they have no healthcare coverage, significantly limiting their access to diagnosis and treatment services for breast and cervical cancer.

Program

- The New Mexico Department of Health Breast and Cervical Cancer Early Detection Program is funded at a level sufficient to serve only ten to fifteen percent of eligible women with funds supplied by the Centers for Disease Control and Prevention, the state general fund, and an American Cancer Society grant.
- Because of a specific Medicaid requirement related to federal funding, some women screened using state funds would not be eligible for treatment paid for by Medicaid in the event they were diagnosed with breast or cervical cancer. At the same time, state funds were restricted to direct screening costs and could not be used for administrative costs.
- The New Mexico Department of Health Breast and Cervical Cancer Early Detection Program worked with American Cancer Society advocates and community partners to secure additional state general funds which the legislature permitted them to use to cover a portion of the administrative costs associated with the Program in order to free federal dollars for screening.

Impact

- Women diagnosed with breast or cervical cancer – previously not eligible for Medicaid treatment because they had not been screened using federal dollars – are now able to receive vital treatment because state action freed up federal dollars for screening allowing them to maintain their eligibility under Medicaid.
- This cost shifting allows the New Mexico Department of Health Breast and Cervical Cancer Early Detection Program to serve an additional 4,549 eligible women this year. With this enhanced provision of services, potentially 40 breast tumors and 54 invasive cervical cancers or pre-cancerous cervical conditions can be diagnosed among these women and necessary treatment can begin.

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GUIDING PLANNERS TO MAKE COMMUNITIES MORE PEDESTRIAN-FRIENDLY

Comprehensive document provides tools and model polices

Public Health Problem

- Physical inactivity is a major risk factor for heart disease.
- Increasing opportunities to be active is an evidence-based strategy for preventing chronic diseases such as heart disease.
- When it's easy and safe to walk and ride bicycles, people walk and bike more.

Program

- With funding from the New York State Healthy Heart Program, the Initiative for Healthy Infrastructure at the State University of New York, Albany developed a transportation policy guide for planners, municipal board members and decision-makers in the state. This document describes national transportation policy models including Complete Streets a model that encompasses all modes of transportation, including walking and bicycling.
- The guide provides policy tools specific to New York's home rule approach to government, allowing for adoption by a many local agencies and governments.
- The guide covers: tools for community planning; integration of Complete Streets concepts; examples of bicycle and pedestrian friendly language; key elements of mixed use development, town center planning, design guidelines, redevelopment of historic central business district streets and form-based codes that define the size, scale and proportions of buildings in graphic format; information on safe routes to school; a model zoning law for bicycle parking facilities; and even a proposed policy for showers and lockers to be used by residents running, skating, walking or bicycling to work. Web site: www.albany.edu/~ihi

Impact

- Several New York communities are using the policies in the guide to increase resident's opportunity to be active:
  - The town of Union in Broome County adopted a Pedestrian Policy making Union a pedestrian-friendly community.
  - The City of Binghamton passed legislation incorporating Complete Streets policy into the city's street reconstruction efforts.
  - The City of Buffalo drafted a Complete Streets policy and expects to vote on it soon.
- These comprehensive, free planning and policy models provide needed assistance to New York's municipalities in their efforts to make it easier and safer to bike and walk.
- Bob Elliott, Deputy Secretary for Local Government in the New York Department of State, says about the guide, "I thought the Planning and Policy Models publication was excellent."

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NEW YORK ORAL HEALTH PLAN: A BLUEPRINT FOR ACTION

Oral health stakeholders now speak with one voice to policymakers

Public Health Problem

- A state oral health plan is a necessary and key component of public health infrastructure that identifies oral health problems and gaps in policy, prevention, access, workforce issues and surveillance and provides a common agenda for taking action.
- New York had no state oral health plan to prior to 2001.

Program

- The New York State Department of Health, Bureau of Dental Health receives funding from the Centers for Disease Control and Prevention to build key oral health infrastructure, including development of a state plan.
- The Bureau partnered with the Schuyler Center for Analysis and Advocacy, an organization that promotes progressive health and education policies in areas that are traditionally overlooked, to form a steering committee of stakeholders to guide the development of a plan.
- Using a consensus building process facilitated by the Bureau and the *Framework for Comprehensive State Oral Health Plans*, the steering committee reviewed other state's plans, identified major issues and formed five work groups to address the key issues: policy, population-based prevention, access to care, workforce and surveillance and research.
- Ensuring both a local and a state level perspective for the plan relieved a potential barrier to action for a large, diverse state like New York. The workgroups identified critical dental public health issues in the state, defined goals, objectives and strategies for each issue, set targets for each objective and identified best and promising practices. The finished plan was widely disseminated and the plan development process was evaluated.

Impact

The oral health plan blueprint for action has resulted in these achievements:

- Formation of a statewide oral health coalition to guide action
- Inclusion of oral health indicators in the health department's overall Prevention Agenda, raising oral health issues to a higher level in the state's hierarchy of prevention measures
- Formation of a New York Dental Association task force to accomplish key objectives in the plan
- Adoption of important oral health recommendations by organizations such as Perinatal Networks, Area Health Education Centers, and Rural Health Networks
- Advocacy by a broader array of health organizations for needed legislative and policy changes to promote oral health

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OKLAHOMA CARES REACHES OUT TO LOW INCOME WOMEN TO IMPROVE CANCER PROGNOSIS

State-funded program expands access to cancer diagnosis and treatment

Public Health Problem

- In Oklahoma, over 500 women die every year from breast or cervical cancer.
- Prompt diagnosis and treatment can reduce this death rate but uninsured women often lack access to these services that could improve their prognosis.

Program

- The Oklahoma Legislature recognized the critical need to provide uninsured women with breast and cervical cancer screening and treatment services.
- The legislature passed a funding bill directing the Oklahoma State Department of Health Breast and Cervical Cancer Early Detection Program, the Oklahoma Health Care Authority, and the Cherokee and Kaw Nations Breast and Cervical Cancer Early Detection Programs to work with breast and cervical cancer advocates in assuring greater access to program services; over $35,000 in support for the program to date.
- *Oklahoma Cares* was created with this funding and is providing assistance to low income, uninsured Oklahoma women meeting eligibility guidelines who have an abnormal breast or cervical test result. Through *Oklahoma Cares* these women obtain access to Medicaid coverage of diagnosis and treatment services for breast or cervical cancer, receiving a full scope of Medicaid benefits until they no longer need cancer treatment. The *Take Charge*! outreach effort is expanding the network to previously non-funded providers so that more women have access to the services they need. There are now more than eight hundred certified screening providers throughout the state. Other services provided include transportation and a patient advocate phone line.

Impact

- Allocation of state funds has expanded program features covered by federal breast and cervical cancer funding to reach more of the group of women ages 19 – 65 years without insurance coverage who would not be likely to receive screening or treatment without the program.
- Screening rates have improved by about fifteen percent for low income or uninsured women fifty and older which has likely increased the early detection of these cancers. Over nine thousand women have been served by the program and over a thousand have received treatment for cancer or pre-cancerous conditions.

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REDUCING BARRIERS TO BREAST CANCER SCREENING FOR UNINSURED WOMEN

Partners share responsibility for providing access to mammograms and clinical breast exams

Public Health Problem

- A number of barriers keep woman from getting breast cancer screening services, such as lack of knowledge or access to services.
- A lower rate of screening among uninsured women creates a disparity in health outcomes between these women and other women in the population.

Program

- To address screening barriers, the Rhode Island Department of Health Women's Cancer Screening Program partners with local hospitals, the American Cancer Society, Blue Cross Blue Shield of RI, Wal-Mart and Stop & Shop to heighten uninsured women's awareness of and increase their access to screening for breast cancer.
- Each partner has a clearly defined role – the American Cancer Society provides funding to support the free breast screening events; Blue Cross Blue Shield of RI creates advertising signs displayed at participating store's pharmacy counters; hospitals recruit physician and ancillary staff volunteers, set up scheduling for mammogram and clinical breast exam appointments and reserve a block of mammogram appointments to ensure availability.
- Cancer program staff enrolls eligible women, assists with case management activities and talks with each participant about additional screening services for cervical cancer available through the program. They also coordinate billing for the hospital and radiology facility which agrees to accept program reimbursement rates for the services provided.

Impact

- The partner program generated over 1800 additional screenings at sixteen free screening events coordinated at three different hospitals.
- Eleven breast cancers were diagnosed. Women needing treatment for breast cancer may apply for Medical Assistance through the Treatment Act to cover the cost.

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PLANNING A BETTER SYSTEM OF DIABETES CARE IN SOUTH DAKOTA

A key result is formation of the South Dakota Diabetes Coalition

Public Health Problem

- A comparison of the Ten Essential Public Health Services to the prevention and care services for diabetes in South Dakota revealed that the diabetes care system in the state was occasionally disjointed, duplicative in some areas, and significantly lacked services to certain parts of the state.
- Stakeholders revealed a readiness to take steps to improve infrastructure, collaboration and coordination, to address deficits in provision of services and to increase opportunities to reduce the burden of diabetes in South Dakota.

Program

- The South Dakota Diabetes Prevention and Control Program contracted with University Partners in Health Promotion, an interdisciplinary team of faculty from South Dakota's university system, to assess the statewide public health system related to diabetes.
- A top priority identified by the state's Diabetes Advisory Council and the assessment was one of the ten essential services: "Mobilizing community partnerships and action to identify and solve health problems."
- Workgroups that included more than fifty stakeholders developed the *South Dakota Diabetes State Plan 2007-2009*. Release of the plan generated statewide media coverage in print, television and radio outlets.
- Major funding was provided through the Wellmark Foundation, the philanthropic arm of Blue Cross and Blue Shield of South Dakota and Iowa as well as the Diabetes Prevention and Control Program cooperative agreement with the Centers for Disease Control and Prevention.

Impact

- Stakeholders learned important information about diabetes and developed a far-reaching state diabetes plan that outlines specific steps they can take to improve the health system for better diabetes prevention and control and optimal health outcomes.
- The process led directly to the formation of the South Dakota Diabetes Coalition whose mission is partnering to improve health outcomes for those affected by diabetes in South Dakota.
- Partners are collaborating to implement plan strategies such as monitoring data on access, availability, and quality of diabetes care and developing recommendations to provide individualized, culturally sensitive care to all patients.

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HEALTH PLAN PARTNERSHIPS IMPROVE BLOOD PRESSURE CONTROL

Self-management reduces hospital stays and emergency visits, lowers blood pressure

Public Health Problem

- Over twenty percent of Utah adults have high blood pressure.
- Well over half of the people with high blood pressure don't have it under control, an important step for preventing strokes and heart attacks.
- Healthy eating, regular physical activity and taking prescribed medication can contribute significantly to lowering blood pressure.

Program

- Surveys of Utah physicians indicated that patients needed to take more responsibility for controlling their blood pressure, but many barriers to achieving this goal existed.
- Patient's said they needed more information to help them to manage their blood pressure and liked the idea of health plan incentives for blood pressure control.
- Partnerships between the Utah Heart Disease & Stroke Program and two Utah health plans, SelectHealth and Molina Health Care, were developed.
- The Utah Department of Health provided technical assistance, and funding to conduct physician and patient focus groups, collect and report data, develop physician education programs for licensure credits, and provide materials for patient self-management kits.
- SelectHealth developed "BP Take Control," a comprehensive blood pressure management program for physicians and members. Molina Health Care focused on high blood pressure with customized education, telephone assessment and incentives for members.

Impact

- Hospital inpatient stays and visits to hospital emergency departments related to high blood pressure and heart disease were reduced by 60% for Molina Health Care participants in the blood pressure self-management program, saving money and improving quality of life.
- A majority of SelectHealth patients reported lower blood pressure following the initial stage of the intervention.
- Over three years, there was a 6% improvement in blood pressure control among SelectHealth patients participating. Control is maintenance of blood pressure below recommended levels.
- Lowering and controlling blood pressure through patient and provider interventions has potentially saved lives and prevented disability from stoke and heart attack.

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ASSISTING PREGNANT SMOKERS THROUGH MEDICAID ENROLLMENT SYSTEM

Utah tobacco program reaches women with a tobacco message that's important for their babies

Public Health Problem

- Over half of the pregnant smokers in Utah are Medicaid recipients suggesting an important role for tobacco cessation services directed at pregnant women receiving Medicaid services.
- The risk for stillbirth, infant death, and sudden infant death syndrome (SIDS) are higher for the offspring of women who smoke during pregnancy as is the risk of certain delivery complications.
- Reaching pregnant women with help on smoking cessation may reduce these serious complications related to smoking during pregnancy and potentially save Medicaid dollars.

Program

- Pregnancy Risk Assessment and Monitoring Survey (PRAMS) data was used to identify the higher rate of smoking among pregnant Utah women receiving Medicaid.
- The Utah Tobacco Prevention and Control Program then worked with the Department of Workforce Services to enable Health Program Representatives to identify pregnant women smokers from Medicaid eligibility encounter information.
- Once identified, the representatives contact pregnant smokers and offer appropriate tobacco cessation services they are eligible for, such as nicotine replacement or other medications and cessation counseling through contracted agencies in addition to standard Utah Tobacco Quit Line services.
- A computer-generated reminder facilitates six-week check-up contacts by the Health Program Representative throughout the pregnancy to encourage women to reduce their smoking and/or remain smoke-free.
- Extended contact, via home visits after delivery, is available even if the woman is no longer on Medicaid as an important support for cessation attempts and to help prevent relapse.
- The Utah Tobacco Prevention and Control Program covers a portion of the cost of prescriptions, cessation counseling and self-help materials, as well as some of the administrative and case management costs. A federal Medicaid match pays remaining costs and the tobacco program pays all of the costs associated with the home visits after delivery.

Impact

- Partnering with the Medicaid program garnered $185,000 in matching funds for the Utah Tobacco Prevention and Control Program to help support their efforts targeting an important group of smokers with cessation help.
- Of those pregnant women participating in this program over 16% quit and more than a third reduced their use of tobacco.

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COLLABORATIVE IMPROVES HEALTHCARE FOR THE UNDERSERVED

Two state projects and a primary care association join forces to reduce health disparities

Public Health Problem

- Healthcare collaboratives track quality measures such as adherence to recommended disease management guidelines as a way to help practitioners assess and improve the care they give to people with chronic diseases.
- By taking steps to impact the most vulnerable populations, such as those people served by community health centers, collaboratives can also reduce health disparities and enhance health outcomes.

Program

- The Virginia Community Healthcare Association is the statewide association for community health centers providing primary health care to people who otherwise would have little or no access to care.
- The Virginia Heart Disease and Stroke Prevention and Diabetes Prevention and Control Projects, part of the Virginia Department of Health, partnered with the Virginia Community Healthcare Association to support a Diabetes and Cardiovascular Health Disparities Collaborative. This Collaborative is part of a national effort, through the Health Resources Services Administration, to eliminate disparities and improve healthcare delivery.
- The partnership, and the continued funding, leadership and technical assistance provided by the two state health department projects under a contract, enabled the Association to enroll forty six community health centers in the Collaborative. These centers serve mostly rural areas and represent over half of the Association's members and over forty percent of the providers.

Impact

- The National Rural Health Association's 2008 Rural Health Quality Award was given to the Diabetes and Cardiovascular Health Disparities Collaborative initiative in recognition of innovative best practice and significant contributions to the quality of health care in rural America.
- The Collaborative has been granted the important "equivalency" status, meaning that centers' participation in the state-based collaborative is considered equivalent to participating on a federal level and that the Collaborative joins the national Health Disparities Collaborative and contributes to its database.
- Numbers of patients in Collaborative registries are increasing dramatically – the cardiovascular patient registry doubled its numbers and the diabetes patient registry has increased by forty-five percent in just one year meaning significant numbers of underserved patients will have their healthcare monitored to ensure quality.

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IMPROVING DIABETES CARE IN FEDERALLY-QUALIFIED HEALTH CENTERS

Wisconsin project seeks to reduce health disparities for consumers with diabetes

Public Health Problem

- Federally-qualified health centers in Wisconsin serve many minority consumers who are more likely to have diabetes than others in the general population.
- Diabetes has serious complications, such as heart attack and blindness, that reduce quality of life for many people with the disease.
- Providing essential diabetes care services, such as lab tests, exams, shots, medical checks and education can reduce complications of diabetes, improve quality of life for people with the disease and save health care dollars.

Program

- The Wisconsin Diabetes Prevention and Control Program, part of the Wisconsin Department of Health and Family Services, funds the Wisconsin Diabetes Quality Improvement Project.
- The Wisconsin Primary Health Care Association coordinates quality improvement within sixteen federally-qualified health centers that formed practice teams and a registry to improve care to patients with diabetes using three proven models: the Learning Model, the Model for Improvement, and the Chronic Care Model.
- Eight key indicators for quality care are monitored monthly and reports are shared with health center teams so they can assess progress and take steps to improve patient care.

Impact

- Federally-qualified health center consumers received more of the types of services that are associated with development of fewer complications for people with diabetes. For example:
  - An increase of forty percent in the number of health center consumers with diabetes who received the recommended test to monitor regular blood sugar control.
  - A three-fold increase in the average percentage of patients with a documented self-management goal. Self-management goals include such things as monitoring blood sugar, getting regular exercise and choosing foods wisely.
- The number of people with diabetes monitored by the registry has increased almost six-fold over five years.

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WISCONSIN COLLABORATIVE DIABETES QUALITY IMPROVEMENT PROJECT

Working together to change diabetes care delivery for the better

Public Health Problem

- Medical costs and lost productivity due to diabetes in Wisconsin are estimated at well over four billion dollars a year.
- Delivering recommended diabetes care, such as lab tests, exams, shots, medical tests, and education can reduce the serious complications of diabetes, such as kidney disease and blindness.
- A health maintenance organization quality improvement collaborative helps providers learn better ways to deliver recommended services and monitor outcomes to benefit people with diabetes.

Program

- The Wisconsin Diabetes Quality Improvement Collaborative Project involves many Wisconsin partners, including the Diabetes Prevention and Control Program, the University of Wisconsin, the state's Quality Improvement Organization, and numerous health care systems.
- Members of the Collaborative share resources, strategies and best practices; evaluate implementation of the Wisconsin Essential Diabetes Mellitus Care Guidelines; and improve diabetes care through a number of quality initiatives.

Impact

- The National Committee for Quality Assurance recognized Wisconsin in 2006 as a top-performing state on three of the seven comprehensive diabetes care measures.
- Performance on all diabetes care measures is improved.
- Wisconsin measures of care are consistently above measures for the U.S. as a whole.
- Collaborative partners now recognize that working together improves care for people with diabetes.

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IMPROVING EFFECTIVENESS OF WISCONSIN CHRONIC DISEASE PROGRAMS

Planning and implementing projects across programs uses resources wisely

Public Health Problem

- Wisconsin chronic disease prevention and control programs in the Division of Public Health target specific conditions, such as diabetes, arthritis and cancer, according to the requirements of the funding agency, the Centers for Disease Control and Prevention.
- Federal cooperative agreements for these programs require each to take similar steps to convene local stakeholders, document disease burden, and develop a statewide plan of action, implementation and evaluation.
- Community-based organization representatives often serve as partners to multiple programs, resulting in duplicate requests, meetings, and projects.

Program

- The Wisconsin Division of Public Health organized a Program Integration Work Group to spur efforts to improve program impact use program funds wisely. The work group, including staff from three different Bureaus, meets bi-monthly to promote intra-program communication, collective problem solving on crosscutting issues and joint projects such as annual disparity reviews.
- Staff members from two different programs co-facilitate the group which includes chronic disease, maternal and child health, WIC, health information, injury prevention, reproductive health, oral health, and management staff from across the Division.

Impact

- *Reduced duplication and best use of funds* – For example, several programs listed the development and distribution of a worksite toolkit as a state plan objective. Rather than develop five different toolkits, one kit was developed to meet the needs of five programs, with the Nutrition & Physical Activity Program taking the lead on development and the Comprehensive Cancer Program supporting testing and evaluation of the kits. All programs promote the kit with their respective advisory groups and utilize it in their disease-specific prevention efforts.
- *Wider reach of existing efforts* – For example, a "Making the Business Case" breakfast was funded by the state's diabetes program to reach human resource directors with the message that it's in employers' best interests to help employees control their diabetes or prevent the disease in order to improve productivity, lower health costs, and improve employee wellness. The following year, all chronic disease programs – heart disease and stroke, diabetes, arthritis, tobacco, cancer and asthma participated, reaching employers with a more comprehensive chronic disease prevention and control message.

- *Better use of health plan performance data* – For example, projects working with health plans and using health plan data from the Healthcare Effectiveness Data Information Set were initiated by the Diabetes Prevention and Control Program and have now expanded to include the Heart Disease and Stroke, Comprehensive Cancer, Tobacco Prevention and Control, Asthma, and Arthritis Programs, providing a more comprehensive picture of the adequacy of chronic disease care in the state.

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IMPLEMENTING SCHOOL HEALTH ACT 1220 LEGISLATION IN ARKANSAS

Coordinated school health approach used as a model for improvements in school environments

Public Health Problem

- Over a third of Arkansas students are considered to be overweight or at risk for overweight, an increase over earlier reported rates.
- Arkansans are more likely to die from heart disease and stroke than residents of other states. Diabetes rates have risen dramatically since the early 1990s. There was also a seventy-seven percent increase in obesity in Arkansas over approximately the same period of time, a condition which raises the risk of developing heart attacks, strokes and diabetes.
- Health eating and physical activity can help students prevent overweight and obesity but in Arkansas most high school students surveyed had a poor diet and over two-thirds were not physically active.

Program

- The Arkansas legislature passed Act 1220 in 2003, mandating height/weight measurements on students; use of an annual School Health Index assessment; and removal of vending machines from elementary schools.
- To improve nutrition and physical activity environments to promote healthy weight and consolidate existing funding and prevention efforts, nine schools became model coordinated school health programs and received a $10,000 grant with funds provided equally by the state education and state health agencies.
- Schools planned interventions and activities including wellness services for school employees, placing health care professionals in schools to serve students at risk and conducting annual evaluations.

Impact

- Leadership for School health was strengthened by training school personnel, state Health and Education Department employees, state legislators, and others at a Summer Institute in Coordinated School Health Implementation.
- A sample of specific achievements in model schools:
  - Surveys show an increase in student's health knowledge and skills in pilot schools
  - One district provides free exercise programs for staff
  - One district provides after school health programs for 1,100 students
  - Kindergarten students in certain schools receive nutrition education exceeding state requirements
  - Wellness screenings for school employees identified three teachers with acute high blood pressure who received immediate medical attention

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KENTUCKY WORKS TO CREATE A STATEWIDE SYSTEM OF STROKE CARE

Task force strengthens partnerships and moves prevention forward

Public Health Problem

- Kentucky ranks in the top ten among all states for both stroke and heart disease deaths.
- Stroke can leave victims with physical, mental, and emotional deficits.
- Efficient, high quality acute stroke care reduces the risk of untimely death and helps prevent disability.
- Using standard stroke transport protocols and promoting compliance with stroke treatment guidelines are two important steps to assure the quality of stroke care.

Program

- The Kentucky Heart Disease and Stroke Prevention Program hosted a retreat bringing together key stakeholders in Kentucky to consider actions to reduce the burden of heart disease and stroke in the state.
- As a result, the Heart Disease and Stroke Prevention Task Force was established to promote collaboration among public and private providers such as hospitals, primary care organizations and universities related to the primary and secondary prevention of heart disease and stroke as well as the elimination of related health disparities.
- Five subgroups of the task force are evidence-based prevention strategies, community and site-based interventions, integrated cardiovascular health delivery systems, policy and funding.

Impact

- The Kentucky Senate adopted a Resolution "urging the development of a statewide system of stroke care" that will improve the quality of stroke care by significantly increasing compliance with stroke treatment guidelines.
- The Kentucky Board of Emergency Medical Services endorsed standardized stroke transport protocols for the state, increasing the likelihood of their adoption by emergency responders.
- Public and private providers throughout the state are being educated on stroke systems of care through a contract with the University of Louisville Stroke Team.
- A new state action plan on heart disease and stroke is being developed by the Heart Disease and Stroke Prevention Program in cooperation with the Heart Disease and Stroke Prevention Task Force and other partners throughout Kentucky.

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STUDENTS MAKE A DIFFERENCE IN PUBLIC SMOKING POLICIES

Raising youth awareness about smoking hazards and the impact students can have on reducing exposure

Public Health Problem

- Twenty-five percent of Kentucky high school students are smokers.
- The health risks associated with tobacco use and secondhand smoke are well documented but in states such as Kentucky where tobacco production is a major cash crop, opposition to adopting smoke-free policies can be strong.
- Students gain confidence and skills by applying their knowledge about tobacco to a project that also helps their community.

Program

- Youth from Kentucky's 4-H Team Leadership Councils participated in a local Help Overcome Tobacco Youth Conference.
- Coordinated School Health Initiative (Kentucky Department for Public Health and Kentucky Department of Education) and the Tobacco Prevention and Cessation Program which are both funded through the Centers for Disease Control and Prevention, jointly planned and conducted regional conferences with the Pike County Health Department through Kentucky's ALERT Regional Prevention Center to raise awareness on tobacco-related issues and to increase capacity for youth advocacy efforts in tobacco use prevention.
- Students learned how to organize a public awareness campaign and to contact elected officials. These teens then organized and led other teenagers to spearhead a petition campaign, ultimately gathering 4,000 signatures in support of a smoke-free ordinance for the Pike County Fiscal Court and Hall of Justice Buildings.
- Representatives from the health department in Pike County, the American Cancer Society, and other groups provided support by offering smoking cessation classes for those affected by the proposed smoking ordinance.

Impact

- The smoking ordinance was approved unanimously. Accomplished through student advocacy, it prohibits smoking in all enclosed areas within the two public buildings or within 15 feet of the buildings.
- This smoking ordinance is a positive model for students and communities in Kentucky on the citizenship role in working together to achieve a healthier community.
- Integrating functions of two federally-funded programs maximized benefit and used program resources wisely.

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COMMUNITY POLICY SUPPORT FOR HEALTHY EATING AND PHYSICAL ACTIVITY

Local policy council expands for sustainable actions to improve resident's health

Public Health Problem

- The food people eat and the amount of physical activity they get are important factors in the quality and length of their lives since poor diet and lack of physical activity contribute to the leading causes of death and play a major role in the development of obesity.
- Holyoke is one of Massachusetts' poorest cities with few grocery stores providing healthy, affordable food options as well as limited resident access to opportunities for indoor and outdoor physical activity.
- Convening local residents, business owners and government officials in a non-partisan policy council can lead to the development of important local action to achieve mutually-beneficial goals.

Program

- The Massachusetts Department of Public Health, Obesity Prevention & Control Initiative, funds four regional community liaison positions to provide technical assistance on healthy eating, physical activity and obesity prevention to local coalitions, cities and towns statewide.
- The Western Region Community Liaison identified a grant opportunity and worked with the existing Food and Fitness Policy Council to expand it to a broader coalition. This coalition applied for and was awarded a Kellogg Foundation Food & Fitness Initiative grant that supports the creation of a comprehensive citywide plan to fight obesity and increase availability of public spaces for physical activity.
- The community liaison serves as a member of the coalition, providing technical assistance and planning support that is helping this group develop practical and sustainable ways to improve the local food and physical activity environment.

Impact

- This Massachusetts community coalition will begin to achieve objectives from the state's written plan to combat overweight and obesity through its leveraging of $500,000 as one of just nine communities to receive a two-year Kellogg Foundation planning grant.
- With a completed community plan, the coalition, called the Holyoke Food and Fitness Policy Council, has the potential to receive additional funding for implementation of significant changes in the food and physical activity environment of the city over ten years.

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IMPROVING DIABETES CARE COVERAGE FOR LOW-INCOME WORKERS

Communities work together to demonstrate the damaging impact of health care cuts

Public Health Problem

- Health care investments in preventive care for diabetes are offset by improved quality of life for people with diabetes and by reductions in the cost of treating long-term complications such as kidney failure.
- The Minnesota Legislature cut coverage for diabetes supplies, equipment and specialty care for 1,600 people with diabetes under MinnesotaCare, a state-subsidized insurance plan for low income workers.
- Additional cuts proposed two years later would have further reduced coverage – for up to 40,000 people.

Program

- The Minnesota Diabetes Program developed a brief but comprehensive fact sheet showing the impact of a lack of insurance on people with diabetes in Minnesota as well as the costs to the state of leaving diabetes untreated and uncontrolled. Find the "Uninsured with Diabetes in Minnesota" fact sheet at: *www.health.state.mn.us/diabetes/pdf/UninsuredwithDiabetes.pdf*
- The Minnesota Diabetes Steering Committee, a group of expert advisors to the Minnesota Diabetes Program, provided a communication network and forum for key organizations to learn about the diabetes care cuts and define their role in assuring access to care.
- Key legislators referenced the Minnesota Diabetes Program fact sheet during their legislative deliberations on health care coverage. Steering Committee members and advocates from the American Diabetes Association and the Minnesota Medical Association used the fact sheet to support improved diabetes care coverage under MinnesotaCare.

Impact

- Improvements in Minnesota's health care policy on diabetes care were proposed and passed by the legislature:
  - MinnesotaCare coverage for diabetes supplies and equipment was reinstated.
  - The annual outpatient care cap was doubled to $10,000, a change that will allow more complete care for patients with diabetes.
- Providing comprehensive public health data and organizing collaborative forums on health care policy issues are key steps for improving access to care for those in need.

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BUILDING SUPPORT FOR COORDINATED SCHOOL HEALTH AMONG SCHOOL SUPERINTENDENTS AND HEALTH OFFICIALS

School Health Leadership assemblies lead to improved health policies in North Carolina schools

Public Health Problem

- North Carolina students have high rates of physical inactivity, unhealthy eating, and tobacco use.
- Decision-making about health improvement programs for North Carolina students is done by local school superintendents and/or local health directors, making their support vital to the successful implementation of the coordinated school health approach in the state's two thousand schools.

Program

- The North Carolina School Health Leadership Assembly was created by the Department of Public Instruction and Division of Public Health, with support from the Division of Adolescent and School Health with the Centers for Disease Control and Prevention, in recognition of the important role of superintendents and local health directors.
- The two Departments jointly sponsored periodic School Health Leadership Assemblies to:
  - Enhance partnerships between public health and public education
  - Identify strategies for enhancing academic outcomes by improving health
  - Acquire resources to support student health policy and school health assessment
  - Create a group of superintendents and health directors who champion student health as a strategy for improving academic performance
- Three Assemblies reached almost half the local superintendents and more than half of the local health directors who collectively serve about two thirds of North Carolina's students.

Impact

As a result of their participation, local superintendents and health directors have:

- Supported the Healthy Active children Policy, creating a School Health Advisory Council in every school district; councils are charged to lead development of required wellness policies
- Led the way to adoption of 100% tobacco-free schools policies in more than forty Local Education Agencies and strongly supported state legislation requiring these policies in all schools
- Supported local participation in both the Youth Risk Behavior Survey and the School Health Profiles, important sources of information about student health habits
- Advocated for the successful School Nurse Funding Initiative that created 145 new, permanent school nurse positions and assured that all Local Education Agencies in the state have at least two school nurses
- Future Assemblies will reach the remaining superintendents and health directors
- Many superintendents use the School Health Leadership Assemblies to formulate local wellness policies mandated by federal legislation.

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TOBACCO-FREE SCHOOLS FOR A TOBACCO-GROWING STATE

North Carolina Healthy Schools Initiative acts to protect children at school

Public Health Problem

- Many North Carolina high school students currently smoke cigarettes and over half of them say they've tried to quit.
- Tackling the smoking problem among youth in a state that grows half of all the tobacco produced in the United States has long presented a significant challenge for both the public health and public school sectors.

Program

- Officials in the North Carolina Department of Public Instruction gained state superintendent endorsement for tobacco free schools and obtained a State School Board Resolution supporting this effort.
- Local communities and partners, supported by the North Carolina Tobacco Prevention and Control Branch of the Division of Public Health, the Health and Wellness Trust Fund and the Tobacco Free Schools initiative, have acted to achieve the state's progress in preventing smoking among youth.
- Individuals and teams working with the North Carolina Healthy Schools Initiative, partly funded through the Centers for Disease Control and Prevention Division of Adolescent and School Health developed and reviewed model policy language, provided access for the state health department's Tobacco Control Program to engage school decision makers; sponsored and participated in regional workshops to train administrators, school nurses, and staff; conducted forums with school superintendents, principals, and school board members, to encourage them to endorse and promote tobacco-free school policies; and supported development of special free signs for schools in districts adopting tobacco-free school policies.

Impact

- The percentage of school districts in North Carolina adopting 100% tobacco-free school policies increased from almost none to seventy-five percent over the seven years of coordinated action described above.
- The state legislature bolstered the effort by passing a law at the end of these seven years of action that mandates statewide compliance with tobacco-free school policies.
- By the following year, all North Carolina school districts were 100% tobacco free.

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CHANGING POLICY TO INCREASE TOBACCO CESSATION INTERVENTIONS

Health care providers trained to use an effective tobacco intervention at hospital admission

Public Health Problem

- Twenty-eight percent of Chautauqua County adults smoked in 2004, a higher rate than the state as a whole.
- Brief interventions for tobacco cessation are effective in helping smokers quit but health care providers do not always take the time or have the knowledge needed to apply this practice.

Program

- Steps to a HealthierNY–Chautauqua County partnered with the local health department Tobacco Control Program and the Women's Christian Association Hospital to establish a hospital policy requiring intervention with patients to promote tobacco cessation as part of the admissions process.
- Health care providers from many disciplines were trained by the Steps program staff to use a brief tobacco cessation model intervention that has been proven effective and to apply it with every patient who currently smokes. This "5A Model" intervention encourages health care providers to ask patients about tobacco use, advise patients to quit, assess patients' willingness to quit, assist in cessation attempts, and arrange for patient follow-up.
- The hospital revised their patient intake form to add a question about patient's tobacco use, then implemented the brief intervention with patients who were current smokers, providing tobacco cessation materials and referrals to the New York State Smokers' Quitline when appropriate.
- Over five hundred health care providers are trained to use the brief smoking intervention.

Impact

- As a result of the new policy, calls to the New York State Smokers' Quitline resulting from health care provider referrals quadrupled over twelve months.
- The Quitline experienced twice the number of calls during this time period compared with a neighboring county that has similar demographics but no intervention. Tobacco quit lines are a proven strategy for reducing tobacco use.
- The percentage of adult smokers in Chautauqua County dropped fifteen percent after two years of Steps program tobacco interventions such as this one.

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STUDENTS EAT HEALTHY AND MOVE MORE WITH NEW WELLNESS POLICY

District policy alters parent, student and staff ideas about the health of the school environment

Public Health Problem

- The rate of obesity among New York children is increasing.
- Even children are susceptible to the harmful effects of obesity, such as increased rates of diabetes and high blood pressure.
- Improving the school food environment is a key strategy to help children adopt better eating habits and become more physically active in order to prevent obesity and chronic diseases such as heart disease and diabetes.

Program

- The Heart Links Project of Suffolk and Nassau Counties, funded by the New York State Health Department's Healthy Heart Program, teamed up with twenty-seven school districts encompassing 137 schools.
- One of these districts, Valley Stream District 13, promoted awareness, education and policy change for healthy eating and physical activity.
- A district-wide wellness committee formed, conducted staff and parent education and recommended a comprehensive wellness policy increasing access to healthy food throughout the school day and encouraging physical activity.
- The Board of Education adopted the wellness policy for this district.

Impact

- The wellness policy adopted by the Board of Education created these meaningful changes in the school environment for over two thousand students:
  - Snack and beverage choices offered for sale in the cafeteria are more healthful (low-fat plain milk, water and 100% fruit juice in reasonable portion sizes, more emphasis on fresh fruit and vegetables) and must adhere to set nutrition standards
  - Food may not be used as a reward and physical activity may not be withheld as a punishment.
  - Classroom celebrations may incorporate physical activity and are non-food related.
  - Fundraisers taking place during the school day omit food.
- District Superintendent Dr. Elizabeth Lison says, "From exercise to diet and nutrition, the relationship between the district and Heart Links has changed the way our parents, students and professional community think about health."
- The message children now receive at school is that having fun doesn't depend on unhealthy food and that healthy snacks are tasty – lessons that leave a lasting impact.

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RHODE ISLAND STUDENTS THRIVE ON IMPROVED SCHOOL HEALTH PROGRAMS

Wellness committees improve the school nutrition environment and leverage legislative support

Public Health Problem

- School success and academic achievement are built on a strong foundation of healthy students learning in safe and caring school environments
- Rhode Island law requires all school districts to establish a school health and wellness committee to develop policies, strategies, and implementation plans to meet federal requirements, decrease obesity and improve the health and wellness of students and employees through nutrition, physical activity, health education, and physical education.

Program

- Rhode Island's coordinated school health program, called *thrive*, has helped school districts implement the new state law and establish district-level health and wellness subcommittees with funding from the Centers for Disease Control and Prevention Division of Adolescent and School Health provided to the Rhode Island Department of Education.
- A *thrive* toolkit contains guidance, model policies, data, and other resources to help schools meet the requirements of the mandate and the *thrive* program has helped recruit parents, registered dietitians, and other health professionals to provide expertise on health and wellness subcommittees.

Impact

- Examples of the impact on local schools include:
  - Implementation of the Cranston Public School District Farm to Schools program, a partnership among a local orchard, community farmer, and parent volunteers to supplement the fresh fruits and vegetables in the district lunch program. This effort supports local businesses and good health habits.
  - Westerly Middle School now specifies that the beverages allowed for sale in school vending machines must be water and/or drinks containing at least 50% fruit juice – a policy developed by the district health and wellness subcommittee.
- Building on the increased awareness on school health and wellness issues brought about by the local wellness committees, the state legislature passed a law requiring only healthy beverages and snacks at schools, adding strength to long-term efforts to build stronger minds, stronger bodies, and stronger schools.

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SOUTH CAROLINA CORRECTIONAL FACILITIES GO TOBACCO-FREE

New policy protects the health of over 30,000 inmates and correctional employees

Public Health Problem

- Many people die prematurely from smoking or exposure to secondhand smoke or have a serious illness caused by one of these exposures to smoke.
- A lawsuit filed by a South Carolina man with asthma resulted in a judgment that his rights were violated when he was exposed to secondhand smoke in prison and he received a significant financial settlement.
- Adopting a tobacco-free policy and providing resources to help people quit smoking is an effective strategy for preventing premature death and illness caused by exposure to smoke.

Program

- The director of the South Carolina Department of Corrections identified health as a priority for his tenure in this agency, which employs almost six thousand people and houses tens of thousands of inmates across twenty-eight institutions.
- Implementing a "best practice" for tobacco control with assistance from South Carolina Department of Health and Environmental Control Region 3 staff, the agency adopted a tobacco-free policy and offered tobacco cessation to employees and inmates in addition to the already-available nicotine replacement therapy.
- With funding from the Centers for Disease Control and Prevention's (CDC) Preventive Health and Health Services Block Grant, staff trained facilitators at three sites participating in a pilot to implement the American Cancer Society's Fresh Start program, a group-based tobacco cessation counseling program.
- The tobacco-free policy was implemented gradually, beginning with five facilities and utilizing resources such as the free South Carolina Tobacco Quitline.

Impact

- A tobacco-free policy now protects the health of more than 30,000 employees and inmates from exposure to secondhand smoke after an implementation with few reported problems.
- South Carolina's Department of Corrections is now on the level of federal prisons which preceded them in becoming tobacco-free.

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ENGAGING LOCAL GOVERNMENT FOR BIKE AND PEDESTRIAN PATHWAYS

Health department generates action on improving safety and access to physical activity

Public Health Problem

- Regular physical activity is associated with a longer, healthier life.
- There is good evidence that increasing access to walking and bike paths is an effective strategy for getting people to be more active.
- Increasing access to places for physical activity requires collaboration among government, non-profit and community agencies.

Program

- The S.C. Department of Health and Environmental Control, with funding from the Preventive Health and Health Services Block Grant, worked to re-establish the Central Midlands Bicycle and Pedestrian Subcommittee of the Central Midlands Council of Governments, a governing body for four South Carolina counties.
- After re-establishment, a health department staff member chaired this subcommittee of concerned citizens and organizations for six years, leading them in support for healthier, more livable communities through the creation of adequate walking and bike-riding facilities.
- The subcommittee seeks to assist with implementation of the Council of Government's Bike and Pedestrian Pathways Plan on alternative modes of transportation.

Impact

Results of the re-establishment of governmental support of bicycle and pedestrian access include:

- Outreach to local decision makers has led communities to adopt the subcommittee's model resolution and endorse strategies and projects outlined in the Council of Government's Bike and Pedestrian Pathways Plan.
- Towns and cities are receiving staff assistance on bike and pedestrian plans within their communities, for example the City of Columbia Bicycle Friendly Committee.
- Council of Government staff continue to participate in workshops and conferences, such as the South Carolina Department of Transportation's Safe Routes To School Training and the South Carolina Coalition for Promoting Physical Activity's 2007 Obesity Prevention Conference.
- Public initiatives, such as Bike-To-Work Day, are raising awareness of physical activity issues.
- Activities such as Columbia Bicycle and Pedestrian Week are engaging community members, elected officials, business leaders, and professional staff in the transportation planning process to make areas more physical activity-friendly, improve safety, and educate citizens and leaders on the value and importance of biking and walking for healthy communities.

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CREATING A MANDATE FOR STATEWIDE COORDINATED SCHOOL HEALTH

Federal and state resources combine to improve the health of Tennessee students

Public Health Problem

- Inadequate physical activity, poor diet, tobacco use and other health risk behaviors can affect the physical and social well-being of young people, as well as their academic achievement.
- Two thirds of Tennessee high school students don't get recommended levels of daily physical activity and a third are overweight or at risk for becoming overweight. Few of them eat enough fruits and vegetables and one fourth are smoking.

Program

- A statewide coordinated approach to school health can improve student health and strengthen academic achievement.
- Tennessee agencies and school health advocates built support for improving the health of the state's students, leading the Tennessee legislature to authorize a pilot program implementing the Centers for Disease Control and Prevention's coordinated school health approach in ten school districts in 2000.
- Based on the pilot's success, state legislators appropriated fifteen million dollars to expand the coordinated school health approach statewide in 2006.
- This funding, along with the collaboration between the Tennessee Departments of Education and Health and support from partners such as Tennessee Action for Healthy Kids and the Tennessee School Health Coalition, led to the implementation of the coordinated school health model in all but one of Tennessee school districts. All schools use the School Health Index to guide planning efforts and benefit from continued technical assistance and materials provided by the Division of Adolescent and School Health with the Centers for Disease Control and Prevention as well as the Office of Coordinated School Health, Tennessee Department of Education. Middle school Youth Risk Behavior Survey data is collected in all funded sites.

Impact

- Tennessee is the first state in the nation to mandate and fund a coordinated approach to improving students' health in every school district in the state.
- Results from the pilot which will now be extended to all Tennessee students, include:
  - Reduced absenteeism
  - Improved nurse-to-student ratios resulting in increased class time
  - Expanded health screenings for students to include Body Mass Index (BMI) and
  - Blood pressure increased access to health care services
  - Increased health education

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ADVOCACY FOR DIABETES CARE ASSURES COVERAGE FOR NEEDED SUPPLIES

Volunteer advocacy committee keeps the issue on the table and educates legislators

Public Health Problem

- Diabetes medications, patient education and test strips and meters to measure blood sugar levels are critical for the comprehensive diabetes management that prevents costly complications.
- The Diabetes Treatment and Management-Managed Care Act sponsored by Utah legislator, Howard Nielson, mandated coverage by state-regulated insurance plans for diabetes supplies and education but contained a sunset review provision.
- The sunset review clause required the insurance commissioner's office to evaluate the financial impact of the bill, measure changes in availability of coverage, and determine the extent to which care improved during the three-year period. A negative report would likely have eliminated the mandated coverage.

Program

- Concerned representatives from state organizations such as the American Diabetes Association, the Association of Diabetes Educators of Utah, and the Utah Dietetic Association formed a volunteer committee with the sole goal of ensuring the mandate was not eliminated at the end of three years, a strategy that proved to be very effective.
- The regional American Diabetes Association advocacy representative met frequently with the committee and formalized a process for supporting continued coverage.
- The Utah Diabetes Prevention and Control Program could not take a position on the bill but was able to provide accurate data to be used in the insurance commissioner's report.
- Committee members sought support from colleagues, friends and family and encouraged them to contact their district's legislators to educate them about the issue.
- Diabetes educators made their presence known in the legislative halls by offering blood sugar screenings to legislators. The diabetes community was kept informed through a listserv and there was a strong effort to ensure an advocate for every census tract.
- In a public forum, a Utah legislator provided guidance on communicating with representatives.
- The insurance commissioner's report on the three-year experience under this legislation indicated that the financial impact on insurance premiums was negligible while coverage of medical supplies and education improved for people with diabetes in the state.
- The estimated cost of the mandate was only an average of two cents per month per client in increased premiums, leading the volunteer advocacy committee to draft a position paper emphasizing the value to people with diabetes of the results described in the commissioner's report, titled Our Two Cents' Worth.

Impact

- Committee efforts along with the favorable insurance commissioner report led to rescinding of the sunset provision, and the bill remains in effect, benefiting insured state residents with diabetes and containing no threat of future sunset reviews.

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MAKING WEST VIRGINIA SCHOOLS A HEALTHIER PLACE TO LEARN

State agencies work together to educate policymakers on school nutrition standards

Public Health Problem

- Students spend a major part of the day at school in an environment that doesn't always support healthy lifestyle choices to prevent obesity.
- Federally funded school nutrition programs are the main source of food and beverages at school but minimum standards for these programs leave room for improvement.
- The West Virginia Board of Education cited data indicating that schools nationwide with high percentages of students who didn't routinely eat well and engage in physical activity had smaller gains in test scores than other schools.

Program

- The West Virginia Office of Healthy Lifestyles and West Virginia Board of Education prepared the way for proposed changes in school nutrition standards modeled on recommendations of the Institute of Medicine which had reviewed how foods and beverages sold at school contribute to a healthy school environment.
- Hosting an event in the House of Delegates chamber at the state Capitol gave the partners an opportunity to show state policymakers the practical aspects of changing nutrition standards through a visual display of the foods meeting the standards.
- A West Virginia expert who served on the Institute of Medicine committee described the available scientific evidence and justification for proposed changes.
- The event also honored twelve schools for outstanding work in school nutrition, providing West Virginia examples of what could be accomplished by the proposed changes.

Impact

- The West Virginia Board of Education Wellness Committee adopted an updated nutrition policy and Governor Joe Manchin III recommended approval. The policy establishes statewide standards for all foods and beverages sold, served or distributed to students during the school day and incorporates many Institute of Medicine recommendations for incorporating healthy foods and beverages. Board of Education policy carries the weight of state law in West Virginia.
- This policy can have a positive effect on the present and future health and well-being of West Virginia students whose health and well-being, like that of other American students is "profoundly affected by dietary intake and the maintenance of a healthy weight," according to the Institute of Medicine.

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NEW RESOURCE TO PROMOTE FRUITS AND VEGETABLES AMONG AMERICAN INDIAN AND ALASKAN NATIVE POPULATIONS

Collaborative work results in valuable resource for communicating important nutrition messages

Public Health Problem

- Health professionals may have limited understanding of the needs and health-related behaviors of the individuals and families in the American Indian and Alaskan Native communities where they work, making them less effective in implementing programs to reduce the burden of chronic diseases such as obesity and heart disease.
- Learning more about American Indian and Alaskan Native health beliefs and practices is enhanced when targeted resources are made widely available.

Program

- The Subcommittee on Special Populations of the State, Regional and Community Interest Group of the National Fruit and Vegetable Alliance Steering Committee, chaired by staff of the Arizona Department of Health Services Bureau of Chronic Disease Prevention and Control produced a first of its kind document entitled, *Resources and Tips for Working with American Indians and Alaskan Natives.*
- This guide is designed to reach health professionals with resources to enable them to consider the traditional food systems of American Indian and Alaskan Native populations when teaching the health value of fruits and vegetables and is available at: www.astphnd.org.

Impact

- This important resource enables health professionals to reach American Indian and Alaskan Native people with a culturally-appropriate messages such as "Traditional foods grown in a sustainable manner are healthy," increasing the likelihood of adoption of health-promoting behaviors.
- The resource guide was distributed at several conferences including one sponsored by the Intertribal Council of Arizona and is also available online. An article in the *Food Distribution Program on Indian Reservations* newsletter alerted readers to the resource guide.

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TRAINING LEADERS FOR ARTHRITIS EVIDENCE-BASED PROGRAMS

California meets the need for arthritis programs through collaboration to provide training

Public Health Problem

- Arthritis is the leading cause of disability in the United States, causing chronic pain and lessened quality of life for many people.
- Preventive intervention on arthritis such as provision of evidence-based physical activity programs can help people with arthritis reduce pain and disability and improve quality of life.
- Expanded program delivery is enhanced by increased capacity to train new instructors in a timely manner.

Program

- The California Arthritis Partnership Program increased training capacity within each California Arthritis Foundation Chapter to increase the supply of leaders for the Arthritis Foundation Exercise Program, Arthritis Foundation Aquatics Program, and Arthritis Foundation Self-Help Programs, all evidence-based physical activity programs.
- The California Arthritis Partnership Program contracted with the Arthritis Foundation, Southern California Chapter to conduct a statewide Train-the-Trainer Certification Workshop and conduct post training follow-up with Chapters and trainers for these three Arthritis Foundation programs.
- Participants received certification in accordance with current Arthritis Foundation standards and practices and were expected to offer a minimum of two training workshops a year in their "home" Chapter or in a nearby Chapter.

Impact

- The training effort….

….. increased the number of available trainers statewide; 160 new instructors and leaders have been certified

….. increased the number of available evidence-based physical activity program leaders

….. increased the number of new programs offered to people with arthritis

- Future trainings will apply important lessons learned to improve the training program….

….. assure that Arthritis Foundation Chapter Program Directors attend a certification workshop to assure familiarity with the material and enable them to support the new trainees

….. approve for training only those trainees who have satisfied pre-requisites

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IMPROVING AWARENESS AND USE OF DIABETES RESOURCES, SERVICES AND TRAINING

Diabetes Information Resource Center developed to answer stakeholder need

Public Health Problem

- California covers a large area, making it difficult for providers and patients to be familiar with the extensive network of programs and services available to fight the diabetes epidemic in California.
- A statewide assessment of diabetes stakeholders confirmed the need to improve communication about programs, services, training opportunities, and resources in order to assure widespread awareness and use.
- Stakeholders clearly wanted the California Diabetes Program to take the lead in developing a system for this purpose.

Program

- The Diabetes Information Resource Center (DIRC) is an online, information management system created with stakeholder input that addresses information related to the national objectives for state diabetes programs and Healthy People 2010. Funded by a grant from the Centers for Disease Control and Prevention as well as industry sponsors, it is designed to reach individuals and organizations working with people who have diabetes or are at risk for developing it.
- The resource center system not only pushes information out to users but pulls in their information for continuous updating of the resources.
- Features of the system keep users engaged. Registered users get a password, create a Partner Profile, link to their own Web site, post resources to share and receive monthly tracking reports. Regular, automatic messages remind registered users to review and update their information. An Event Calendar feature helps users promote events, automatically collect responses to invitations, send reminder emails to participants and easily create name badges and sign-in sheets.
- Registered users have access to online forums on many topics and can post documents to share with their discussion group.

Impact

- The Diabetes Information Resource Center infrastructure was built by the California Diabetes Program and belongs to the state users. It is maintained by both the California Diabetes Program and registered users who take responsibility for keeping their own information current.
- Over one hundred thousand visits to the online system occurred in the first year of existence.
- In a recent ten month tracking period, there were over thirty thousand visits to Partner Profiles and over one hundred thousand visits to the Resources section.
- A user describes its value: "Thank you so much for your excellent work building DIRC! I sincerely believe you and your team deserve an award for excellence in public service."

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CONSOLIDATING TRAINING TO BUILD PUBLIC HEALTH WORKFORCE CAPACITY

Offering training sessions to a wide audience maximizes training resources

Public Health Problem

- State health departments are responsible for providing essential public health services.
- Successful implementation of these essential services depends on the knowledge and capacity of the public health workforce.

Program

- The Prevention Services Division of the Colorado Department of Public Health and Environment which includes chronic disease, health promotion, maternal-child health, and nutrition programs reorganized into functional units to increase coordination and integration of program efforts, support staff in applying best practices, improve communication, preserve core public health functions and position the Division for the future.
- A Training Center was formed with resources and staff from Division programs to enhance the CAPACITY to achieve these objectives. Staff from many branches within the division serves on the Training Project Team, which develops and implements a division training plan.

Impact

- Organizing training for all of the Division's chronic disease programs at once rather than having each program develop individual sessions is a wise use of resources to build capacity for program accomplishment.
  - Two trainings have been provided on topics with universal application to Division programs: an introduction to public health and user-friendly evaluation. More are in development and may be offered to external partners as well, increasing partner capacity.
- Where appropriate, grantees of Division chronic disease programs – the Cancer, Cardiovascular Disease and Pulmonary Disease Competitive Grants Program, LiveWell Colorado and the State Tobacco Education and Prevention Partnership – receive training that is offered by one program to grantees from many programs, as a way of extending resources into the community and building capacity to support state program efforts.

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CONNECTICUT PROFESSIONAL EDUCATION CONFERENCE PROMOTES BETTER DIABETES CARE

Training across disciplines improves knowledge and skills of practitioners

Public Health Problem

- More than six percent of Connecticut adults have been diagnosed with diabetes and 70,000 more are estimated to have undiagnosed diabetes.
- Diabetes costs to the state are at least an estimated 1.7 billion dollars annually.
- Good prevention and control of diabetes begins with training providers to apply up-to-date guidelines and evidence-based practices.

Program

- The Connecticut Diabetes Review and Update is offered annually to nurses, dietitians and other health professionals working in hospitals, schools, local health departments and community based organizations – almost 350 have been trained since 2005
- The program is planned and implemented jointly by the Connecticut Diabetes Prevention and Control Program, the Connecticut Association of Diabetes Educators and the American Diabetes Association.
- Team teaching by endocrinologists, certified diabetes educators, pharmacists, nutritionists, exercise scientists, and counselors includes didactic sessions and skill building.

Impact

- Evaluations show that more than three fourths of attendees found the conference improved their knowledge of best practices for prevention and control of diabetes and most were confident they could implement these practices.
- For conference attendees, identification and treatment of diabetes improved through skills learned in assessment, use of proper treatment, and patient diabetes self management education.
- The distribution of diabetes educators across the state has been enhanced through the program.

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CONNECTICUT EDUCATES PROVIDERS ON THE CONNECTION BETWEEN DEPRESSION AND DIABETES IN WOMEN

Seminar increases needed screening, counseling and medication prescriptions

Public Health Problem

- Women suffer depression at twice the rate of men and people with diabetes suffer from depression at twice the rate of those without diabetes.
- Diabetes management can be undermined by the existence of depression.
- Health care providers can facilitate screening, referral and treatment, which are essential for both of these conditions, if they are aware of the connection between diabetes and depression and have the skills and resources to take action.

Program

- The Connecticut Diabetes Prevention and Control Program using grant support from the Women's Health Council of the National Association of Chronic Disease Directors made available through funding from the Division of Diabetes Translation at the Centers for Disease Control and Prevention, developed health care professional education on the topic of women, diabetes and depression.
- Partners on this project included the state's American Diabetes Association chapter, the Area Health Education Center, the Connecticut Association of Diabetes Educators, the Community Health Center Association of Connecticut, the African American Affairs Commission, and the University of Connecticut's Department of Behavioral Science and Community Health.
- The goal of the education is to increase awareness, knowledge and skills related to the impact of depression on diabetes management among health care providers and to promote favorable changes in provider practice. Programs are designed to reach physicians, physician assistants, advanced practice registered nurses, certified diabetes educators and community health workers through in-person and online seminars.

Impact

A participant survey shows the results of the education:

- More health professionals who participated are using a validated screening questionnaire
- More health professionals who participated are counseling patients
- More health professionals who participated are prescribing needed antidepressant medication
- Improved healthcare provider knowledge, attitudes, confidence, and intention in the short term which may decrease barriers to taking action and ultimately lead to improved practice patterns related to women with diabetes and depression.

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LIBRARY LENDS A HELPING HAND TO RESIDENTS WITH DIABETES

Diabetes Prevention and Control Program helps create community-based diabetes self-management education program and resource center

Public Health Problem

- A third of African American women over age fifty in the District of Columbia have diabetes, as well as twenty percent of people who are unable to work.
- Diabetes is a leading cause of kidney failure and stroke in the District of Columbia.
- The District of Columbia Primary Care Association found that entire communities lacked adequate access to routine medical services and ongoing treatment for problems such as diabetes.
- Teaching people to manage their diabetes by taking necessary medication, eating right, being active and getting important medical tests helps them prevent or delay complications, saves health care dollars and improves their quality of life.

Program

- The Diabetes for Life Learning Center was developed in collaboration with the District of Columbia Public Library System, the Department of Health Diabetes Prevention and Control Program and a local health care organization in response to the need for improving the self management skills of people with diabetes and providing peer support in a safe, easy to access community space.
- The Center provides structured diabetes education, an ongoing diabetes support group, medical lab tests for blood sugar and learning resources including computers designated for participant's use to promote the best clinical outcomes for residents with diabetes.

Impact

- The Diabetes for Life Learning Center improved access to diabetes education and had an impact on over a thousand primarily African-American people with diabetes, many of whom had no prior self-management training.
- Participants in a follow-up group showed improvements in blood sugar control, which research shows is associated with significant health care cost savings and improved long-term health outcomes.
- Evaluation results also show:
  - An increase in participant knowledge of treatment recommendations
  - Improved attitude about their disease
  - Fewer costly visits to hospital emergency departments for diabetes problems such as blood sugar that's too high or too low
- The Diabetes for Life Learning Center won the 2007 Public Health Award in Organization Achievement from the Metropolitan Washington Public Health Association.

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PASSPORT TO A HEALTHY FUTURE IN CITRUS COUNTY

Reaching vulnerable children and mothers with nutrition education to reduce obesity

Public Health Problem

- One in four children in the Women, Infant, and Children (WIC) Program in Citrus County, Florida are overweight or at risk of becoming overweight putting them at increased risk for chronic disease as obese adults.
- Improving eating and physical activity habits among children can help them prevent weight gain and adult obesity. Although there is limited information about children's eating habits in Florida, few adult residents eat the recommended daily servings of fruits and vegetables and one fourth have a sedentary lifestyle.

Program

- The Citrus County Health Department collaborated with a WIC program registered dietitian and a nutrition educator to teach kindergarten through third grade students about healthy eating and physical activity.
- The teaching team used several curriculum guides – Read for Health, Florida curriculum benchmarks, and Sunshine State Standards Benchmarks – as a starting point to create the Nutrition and Fitness Passport Program which provides six weekly classes.
- Students record one or more healthy examples in their passport at the end of each class to receive a "passport stamp" that allows them to "travel" to the next class. Students sign a pledge committing to a healthy lifestyle and their parents get a weekly letter with steps to take at home that helps engage them in the educational process.
- Initially funded from a settlement award, the program is now supported by the Preventive Health and Health Services Block Grant, the Board of County Commissioners, the Citrus County Health Department, and the Citrus County School Board Nutrition Department.

Impact

- School cafeteria staff reports an increase in fruit and vegetable consumption and a decrease in high-fat, whole milk purchases by students.
- Teachers report that children are eating healthier meals and bringing healthier snacks into the classroom.
- All Citrus County elementary schools are now implementing the Nutrition and Fitness Passport Program classes, reaching over three thousand students in the classroom and through "family night" activities.
- The Nutrition and Fitness Passport Program will be expanded to county middle schools, increasing the number of children who will benefit from healthy eating and physical activity education.

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INCREASING CAPACITY OF FAITH COMMUNITIES TO PROMOTE HEALTH

Live Healthy in Faith tools, resources, and training on healthy eating and physical activity

Public Health Problem

- Almost two-thirds of Georgia adults are overweight or obese.
- Faith is a fundamental influence in many Georgian's lives.
- Faith communities provide social support, community leadership, and reinforcement that can help members make lifestyle changes to achieve and maintain a healthy weight as well as help prevent the development of chronic diseases such as heart disease and diabetes.

Program

- The faith-based workgroup of the Take Charge of Your Health Georgia Task Force developed the Live Healthy in Faith tool kit to assist faith communities in implementing healthy eating and physical activity strategies to decrease the burden of overweight and obesity.
- The tool kit describes the relationship between faith, health and wellbeing and provides obesity prevention strategies for large and small faith communities of all religious affiliations.
- Materials in the tool kit describe the process for establishing a church health committee, provide instructions for doing health assessments, and describe health promotion strategies.
- Tools and resources allow for variability in the user's interest and abilities. Suggestions related to monthly health observances and easily-applied evaluation methods are provided. The tool kit is available at: http://www.district4health.org/pdf/faithbased%20toolkit.pdf
- Two state-wide trainings have been conducted and seven regional trainings have been offered.

Impact

- Development and distribution of the tool kit helps the Division of Public Health reach several intermediate objectives of the Georgia Nutrition and Physical Activity Plan – to increase the number of programs and the capacity of faith-based organizations to implement and sustain initiatives which promote awareness and skills related to healthy eating and physical activity.
- Tool kit users say, "The toolkit helped us to get the buy in we needed from leadership to expand our wellness outreach efforts" and "We LOVE your Live Healthy in Faith resource guide."

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STUDENTS THINK HEALTHY, EAT HEALTHY

Educating students on the benefits of eating a variety of colorful fruits and vegetables

Public Health Problem

- Most elementary school students in Guam are facing health problems such as overweight and obesity at an early age due to unhealthy eating habits and physical inactivity.
- Almost half the students identified through testing as overweight or obese were not aware they had a health problem.
- School nurses can provide education and counseling on lifestyle habits to help students achieve and maintain a healthy weight.

Program

- The Cancer Awareness and Prevention Program of the Guam Department of Public Health and Social Services collaborated closely with public school nurses to educate elementary school students about the importance of eating generous amounts of fruits and vegetables.
- Students are served fruits and vegetables daily as part of the federal meal programs but they may not understand the health benefits of including more fruits and vegetables in their daily diet.
- A "taste game" which challenged students to identify fruits and vegetables while blindfolded and a questionnaire and puzzle board titled "Reduce Cancer" were used in classroom groups of students, along with educational presentations. Pre- and post-tests assessed student's knowledge about cancer and health habits.

Impact

- The education and activities increased student's knowledge about eating generous amounts of a variety of fruits and vegetables and reducing the risk of chronic diseases such as cancer and diabetes.
- The program effectively met a student need for health education with these results:
- Over a hundred students were identified as unaware of the importance of healthy lifestyle behaviors or that fruits and vegetables help prevent cancer
- Two hundred students were educated and then tested on the benefits of fruit and vegetable consumption with ninety percent correctly understanding the meaning of fruit and vegetable color groups and the importance of healthy food choices
- Many students were motivated by the information and activities and made a decision to include a healthy snack as part of their efforts to stay healthy.

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NETWORKING AND EDUCATION TO IMPROVE COORDINATION ON DIABETES AND OBESITY

Kentucky Share-Fest event brings those with common goals together to promote effective actions

Public Health Problem

- Kentucky is experiencing twin epidemics of obesity and diabetes and has three state public health programs which are mobilizing local, regional and state partnerships to address these conditions, such as community-based diabetes coalitions, the Kentucky Diabetes Network, regional Partnership for a Fit Kentucky groups and a statewide obesity partnership.
- Obesity is also a risk factor for the development of diabetes and each condition benefits from interventions related to nutrition, physical activity and self-management.
- These Kentucky coalitions frequently have overlapping goals, objectives and interests which can be addressed more strategically through collaboration and ongoing communication at all levels.

Program

- *Coalition Share-Fest 2007*, a two and a half day conference, was jointly planned and conducted by the Kentucky Diabetes Prevention and Control Program, Nutrition and Physical Activity Program, and Obesity Prevention Program along with representatives of many coalitions. Conference funding was provided by the diabetes program and other cosponsors as cash and in-kind contributions.
- Interactive sessions designed to help participants develop or strengthen coalition leadership skills and time allotted for sharing success stories, tools and lessons learned were highlights of the conference. The conference also included panel discussions, presentations, round table discussions, interactive sessions, displays, and plenty of networking time.
- Conference participants each received a compendium of the state's successful coalition projects and contacts for additional information.

Impact

- Maximized use of resources and limited duplication of effort through joint planning and development by three federally-funded programs and two statewide coalitions
- Increased communication and collaboration among key stakeholders at the state, regional and local levels
- Provided a forum for sharing knowledge, experience, and tools and an opportunity to foster linkages among state, regional or local coalitions that focus on diabetes control, healthy nutrition and/or physical activity.
- Promoted coordination to maximize resource use among Kentucky coalitions

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DIABETES ALERT DAY INCREASES AWARENESS OF DIABETES

Local health departments assess risk and refer participants to helpful resources

Public Health Problem

- The symptoms of type 2 diabetes are subtle and can go undiagnosed for many years until it's too late to avoid serious complications such as heart attack and vision problems.
- In Maryland, it's estimated that 143,000 people have diabetes and don't know it.
- A Maryland Diabetes Prevention and Control Program provider survey confirmed the need for continued awareness activities.

Program

- The Maryland Diabetes Prevention and Control Program promoted American Diabetes Alert Day to raise awareness among Maryland residents about risk factors for diabetes and to empower individuals to assess their risk of developing diabetes.
- The Program provided posters and a risk test to partners in every local health department to insure coverage across the state. Health department partners were asked to display the materials and to track responses to questions they asked of participants about their awareness of the risk factors for diabetes before taking the test and the actions they would take in response to their risk assessment. People scoring ten points or more on the risk test are considered to be at a high risk for type 2 diabetes and are encouraged to see a health care professional for further evaluation.
- The Program also provided funds to the local chapter of the American Diabetes Association to augment the awareness campaign with an American Diabetes Alert Day television station special event that included six, sixty-second cut-ins featuring brief interviews with health professionals speaking on topics specific to diabetes. A phone bank in the studio was staffed by health professionals who answered viewer questions about diabetes. A banner ad on the station Web site linked directly to the risk test on the American Diabetes Association Web site.

Impact

The results of this awareness activity include:

- Awareness materials were available in every jurisdiction across the state of Maryland
- Of those taking the risk test, all reported an increase in knowledge about diabetes risk factors and an intention to take action
- About one hundred callers were referred to an appropriate resource for help with their question or concern and received useful diabetes education publications.

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PREVENTING TOBACCO USE BY MAINE YOUTH

Evidence-based interventions in schools help prevent premature death from smoking

Public Health Problem

- About one third of Maine children who smoke are expected to die prematurely of tobacco-related disease.
- Most Maine youth underestimate the health consequences of smoking.
- Most Maine youth don't believe that they will become addicted to tobacco.
- Most Maine adults who smoke started smoking before the age of 18.

Program

- Partnership For A Tobacco-Free Maine, a program within the Maine Center for Disease Control and Prevention, provides training and materials for the junior high school *LifeSkills Training* Program at no cost to schools that agree to implement the program for the three year commitment as trained.
- Schools that are part of the Partnership For A Tobacco-Free Maine-funded Healthy Maine Partnership initiative are required to implement the *Life SkillsTraining* Program
- The *LifeSkills* Training program content is linked to the Maine *Learning Results* Health Education Standards as appropriate
- Nine School Health Coordinators were trained to provide regional trainings of the *Life Skills Training* Program to health teachers from schools who agree to implement the program for the three year commitment as taught.

Impact

- Smoking among high school students in Maine decreased by sixty percent from 1997 to 2004.
- Over 150 Maine middle school personnel have received LifeSkills Training Program training.
- Educational programs such as LifeSkills Training, combined with an increase in state tobacco excise taxes, statewide counter marketing campaigns and community, evidence-based, tobacco prevention and control programs are significantly lowering tobacco use by youth.

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TRAINING SUPPORTS STATEWIDE HEART ATTACK AWARENESS

Preventing delays in emergency treatment for heart attack increases survival chances

Public Health Problem

- Almost half of all heart attack deaths happen before an ambulance arrives.
- People's awareness of heart attack symptoms makes it possible for them to recognize a heart attack while it's happening, leading to early treatment and improved outcomes such as survival and better quality of life.

Program

- The Maine Quality Forum launched In a Heartbeat, a state-wide effort to enhance heart attack systems of care in Maine. In partnership with the Maine Cardiovascular Health Program, they led the Acute Myocardial Infarction Community Engagement Workgroup whose priority is development and state-wide distribution of consistent messages and resources to help Maine residents promptly recognize and respond to heart attack symptoms.
- Workgroup members developed a toolkit and conducted regional trainings, with the goal of increasing the number of community organizations and partners able to train others to deliver consistent heart attack awareness messages to Maine residents.
- Financial support for the state-wide launch was provided by three major hospitals, with training, development and implementation support provided by the Maine Centers for Disease Control and Prevention's Cardiovascular Health Program, the Maine Quality Forum and the Acute Myocardial Infarction Community Engagement Workgroup.
- Find training resources at: www.healthymainepartnerships.org/mcvhp/resources.aspx

Impact

- Evaluation of the pilot training indicates that most respondents say they will call 911 first if witnessing potential heart attack symptoms.
- A majority of trainees said that having the toolkit will motivate and/or assist their community to provide more public awareness education specific to heart attack.
- Six regional training sessions reached over a hundred trainees; community partners have distributed over eighteen thousand In a Heartbeat educational resources to support message recall among local audiences. Provision of technical assistance to state-wide partners is an ongoing component.
- In the first six months of the initiative, over 100 heart attack awareness presentations reached more than 1,300 residents across two-thirds of Maine's counties.
- Increasing Maine resident's recognition of heart attack symptoms and the importance of calling 911 is improving the chance of better clinical outcomes associated with heart attack.

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EXPANDING KNOWLEDGE FOR EFFECTIVE PHYSICAL EDUCATION

New physical education curriculum emphasizes life skills and regular physical activity

Public Health Problem

- Overweight and inactivity are a problem among youth in Michigan since twenty-eight percent of high school students are either obese or overweight, less than half meet recommended levels of physical activity, and fifteen percent said they hadn't participated in recommended amounts of physical activity on any day during the previous week, when asked.

Program

- The Michigan Departments of Education and Health supported the development of the Exemplary Physical Education Curriculum as part of the state's coordinated school health program.
- This curriculum for grades K-12 is designed to enhance physical activity knowledge, personal, social, and motor skills, and physical activity and fitness levels to enable students to be active for life. The lessons address content standards from the National Association of Sport and Physical Education as well as the Michigan Physical Education Content Standards.
- The Michigan Department of Education, with the support of the Centers for Disease Control and Prevention Division of Adolescent and School Health, participated in an evaluation of the curriculum, measuring its effectiveness among fourth and fifth grade students in improving attitude toward and confidence in physical activity, as well as motor skills, physical activity levels, and fitness as compared to students who were taught using different physical education curricula.

Impact

- Evaluation shows that compared with same-grade students receiving alternate physical education curricula, among those exposed to the Exemplary curriculum:
  - 4th grade students had greater levels of confidence in their ability to perform motor skills.
  - 5th grade students had greater levels of physical activity knowledge.
  - 4th grade and 5th grade students demonstrated higher levels of motor skills.
  - 4th grade students reported more total minutes of physical activity.
  - 4th grade students reported more energy during physical activity.
- The Michigan agencies involved are emphasizing the elimination of disparities in physical activity by encouraging quality nutrition and physical education in Michigan's low income schools and providing the curriculum, training, and materials free-of-charge.

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ASTHMA PLANNING AND EDUCATION TO IMPROVE OUTCOMES

Minnesota is one of six states funded for full implementation of its state asthma plan

Public Health Problem

- Asthma causes missed days from school and work, interrupts sleep, and limits physical activity.
- Fifteen percent of Minnesota adults with asthma visited an emergency room or urgent care center at least once in a year because of their asthma – an indication of poor control.
- The Minnesota state asthma plan identifies health care providers, school personnel and coaches as essential to efforts to educate children and adults with asthma to control their asthma and reduce costly hospitalizations.

Program

- The Minnesota Department of Health Asthma Program is one of six programs funded by the Centers for Disease Control and Prevention for full implementation of its state plan to address asthma as an emerging public health problem. Many stakeholders developed the plan and the Program established an asthma surveillance system.
- The Program also created the first interactive asthma action plan. Providers use the action plan to determine asthma severity level and prepare individual asthma action plans to prevent development of severe symptoms and reduce the need for emergency room visits or hospitalizations for adults and children with asthma (www.mnasthma.org/aap/).
- The Program developed a manual and trained school personnel. These trained staff then collectively reached thousands of students with asthma to help with asthma control. Training reached over 900 people from about two thirds of state school districts.
- Working with the Utah Department of Health, the Asthma Program also developed an online training for coaches called *Winning with Asthma*, targeting physical education teachers and coaches, groups not generally thought of as public health partners, to help them with management of student asthma episodes (www.WinningWithAsthma.org).

Impact

- The trainings significantly improved the asthma knowledge of school personnel and resulted in changes such as developing standardized procedures and working on inhaler techniques.
- The interactive asthma action plan is one of ten web sites recommended by the American Thoracic Society for asthma action plans and is used by many practitioners, several clinics, and by medical students during residency.
- Feedback from coaches indicates they utilized what they've learned and are seeing improved performance from athletes with asthma. Coaches from several states have completed the training and some asthma coalitions are promoting it to coaches in their states or regions.

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ENGAGING FAMILY PHYSICIANS IN REACHING CANCER PLAN OBJECTIVES

Continuing medical education offerings are well-received and sustainable

Public Health Problem

- Family Physicians and other primary care practitioners have an important role to play in cancer prevention and control.
- Recent information in the North Carolina Medical Journal indicates a lack of access to, but high demand for cancer-related continuing medical education topics.

Program

- The North Carolina Division of Public Health Comprehensive Cancer Program developed a strategy to utilize on-going continuing medical education as a method of providing information and enlisting participation by primary care physicians in the implementation of North Carolina's Cancer Plan by working through the North Carolina Academy of Family Physicians, the state's largest specialty medical association.
- A three-hour program called, *What Every Family Physician Should Know About Cancer*, was developed with the then-President of the American Cancer Society as a principal speaker.
- A year later, a one-hour update session was sponsored and actively participated in by Comprehensive Cancer Program staff who also developed tailored resources such as a pocket guide.
- The sessions included an informal introduction to the state's Cancer Plan and recruitment for community-based comprehensive cancer activities.
- This continuing medical education program was funded through both state and Centers for Disease Control and Prevention funding. In the second year of the program the expense was approximately nine dollars for every family physician reached.

Impact

Evaluations of the training sessions show:

- Session presenters, materials, and relevance were rated very good to excellent for all sessions.
- Because of these encouraging evaluation results, the *What Every Family Physician Should Know About Cancer* training will be presented annually.
- A Web-based version of the training has been developed and a Cancer Update and Cancer Survivorship session for family physicians is slated for the near future.
- The Comprehensive Cancer Program is exploring ways to measure increased knowledge, involvement, and participation of family physicians in targeted Cancer Plan intervention activities.

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MEETING CULTURAL AND HEALTH NEEDS FOR NORTHERN PLAINS INDIANS

Diabetes…Finding the Balance guide on caring for body, mind, heart, and spirit

Public Health Problem

- Diabetes rates in North Dakota's American Indian tribes are over twice as high as those of the general population.
- Most educational materials written for American Indians do not consider the culture of the Plains Indian Nations of North Dakota, such as those who live in the Aberdeen Area Indian Health Service area.

Program

- The North Dakota Diabetes Prevention and Control Program sponsored a cooperative project among representatives from Standing Rock Nation; Spirit Lake Nation; Turtle Mountain Band of Chippewa; the Mandan, Hidatsa and Arikara Nation; KAT Productions, a consulting group; and the American Diabetes Association – North Dakota office.
- The need for the guide was identified and its content was developed as a result of two focus groups of American Indians. The participants included American Indians of various ages, living on reservations or in cities. American Indian physicians served as medical review experts for the publication.
- Native artists provided original art work and photographs.
- Tribal technical and cultural consultants, diabetes educators, dietitians, and others involved in diabetes care from across North Dakota offered guidance on development of the publication at all stages of production. Advice from reservation-based diabetes program staff was also invaluable.
- Over six thousand wellness guides have been distributed to individuals, organizations and tribes in North Dakota and other states. View it at: http://www.diabetesnd.org/Diabetes.pdf.

Impact

- The comprehensive guide to diabetes for the Northern Plains Indians, *Diabetes…Finding the Balance*, was widely distributed to tribes in North Dakota.
- Evaluation results show that recipients of the guide find the information easy to understand and useful, are appreciative of the native artwork and culture represented in it, and say the guide will help them make changes in their eating and activity habits for better diabetes control.
- Health professionals in twelve states with American Indian populations requested the guide, expanding its reach and signifying the value of this useful resource to other state diabetes and health programs.

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IDENTIFYING WOMEN WITH DIABETES AND DEPRESSION

Training participants indicate an interest in implementing a formal screening process

Public Health Problem

- Women suffer depression at twice the rate of men and people with diabetes suffer from depression at twice the rate of those without diabetes.
- Diabetes management can be undermined by the existence of depression.
- Health care providers can facilitate screening, referral and treatment, which are essential for both of these conditions, if they are aware of the connection between diabetes and depression and have the skills and resources to take action.

Program

- A group of partners including the New Hampshire Diabetes Education Program, the Southern and Northern New Hampshire Area Health Education Centers and others, developed training on diabetes and depression using grant support from the Women's Health Council of the National Association of Chronic Disease Directors made available through funding from the Division of Diabetes Translation at the Centers for Disease Control and Prevention.
- The purpose of the training is to reach health care professionals to raise awareness about the effects of coexisting diabetes and depression in women and to improve identification of depression among women with diabetes.
- Project activities include offering fourteen training sessions, disseminating written information on diabetes and depression, and performing an initial and a follow-up audit of practice related to screening, diagnosis, and treatment of diabetes among women with diabetes.

Impact

- In a follow-up survey two out of ten practice sites where training was implemented indicated that they were already conducting depression screening and seven indicated interest in implementing a formal screening process.
- Participants identified strategies they could use to make a stronger connection between diabetes and depression screening.
- The project leveraged funding to offer training at four additional sites; will continue to offer training as funds permit; and will seek funds to implement technical assistance to help sites develop screening programs, filling a need identified by participants.

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NEW MEXICO DIABETES AND DEPRESSION COURSE INCREASES PROVIDER KNOWLEDGE AND SKILLS

Online access is a plus for rural providers with limited resources outside of metro areas

Public Health Problem

- Diabetes management can be undermined by the existence of depression leading to poor health outcomes and greater medical costs.
- The prevalence of diabetes and depression is high in New Mexico and there is a shortage of providers knowledgeable about this issue, especially in rural areas of the state.
- Online courses are an effective way to reach health care professionals who practice in rural and frontier areas.
- Health care providers can facilitate screening, referral and treatment for diabetes and depression if they have the tools, resources and expertise to take action.

Program

- The New Mexico Diabetes Prevention and Control Program coordinated a project using a contractor, MediaDesigns Inc., to develop an online educational program that teaches providers to diagnose depression and prescribe appropriate and effective treatment as well as track and monitor patients throughout the process. Program staff and volunteer experts offered content and instructional design support. Find course information at: http://www.diabetesnm.org
- Funding was provided through the Program's cooperative agreement with the Centers for Disease Control and Prevention along with substantial in-kind support from partners. The course is available at no cost to participants.
- A testing service evaluates student results and provides certificates on completion. An online database specialist tracks course use and participant data.
- More than five hundred users from forty states have taken the course, primarily physicians, nurses, pharmacists, dietitians, social workers, and health educators.

Impact

- This ongoing project overcomes barriers to treatment and prevention of diabetes by offering tools to health care providers, accessible online at no cost, and providing needed continuing education with credits that help fulfill licensing requirements for physicians, nurses, pharmacists, health educators, dietitians and social workers.
- The availability of federal funds leveraged additional in-kind support from partners.
- The course reaches across state boundaries to fill a need identified by additional providers.
- One trainee expresses her enthusiasm for the course as, "Very good explanation of research in diabetes and depression – very useful in my current practice. Thank you!"

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FINE, FIT & FABULOUS NUTRITION AND FITNESS PROGRAM GETS RESULTS

Bronx-Queens Coalition to Prevent and Control Diabetes makes it happen

Public Health Problem

- Racial and ethnic minorities living in the southwest Bronx face huge disparities in health outcomes and rates of disease.
- A higher percentage of residents, compared to other parts of New York City or the state, are obese, have diabetes, are getting little or no physical activity and live in an environment where fruits, vegetables and low fat milk products are difficult to buy due to the proliferation of corner stores and fast food restaurants that sell mostly high-fat, high-calorie foods.
- Community-based programs that support behavior changes related to physical activity, healthy eating, and reaching a healthy weight can help prevent the serious complications of diabetes such as amputation and vision impairment.

Program

- The Fine, Fit & Fabulous Nutrition and Fitness faith-based program is a twelve-week, spiritually-based support group program created by a Bronx-Queens Coalition to Prevent and Control Diabetes member who serves as a health coordinator for her church as part of the Bronx Racial & Ethnic Approaches to Community Health (REACH) initiative.
- Primarily female participants actively engage in fitness instruction, group discussions, role-playing and educational sessions on weight management with emphasis on nutrition and portion control as part of the program curriculum.
- Participants receive the curriculum, exercise mat, pedometer, Fine, Fit & Fabulous T-shirt, sweat bands, and refrigerator magnets that remind participants to "Dump the Junk" as well as marked plates and cups for learning portion control.
- Participants set nutrition and fitness goals, are assigned a "buddy," and are encouraged to anchor goals to their spiritual/religious values for motivation and sustained commitment.
- Four churches are implementing the program, reaching over one hundred people.

Impact

- The Fine, Fit & Fabulous program yields "graduates" who are more empowered, educated and motivated to maintain healthy lifestyles to better manage or help prevent diabetes. As one said in a letter to the program, "I learned to be more disciplined, exert more self-control to resist temptations more….I will continue with my program."
- Results from two completed groups show that participants, many of whom have diabetes or are at high risk for developing it, gained nutrition knowledge and many have lost weight.
- Program "graduates" will be trained to implement the program in additional church locations.
- The program is being adapted for use among Spanish-speaking congregations.

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MEETING HEALTHY PEOPLE 2010 GOALS FOR PEOPLE WITH DIABETES

Diabetes management education is made available in Madison County, New York

Public Health Problem

- Adults in Madison County, New York are more likely to be obese and to get little or no regular physical activity compared to adults in the state as a whole.
- Madison County adults are also hospitalized for diabetes-related conditions at a rate much higher than the Healthy People 2010 goal for the nation.
- Programs to educate people with Type 2 diabetes about managing their condition are very limited in the county and many cannot afford the only program offered.

Program

- The Madison County Health Department, a member of the Central New York Diabetes Prevention Partnership, partnered with Cornell Cooperative Extension of Madison County to offer three sessions of a six-week nutrition education program for people with Type 2 diabetes, the type most associated with obesity and lack of physical activity.
- "Eating Well with Diabetes" is free to people with diabetes and each participant is encouraged to bring a family member or friend who is helping them manage their condition.
- A nutrition educator from Cornell Cooperative Extension facilitates the program of five lessons on portion control, food labels and shopping, menu planning, healthy cooking practices, and physical activity. A registered dietitian teaches carbohydrate counting, a diet management technique for people with diabetes.
- Weekly incentives, such as cookbooks and pedometers as well as door prizes, such as gift cards to local stores that promote physical activity, encourage attendance. Most participants attend every session.

Impact

- This free program increases the availability of self-management education for Madison County residents of any income level and helps achieve a national self-management education goal of the Healthy People 2010 national health objectives.
- Feedback from participants shows:
  - An increase in knowledge, based on pre- and post-tests
  - An almost fifty percent increase in the number of participants who include whole grains in their daily diet, a key concept stressed throughout the series
  - Many other healthy behavior improvements such as increased use of daily carbohydrate counting, making overall healthier food choices, more physical activity, paying more attention to portion sizes, and making healthful ingredient substitutions when cooking and baking.

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WORKSITE DIABETES EDUCATION PROMOTES AWARENESS AND PREVENTION

Employees benefit from education and changes in the workplace environment

Public Health Problem

- Diabetes is a serious and growing problem.
- Many working people don't participate in lifestyle change and education programs because it's difficult to fit them into a busy schedule.
- Worksite health programs have been shown to yield a high return on investment from results such as higher productivity, fewer missed days of work and happier, healthier employees.

Program

- The New York State Department of Health funds diabetes coalitions throughout the state to implement steps to prevent and control this condition.
- The Employee Assistance Program Coordinator of the New York State Department of Motor Vehicles expressed concern to the coalition about employees with diabetes and other workers at risk for this condition due to obesity.
- The Diabetes Resource Coalition of Long Island created a worksite wellness program plan that included education about diabetes & childhood obesity awareness and prevention.
- Employees were given an hour of the work day to attend educational sessions.

Impact

- This program made it easy for well over a hundred employees to get needed education on diabetes and obesity at work by supplying leave time during the work day.
- The education led to beneficial changes in the workplace environment initiated by the workers themselves including healthier foods at meetings.
- Employees also reported making changes outside of work such as consuming smaller portions, eating more fruits and vegetables, eating less fast food and sugary beverages, switching to whole grains and becoming more physically active.
- The positive results, presentations to additional Employee Assistance Program coordinators in other agencies and discussions with the Suffolk County Executive are promoting expansion of the program to other state and county agency employees.
- Educational seminars received high ratings in follow-up surveys, including, *"Your seminars were well received and staff is still talking about your presentation."*

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STROKE HEROES ACT FAST TO RAISE AWARENESS AND SAVE LIVES

Teaching signs and symptoms of stroke spurs quick action to seek emergency care

Public Health Problem

- Almost half of stroke victims die before being hospitalized.
- Stroke is also the leading cause of adult disability in the United States.
- Early treatment can reduce disability and deaths due to stroke but only if people recognize the sometimes-subtle symptoms and seek emergency treatment.

Program

- With funding from the New York State Department of Health, St. Vincent's Hospital Healthy Heart Program educated workers in New York City, Queens, Staten Island and Brooklyn about stroke.
- The Stroke Heroes Act FAST educational program, created by the Massachusetts Department of Health, uses the FAST acronym to teach stroke signs and symptoms.
- FAST stands for **F**ace, **A**rm, **S**peech and **T**ime to call 9-1-1 and its use leads to immediate recognition of a majority of strokes.
- Program participants completed a quiz assessing their knowledge of stroke signs and symptoms before and after the presentations.

Impact

- Participants in the educational program increased their knowledge of stroke signs and symptoms.
- *Two worksites credit the stroke awareness presentation with saving the life of an employee*. Both employees avoided serious injury because the stroke awareness program helped colleagues recognize the urgency of the situation and the need for immediate action.
  - A twenty-four year-old male employee told a colleague he wasn't feeling well. The colleague, having attended the stroke program, recognized the symptoms as stroke-related and persuaded him to seek emergency care.
  - A fifty year- old woman recognized her own symptoms and sought immediate care.
- Feedback indicates that participants will share the important stroke information they learned with co-workers, family and friends, extending the reach of the educational program.

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IMPROVING HEART HEALTH FOR PEOPLE WITH DISABILITIES

Educational program adopted as a standard in recognition of its value

Public Health Problem

- A third of New York's disabled adults are obese putting them at higher risk for having a heart attack or developing diabetes.
- Many more disabled adults have heart attacks or strokes compared to the average for New York adults.
- People with disabilities living in group homes are dependent on staff to purchase and prepare healthy food for them.
- Educating group home staff who are responsible for food shopping and preparation can increase the availability of healthy food and help reduce the risk for overweight and diet-related chronic diseases for the adults living in these homes.

Program

- With funding from the New York State Health Department Healthy Heart Program, dietitians from People, Inc. developed a nutrition training workshop to educate group home staff with the goal of improving the nutrition and health status of this population.
- Training covers the American Heart Association nutrition guidelines, the exchange system for people with diabetes, the benefits of fiber & water, healthful eating out, label reading, food storage & safety, cooking basics and portion control.
- Over two thousand staff members have received the training – these staff members are responsible for over four thousand individuals living in People Inc-run homes.
- The dietitians survey each group home yearly to evaluate healthy food choices.

Impact

- People Inc staff increased their knowledge of healthy eating principles.
- Resident eating habits have improved, both for in-home meals and away-from-home meals.
- A review of grocery receipts for group home food purchases shows a seven percent increase in heart healthy foods purchased, including higher fiber bread and cereals, lower fat meat and dairy products, and lower sodium foods
- The obesity rate in the homes has decreased slightly since the start of the program
- The training is now a mandated part of agency-wide orientation in recognition of its value in improving the quality of life for group home residents. The Office of Mental Retardation and Developmental Disabilities adopted the People Inc. criteria for nutritional surveys and menu system as "best practice" for their own facilities, extending this valuable program.

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MOTHERS REDUCE TOBACCO USE WHILE LEARNING TO PREVENT CHILDHOOD OBESITY

Steps to a Healthier Cleveland's Community Health Worker program collaborates with existing MomsFirst program

Public Health Problem

- Childhood obesity and tobacco use/exposure are significant health issues in Cleveland and are targeted risk factors of Steps to a Healthier Cleveland.
- Pregnancy is an opportune time to counsel smokers, since they are more likely to quit smoking to protect the fetus.
- Expectant mothers and women with children are also receptive to good parenting messages about preventing overweight in their children

Program

- Steps to a Healthier Cleveland's Community Health Worker and Health Care Provider programs partnered with MomsFirst, an existing federally-funded maternal-child initiative that provides comprehensive outreach and case management services to high-risk pregnant and post-partum women and teens.
- The MomsFirst community health workers, who serve as case managers, were trained on the additional topics of smoking cessation and childhood obesity assessment and management and use this information in their regular contacts with pregnant and post-partum women.

Impact

- Mothers who smoked at the start of MomsFirst interventions reduced their cigarette use and two-thirds attempted to quit smoking.
- Most of the community health workers completing the evaluation increased their knowledge about smoking cessation and childhood obesity.
- Community health workers immediately applied the skills and tools gained through this intensive training to their community or clinic settings.
- The training was low cost and can be shared using a Train-the-Trainer approach.

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FAMILIES IN FAYETTE COUNTY SHAPE HEALTHIER LIFESTYLES

Private partner shares responsibility with government for the implementation of a needed program

Public Health Problem

- Obesity and overweight can cause children to develop conditions such as type 2 diabetes and high blood pressure, leading to disability and even death as adults.
- Over a third of Pennsylvania eighth graders are either overweight or at risk of overweight.
- Local school nurses and pediatricians identified a need for a weight management program to help local children & their family members reach and maintain a healthy weight through physical activity and healthy eating.

Program

- Steps to a Healthier Pennsylvania – Fayette County partnered with Highmark Blue Cross/Blue Shield to bring KidShape® to their county.
- Steps to a Healthier Pennsylvania – Fayette County coordinates and runs the program. Highmark Blue Cross/Blue Shield pays all program costs, including materials and staff (project coordinator, dietitian, physical activity and mental health specialists).
- KidShape® is an evaluated program for overweight children ages 6–14 and children at risk of becoming overweight, and their families.
- Families participating in seven out of nine sessions have their nominal registration fee returned. Thirty-two high-risk families have participated.

Impact

- Participating families report eating more fruits and vegetables and spending more time being physically active, according to an evaluation of the program by its developers.
- Families describe what they've gained from the program as:
  - We learned "as a family to watch portions and slow down when eating."
  - "Portion-size opened my eyes, as did the pedometers. I thought I walked more (in) a day!"
  - "I am much more aware."
- School districts in Fayette County where body weight is regularly assessed can now connect overweight children & their families to this needed resource for help in reaching and maintaining a healthy weight.
- Local pediatricians and family practitioners now have an effective program to offer to children they identify as overweight or at risk of becoming overweight.

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REACHING THE CHINESE POPULATION TO PREVENT OSTEOPOROSIS

Culturally-appropriate workshops and educational materials increase awareness and healthy behaviors

Public Health Problem

- More than half of Asian women aged 40 and older tested in Philadelphia were identified as having osteoporosis or low bone mass which is associated with developing osteoporosis.
- Preventing this disabling condition requires getting adequate amounts of dietary calcium and being physically active.
- Many Asians in Philadelphia are Chinese-speaking immigrants who need to have health information presented in a culturally-appropriate way and in a language they can understand.

Program

- The Pennsylvania Department of Health and the Chinese Information Center at Thomas Jefferson University implemented the Osteoporosis Education Project for the Asian community.
- Staff conducted three workshops on bone health, including osteoporosis prevention and treatment, in communities with a high concentration of Asian residents. Culturally appropriate educational materials were developed in Chinese.
- Physicians who were familiar to community residents presented information at the workshops in Mandarin Chinese and Cantonese, two predominant Chinese dialects.

Impact

- Many participants learned to recognize calcium-rich foods and the kinds of physical activity that promote bone health after attending the workshops.
- More than a third of the participants say they are eating more calcium-rich foods and getting more Vitamin D as well as increasing their physical activity. Both of these are important preventive steps for osteoporosis.
- The Center's workshops are breaking down the cultural and language barriers to increase understanding and prevent osteoporosis among the Chinese population.

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LINKING EDUCATION AND FATHER'S DAY TO PROMOTE PREVENTION

Popular celebration day provides a way to reach men with important information about diabetes

Public Health Problem

- In the Republic of Marshall Islands men with diabetes have a rate of lower limb amputation that is three times that of women with diabetes.
- Although diabetes is much less common in men than women, public health officials realized that men were not seeking medical care for diabetes until it was too late to prevent amputations.

Program

- The Republic of Marshall Islands Diabetes Prevention and Control Program worked with Primary Health Care Services to reach people at risk for diabetes complications, identifying men as a group needing attention due to their high rate of amputations.
- The Diabetes Prevention and Control Program uses existing cultural and community events as a key venue for diabetes outreach and Father's Day is one of the largest community events in the Marshall Islands. Linking health seminars with local Father's Day celebrations allowed them to address men's attitudes and behavior related to prevention and to teach them ways to protect their health.
- Diabetes advisory group members and stakeholders helped plan the first Father's Day health seminar which featured culturally appropriate music, singing, and incentive gifts while providing preventive health screening, cooking demonstrations, and presentations on tobacco use, healthy eating, and physical activity. Many workplaces and churches were asked to send two male leaders from their sites to participate in the seminar.

Impact

- One participant shared his comments on the seminar:
  "The beauty of the event is having a separate seminar for men...If there were women, many would have hesitated to ask questions." and "men do not always read the page on health issues in the newspaper. So, having a men's health seminar really opens our eyes to the good information."
- A church sponsored a second, similar workshop for community leaders and other men from the community and the diabetes program is filling requests for additional programs specifically for men in workplaces and churches.
- The diabetes program has noticed increased participation in diabetes support groups.
- Health partners are joining the educational effort, adding other critical health messages on cancer and tuberculosis.

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TRAINING HEAD START WORKERS TO REDUCE PRESCHOOL OBESITY

Focus on lifestyle messages promotes healthy weight in a more positive and effective way

Public Health Problem

- A fourth of low-income preschool children in South Carolina are overweight or at risk of becoming overweight.
- Leaders and staff in Head Start programs noticed that the children served by their programs were also getting heavier and had higher body fat measures.
- Engaging parents of these children in discussions about improving their child's health and weight status was a difficult and uncomfortable task for staff.

Program

- The South Carolina Department of Health and Environmental Control Public Health Region 7 is partnering with Head Start programs in Berkeley, Charleston and Dorchester counties to stop or slow the upward trend in body mass index and weight among preschool children.
- With state health department regional funding and federal Preventive Health and Health Services Block Grant funds, the 5+-2-1-0 program was added to the existing Color Me Healthy interventions in Head Start centers. Color Me Healthy is a program using fun, interactive learning activities to promote physical activity and healthy eating. The 5+-2-1-0 program encourages lifestyle goals for families that will help all family members achieve and maintain a healthy weight: eat at least five servings or 2-½ cups of vegetables and fruits every day; limit screen time to two hours or less each day; get moving for one hour of physical activity every day and avoiding soda and sugar-sweetened drinks.
- All Head Start staff received training on the basics of childhood obesity, Color Me Healthy and the 5+-2-1-0 messages. Some Head Start staff received training on the additional topic of collecting accurate height and weight data, calculating body mass index and goal setting.
- Six Field Day events were held, reaching sixteen hundred children.

Impact

- A new focus by Head Start caregivers on making healthy choices instead of a child's weight alone has improved the dialogue between parents and Head Start staff, and promotes relationships that help children become healthier.
- Baseline and follow-up measurements on preschoolers are collected by Head Start staff and are now available to health officials for monitoring the health status of children.
- The Color Me Healthy and 5+-2-1-0 programs are reaching 1,600 preschoolers with physical activity and healthy eating messages in all Head Start sites in Berkeley, Charleston and Dorchester counties.

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TEEN GIRLS INCREASE PHYSICAL ACTIVITY, EAT HEALTHIER

Lifestyle workshops and activities promote positive life choices

Public Health Problem

- Over thirty percent of South Carolina high school students are overweight or obese, and rates are increasing.
- To achieve and maintain a healthy weight, teen girls need motivation and education on how to be physically active and choose a healthy diet.

Program

- DIVA, Incorporated is a non-profit community organization in Columbia, South Carolina that helps young women make positive life choices. With Centers for Disease Control and Prevention Preventive Health and Health Services Block Grant funds provided as an All-Health Team award by the state health department, DIVA, Incorporated expanded their Healthy Lifestyle Project to include more young women.
- For years the teenage girls in the DIVA, Incorporated program were observed using foods such as candy bars, potato chips and soft drinks as a way to cope with stress. Many gained weight, putting themselves at risk for chronic diseases such as diabetes.
- The Healthy Lifestyle Project created a committee to coordinate ongoing healthy lifestyle workshops, made physical activity equipment available, taught girls physical activity routines, and distributed materials to public housing units and an alternative school.
- They also partnered with Columbia City Parks and Recreation to sponsor the first Super Woman Conference.

Impact

- Teen girls participating in the Healthy Lifestyle Project have made positive lifestyle changes to increase their physical activity and improve eating habits. For example:
- Two participants lost significant amounts of weight to bring them closer to a healthy weight.
- One participant is no longer in a pre-diabetic state and her blood sugar level is now lowered to a normal level.
- Fourteen teenage girls from a local alternative school started a "Fightin' the Fat" program to help them achieve a healthy weight.
- Ninety-five women and their daughters attended the Super Woman Conference and learned more about healthy eating and physical activity.

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KERSHAW COUNTY PRESCHOOLERS TASTE THE BENEFITS OF VEGETABLES AND FRUITS

Vegetable and fruit education program promotes healthy lifestyles for children and their families

Public Health Problem

- Childhood obesity is increasing dramatically and can lead to health problems not commonly found in teens and younger children, such as type 2 diabetes, high blood pressure and high blood cholesterol.
- Teaching children to make healthy food and physical activity choices can help reverse the obesity trend and make it more likely that they'll practice healthy behaviors as they get older.

Program

- Four childcare centers in Kershaw County implemented the Color Me Healthy curriculum and a supplemental vegetable and fruit initiative designed to introduce them to the taste and nutritional value of unfamiliar vegetables and fruits in order to promote healthy food choices.
- This program is a partnership between Kershaw County First Steps, Clemson University Cooperative Extension Service, Kershaw County office and the South Carolina Department of Health and Environmental Control Region 4.
- The Centers for Disease Control and Prevention's (CDC) Preventive Health and Health Services Block Grant supplies funds for a health educator who assists in teaching monthly classes and providing vegetable and fruit taste-testing opportunities for students.
- Parents are kept up-to-date on what their child is learning and the recipes from the lessons.

Impact

- Almost one hundred children and their parents were reached with the message that vegetables and fruit taste good and are a healthy choice for meals and snacks. This effort will be replicated in these centers and additional centers next year.
- Students have begun making healthier food choices and increasing their amount of daily physical activity. Homestyle Childcare Center in Elgin increased their vegetable and fruit offerings during the day and has a small school garden where the children can learn how their vegetables grow.
- Students look forward to the classes each month and are eager to learn about healthy lifestyles.

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AWARD-WINNING PROGRAM PROMOTES HEALTHY EATING AND PHYSICAL ACTIVITY

Reaching preschoolers and their parents to decrease overweight and obesity

Public Health Problem

- In South Carolina, more than a quarter of the preschool children in low-income families are overweight or at risk of becoming overweight.
- Overweight children are more likely to develop Type 2 diabetes, previously considered an adult disease, as well as other chronic conditions.
- Head Start and other programs reaching low-income families have an opportunity to promote healthy behaviors to a population most in need.

Program

- The South Carolina Department of Health and Environmental Control used PHHS Block Grant funding as seed money to implement *Color Me Healthy*, a national award-winning health program created in North Carolina.
- Interactive lessons and take-home toys such as jump ropes and balls promote healthy eating and increased physical activity for 4- and 5-year-olds and their families.
- Extra programming for parents combines two existing programs: "Cooking with a Chef," (hands-on food preparation and planning) and "Families Eating Smart & Moving More," (making healthy food choices and increasing physical activity) .
- Pilot sites offer six-week classes on these topics, including ways to include more fruits and vegetables in family meals and decrease television time. *Color Me Healthy* parent newsletters and special Parent's Night activities reinforce the messages about health.

Impact

- Time allotted to structured physical education has doubled to two, thirty-minute periods a week, at parents' request, for children at the Advent Children's Center, a pilot site in Spartanburg.
- Evaluation of *Color Me Healthy* by the developers found that a majority of teachers using the program say their preschool students are willing to try new fruits and vegetables as a result.
- More than 16,000 South Carolina children in Head Start programs, preschools, and daycare centers benefit from *Color Me Healthy* messages and practical tips provided to parents and children across the state by well over seven hundred program-trained childcare providers, preschool teachers and parish nurses.
- The success of the program has motivated state partners to earmark funds for statewide expansion of the program.
- Using a tested program allows the state to save dollars on development costs and invest in reaching more children.

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EDUCATIONAL TV SESSIONS HELP TEACHERS IMPLEMENT WELLNESS POLICIES

Sessions are easy-to-access and help teachers meet recertification requirements

Public Health Problem

- South Carolina rates of childhood obesity are among the highest in the nation.
- The federal Child Nutrition Act and the South Carolina Student Health and Fitness Act of 2005 require new policies in schools to decrease obesity, poor nutrition and physical inactivity.
- Meeting these wellness requirements could become a burden to teachers without expert assistance.

Program

- The South Carolina Department of Health and Environmental Control, Region 3, partnered with the state Department of Education and South Carolina Instructional and Educational Television to develop a professional development series for teachers, administrators and food service workers to help them put mandated wellness policies into action, partially funded through the federal Preventive Health and Health Services Block Grant.
- The monthly series is broadcast to teachers in the classroom or is accessed online from any computer site, and can be used to meet recertification requirements.
- The series highlights successful nutrition, physical activity and wellness programs being implemented in real schools, provides information on ways schools can incorporate these programs into daily work in the classroom, and features recognized health authorities.

Impact

This innovative partnership among health, education and the broadcast media achieved:

- Regularly broadcasts to over 1,100 schools throughout the state.
- A three-fold increase in visits to the Web site highlighting South Carolina schools where the wellness information is being successfully applied. Visit: www.knowitall.org/healthy.
- Recertification credit for teachers which encourages them to learn more about wellness activities benefiting themselves, their students and the school wellness environment.
- A Healthy South Carolina Challenge special media award from South Carolina Governor Mark Sanford for outstanding efforts to improve health and wellness.

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AFRICAN AMERICAN WOMEN COME TOGETHER TO FIGHT OBESITY

Sisters Together program helps reduce diabetes-related health disparity in Tennessee

Public Health Problem

- Almost three quarters of the adults in Hamilton County, Tennessee are overweight or obese putting them at higher risk for developing diabetes.
- This region of Tennessee also has the highest diabetes death rate for both men and women.
- Healthy eating and physical activity are the keys to achieving and maintaining a healthy weight and can help prevent and/or control diabetes.

Program

- The Urban League of Greater Chattanooga Tennessee implemented a pilot adaptation of an evaluated National Institutes of Health healthy weight program called *Sisters Together: Move More, Eat Better* which is designed to appeal to African American women, a population group with a high rate of obesity.
- Funding was provided by the Blue Cross Blue Shield of Tennessee Health Foundation, Unum, a Tennessee-based insurance company, the Lyndhurst Foundation, and the Tennessee Department of Health.
- The main objective was to implement a sustainable program so that many more African American women would be able to reach fitness and nutrition goals following the pilot implementation. The Tennessee Department of Health Diabetes Prevention and Control Program, Waterhouse Public Relations, the Black Nurses Association, and Erlanger Health System joined the original partners to enhance sustainability of the program.

Impact

- All participants reported improved eating habits and increased weekly physical activity.
- Almost a third of the participants lowered their body mass index, an indicator that correlates with the amount of body fat a person has.
- The Urban League and local partners are extending this successful program as a “Little Sisters” program for teens, reaching a vulnerable group earlier in the cycle of developing obesity.

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DINING WITH DIABETES – A COOKING SCHOOL FOR HEALTH

Partnership with Cooperative Extension helps people with diabetes live healthier lives

Public Health Problem

- Diabetes patient education is an effective strategy for preventing long-term complications from diabetes.
- In Virginia, about half the adults with diabetes don't receive the education they need to help them make the many daily decisions needed to manage their disease.
- A Healthy People 2010 objective for the nation highlights the need to reach more people who have diabetes with formal diabetes education.

Program

- The Virginia Diabetes Prevention and Control Program implemented Dining with Diabetes, a tested program offering nutrition education and practical hands-on meal planning experience to adults with diabetes, through a contract with Virginia Cooperative Extension.
- Implementation of the program met the Virginia Cooperative Extension mission of leading research-based education programs. It also provided the Virginia Diabetes Prevention and Control Program with baseline medical indicators to help them measure progress in meeting national diabetes objectives.
- Preventive Health and Health Services Block Grant funds supplemented limited diabetes program funds to enable implementation of the program in an initial five sites. Virginia Cooperative Extension added resources and offered the program in three more sites.
- Participants knowledge of diabetes management practices was assessed and clinical indicators were measured.

Impact

- Many participants implemented recommended meal planning methods and increased their daily physical activity – both of which will help them control their diabetes.
- Over half of the participants achieved a lower A1C level which means their blood sugar was better-controlled. For every percentage point drop in this test measure the risk of eye, kidney and nerve disease is reduced by forty percent.
- Over ten percent of participants reduced their blood pressure to an acceptable level.
- Utilizing established partnerships with statewide organizations increased the Virginia Diabetes Prevention and Control Program's ability to reach populations in need with diabetes self-management resources.

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RESOURCES FOR HEALTH PROFESSIONALS ON WOMEN, DIABETES AND DEPRESSION

Raising awareness of the benefits of screening, referral and treatment

Public Health Problem

- Women suffer depression at twice the rate of men and people with diabetes suffer from depression at twice the rate of those without diabetes.
- Diabetes management can be undermined by the existence of depression.
- Health care providers can facilitate screening, referral and treatment, which are essential for both of these conditions, if they are aware of the connection between diabetes and depression and have the skills and resources to take action.

Program

- The Virginia Department of Health create a *Women, Depression and Diabetes* Kit and Web site using grant support from the Women's Health Council of the National Association of Chronic Disease Directors made available through funding from the Division of Diabetes Translation at the Centers for Disease Control and Prevention. Visit: www.YouCanVA.com
- The project goal was to increase awareness about the issue of women, depression and diabetes and influence referral patterns between medical and mental health care providers.
- Kits have reached two hundred and fifteen medical and nursing providers.
- Virginia women's organizations and the Emergency Medical Services team are also raising awareness and/or distributing Kit materials through newsletters and meetings.
- Over five hundred Women, Depression and Diabetes Kit flyers were distributed to family physicians and pharmacists at annual conferences

Impact

- As a result of having the Kit resources:
  - Two thirds of recipients are talking with clients about the diabetes/depression connection
  - Twenty to thirty percent of recipients are starting to screen clients with depression for diabetes or clients with diabetes for depression
  - Small but important percentages of recipients are referring clients for treatment of diabetes and/or depression
- Donated graphic art services leveraged grant money to widen the reach of the project with exhibits at state health care conferences.
- Most Kit recipients who originally said they didn't have a high level of awareness about the connection between women, depression, and diabetes report an increase in awareness about this connection.

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PREVENTING VISION LOSS CAUSED BY DIABETES

Educating consumers and providers about dilated eye exams with an educational DVD

Public Health Problem

- Diabetes is a leading cause of adult blindness.
- Regular dilated eye exams are essential for the early detection of diabetic eye disease because there are often no early symptoms.
- Early detection of diabetic eye disease, along with proper treatment can slow the progression of eye diseases and blindness.
- Focus group results showed that many Wisconsin residents with diabetes did not know that the purpose of a dilated eye exam was to slow the progression of eye disease and did not understand the difference between the various types of exams.

Program

- Wisconsin's Quality Improvement Organization, MetaStar, Inc., conducted focus groups in Wisconsin and identified the need to educate people with diabetes about the need for an annual dilated eye exam.
- The Wisconsin Diabetes Prevention and Control Program, the Wisconsin Lions Foundation and other partners produced an Eye Exam DVD in English and Spanish to provide this education with the goal of improving annual dilated eye exam rates in Wisconsin, a Healthy People 2010 goal. Funding was provided by the Wisconsin Lions Foundation, Lions Clubs International, and the Wisconsin Diabetes Prevention and Control Program. http://www.wlf.info/
- Real people living with diabetes tell their stories in the DVD and encourage people with diabetes to take charge of their health and make an annual eye exam appointment. A Diabetes Self-Management Information Booklet is included with the DVD

Impact

- The success of the DVD project has encouraged Lions Clubs International to promote the DVD throughout the United States, North and South America, and Europe.
- Anecdotal information indicates that primary care providers are receiving an increased number of Eye Exam Communication forms from optometrists and ophthalmologists, assisting with medical records documentation that dilated eye exams are being done. Partners plan to use data from the Health Plan Employer Data and Information Set and Behavioral Risk Factor Surveillance System to measure the impact as soon as data is available.
- DVD distribution substantially increased requests for the Diabetes Self-Management Information and Record Booklet, designed to inform people with diabetes of recommended health care.

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DINING WITH DIABETES – BETTER SKILLS FOR BETTER QUALITY OF LIFE

Program helps people manage their diabetes through better food and cooking knowledge

Public Health Problem

- West Virginia has a much higher rate of diabetes than the rest of the nation and the people with diabetes are more likely to be obese than the general population.
- Diabetes patient education is an effective strategy for preventing long-term complications from diabetes that are related to obesity and poor blood sugar control.
- One of the Healthy People 2010 national health objectives cites the need to reach more people who have diabetes with formal diabetes education.

Program

- The West Virginia Bureau for Public Health, in collaboration with West Virginia University Extension Service and local healthcare professionals, offers the Dining with Diabetes course to increase self-efficacy and support lifestyle behavior changes related to diabetes self-management.
- The course is offered at no cost to participants who may attend without referral and has reached six thousand people in the state.
- Each class has a lecture component and a cooking demonstration, with food sampling for participants who may attend with a companion. Participant's blood sugar and blood pressure are monitored at the beginning and end of the course.

Impact

- Results of pre- and post-tests show that participants feel more confidence in their ability to accomplish the difficult task of managing their diabetes.
- Participants also report an increase in healthy food choices.
- The course has been adopted in twenty-five states, allowing them to use their program dollars for implementation rather than program development. West Virginia partners also offer training to professionals in other states to extend the course's reach.
- The Northeast Extension Directors' Award of Excellence was awarded to Dining with Diabetes.

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