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NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Why States Are Taking Action to Prevent and Control Chronic Disease

The success stories in this document illustrate the actions states are taking to reduce the burden of chronic disease to state residents. Here are three important reasons why states are taking this action:

- *Chronic Disease Costs Are Escalating*

State general funds pay more and more of the Medicaid bill – about 22% of all state spending. Eighty-three percent of Medicaid spending is for people with chronic conditions. States may need to pay \$250 billion to support Medicaid by 2014 – twice what they currently contribute.¹

Health care costs to employers are escalating, largely due to chronic disease care.

Medicare beneficiaries treated for five or more chronic conditions account for all Medicare spending growth over the past 15 years, according to a recent study.²

- *Chronic Disease Takes a Huge Toll on State Residents*

Seven out of every ten deaths in the U.S. are related to chronic diseases which are also major causes of illness and disability.

“Americans lose on average 15 years of life from chronic diseases—valuable time with family or friends gone forever. Even more startling, many diseases such as diabetes and obesity, traditionally seen in older adults, are more and more common in children.”

-- NCCDPHP, Centers for Disease Control and Prevention

- *Chronic Diseases Can Be Prevented*

Much of the nation’s medical care costs are spent caring for people with chronic conditions that might have been prevented.

Chronic disease prevention requires the kind of broad and inclusive public health, population-based approach that states are uniquely positioned to provide. Actions and decisions by state and local government are required.

States are implementing the comprehensive strategies - changing individual risk factors and changing environments, policies and systems in communities – that are necessary to prevent and control chronic diseases.

Actions Policymakers Can Take to Help States

Here are a few examples of actions policymakers can take to reduce the burden of chronic disease to states:

➤ *Implement incentives and policy changes to promote healthy choices*

- Establish healthy policies in public buildings and for public employees, such as healthy options in cafeterias, smoke-free workplaces, physical activity breaks for workers, employee health promotion
- Establish zoning and other environmental codes that support opportunities for physical activity such as walking and biking, for healthy food options, for smoke-free communities and for other healthy behaviors
- Support a healthy environment in local schools

➤ *Be a champion and role model for chronic disease prevention & control*

- Take advantage of media opportunities to spread the message of the importance of chronic disease prevention & control
 - Create or serve on a task force
 - Display educational materials in your office
 - Share a personal story about a family member's chronic disease
- Promote awareness of chronic disease prevention & control to the public you serve

➤ *Promote coverage and use of preventive health services*

- Consider tax incentives and other policy initiatives that support preventive health benefit packages for workers in your area
- Recommend changes to health services programs under your control

➤ *Make sure communities have life-saving services*

- Take action to assure emergency services are up-to-date
- Make screening and treatment available to everyone

NACDD State Success Story Project

The National Association of Chronic Disease Directors (NACDD) was founded in 1988, as a national association of public health professionals with expertise in state-based chronic disease prevention and control. The NACDD links chronic disease program directors in every US state and territory and provides a national forum focused on efforts to reduce the impact of chronic diseases and their risk factors on states and communities nationwide.

NACDD created the State Success Story Project in 2005 through a cooperative agreement with CDC, and is tracking success story use. The following are a few examples:³

.... NACDD Legislative and Policy Committee members routinely provide stories when visiting members of Congress.

....Texas and North Carolina submitted success stories to journal publishers for review as potential article topics.

....NACDD partners such as the American Diabetes Association and the American Heart Association enhance printed briefing materials with NACDD success stories.

....Congressional staff use stories from the NACDD web site as program examples for members of Congress.

....The Research 2 Prevention coalition provides success stories to Congressional budget committee members, appropriators, and staff in face-to-face meetings.

....Stories are provided as potential examples for the annual report of the Centers for Disease Control & Prevention.

....North Carolina shared success stories during a Health Plan Summit to garner support for preventive benefits for people with diabetes.

If you have information about a successful state chronic disease intervention, please share that information with NACDD. Go to www.chronicdisease.org, click on “Promoting State Success” and follow the instructions under “Submit a story now” OR email the details of your story to yen@chronicdisease.org. Be sure to include contact information for questions about the story. The State Success Story Team will create the one-page story and return it to the state contact and the state’s NACDD Representative Member for review.

DEVELOPING A COMPREHENSIVE HEART DISEASE & STROKE PLAN

Legislative briefings and public forums in California are the first steps

Public Health Problem

- Heart disease and stroke are the first and third leading causes of death in California, costing the state's economy an estimated \$40.3 billion each year.
- More people die each year from heart disease and stroke than from the next four leading causes of death combined.
- California needed a master plan for heart disease and stroke to guide implementation of prevention and treatment strategies and position the state to receive federal funding for a comprehensive program.

Program

- The California Heart Disease and Stroke Prevention Program provided technical assistance for a legislative briefing to educate California's policymakers about the impact of heart disease and stroke on the state's population and economy, and the need for statewide prevention and treatment strategies.
- The Program also organized regional public forums in six areas of the state, both urban and rural, to gather recommendations for the master plan from local stakeholders. Public health officials, physicians and other healthcare providers, city planners, and community representatives contributed expertise.

Impact

- Educating California's Legislators increased understanding of the burden of heart disease and stroke to the state.
- The California Legislature passed Assembly Bill 1220, creating a task force charged with developing a comprehensive master plan for heart disease and stroke prevention and treatment.
- Because of the high visibility of this governor-appointed task force, \$150,000 was leveraged from private sources to begin plan development. A funding source other than state funds is required by Assembly Bill 1220.
- Public forums brought together individuals, institutions and community-based organizations, often for the first time, to pursue collaborative strategies for the prevention and control of heart disease and stroke.
- The public forums identified potential partners for implementation of the master plan.

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BLOCK GRANT FUNDING HELPS FLORIDA COMMUNITY-BASED PROGRAMS TARGET HEART DISEASE & STROKE PREVENTION

Model chronic disease program coordinates resources and addresses the most common risk factors for chronic disease to maximize prevention results

Public Health Problem

- Chronic diseases such as heart disease, stroke, cancer and diabetes cause nearly 75 percent of all deaths in Florida each year.
- Heart disease and stroke are the first and third leading causes of death.
- A high percentage of Florida's adults have one or more risk factors for these conditions. Nearly 60 percent are either overweight or obese, one-third have high blood pressure, and more than a quarter have no leisure-time physical activity.

Program

- The Chronic Disease Health Promotion and Education Program (CDHPE), using Preventive Health and Health Services Block Grant funds, has evolved over eight years from a few pilot projects to comprehensive statewide coverage of Florida's 67 counties.
- The program focuses on heart disease and stroke prevention by addressing risk factors such as physical activity, nutrition, diabetes, obesity and tobacco use.
- CDHPE coordinators develop health councils, assess local health needs, write grants, and help communities implement and evaluate proven chronic disease programs.
- Participating communities must provide 25 percent of program funding from local sources.

Impact

- Many of Florida's counties have implemented successful chronic disease prevention programs. Examples include:
 - Baker County has promoted structured physical activity in elementary schools during recess and after-school programs.
 - Collier County Health Department partnered with the Boys and Girls Clubs to develop public service announcements on obesity prevention.
 - Hendry County passed a "tobacco free" ordinance for all county-owned parks.
 - Hernando County instituted a "Smoke-Free Home Pledge Program" that was recognized by the Environmental Protection Agency.
- The state has promoted physical activity through improved lighting, sidewalks and walking trails. Counties also participate in "Step Up Florida -- On Our Way to Healthy Living," a border-to-border county relay that covers the entire state of Florida. More than 1,300 partners participate each year, covering over 305,000 miles.

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IDENTIFYING THE NEED FOR EMERGENCY MEDICAL DISPATCH TRAINING

Kansas program seeks to improve emergency care for heart attack & stroke victims

Public Health Problem

- Heart attack is a leading cause of death in Kansas, accounting for more than a third of all deaths.
- Almost half of heart attack deaths occur before an ambulance arrives.
- Rapid emergency response and the use of standard protocols for care can lessen the possibility of long-term disability or death from heart attack.

Program

- The Kansas Heart Disease and Stroke Prevention Program and the Kansas Trauma Program assessed emergency medical dispatch centers throughout the state to identify gaps in knowledge, assess the use of standard protocols of care, and identify costs and resources for implementing training.
- More than three-fourths of the state's 133 centers responded to the survey which found:
 - One-fourth of the centers don't require any formal training for dispatchers
 - Many emergency centers have no requirement for continuing education
 - More than half of the centers do not require that their dispatchers are trained in providing instructions to callers requesting emergency assistance on actions they should take before the emergency staff arrive.
 - Lack of funding was cited as a major barrier by half of the respondents

Impact

- The Kansas Heart Disease and Stroke Prevention Program and the Kansas Trauma Program identified a statewide need for standardized emergency medical services dispatcher training.
- A partner contract agreement established a training network for each of the state's six regional trauma councils, providing standardized training to key emergency medical dispatch personnel.
- More than 330 emergency medical dispatch personnel have been trained to use standard protocols that enable recognition of signs and symptoms of heart attack and facilitate quick treatment for heart attack victims.

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KENTUCKY DEPARTMENT FOR PUBLIC HEALTH WORKS WITH HOSPITALS TO PREVENT HEART ATTACKS & STROKES

Applying accepted treatment guidelines to patient treatment and discharge from the hospital

Public Health Problem

- More than three-fourths of Kentucky adults have at least one risk factor for heart disease or stroke, such as having high blood pressure or being overweight.
- Four of every ten hospitalizations in Kentucky are due to heart disease or stroke.
- These two conditions cost the state's economy more than \$863 million in hospital expenses alone.
- Using tested treatment protocols for hospital patients and at discharge from the hospital increases the likelihood of preventing a heart attack or stroke.

Program

- The Cardiovascular Health Program, part of the Kentucky Department for Public Health, partnered with the American Heart Association, the Kentucky Hospital Association, Healthcare Excel (a health care quality organization) and the American College of Cardiology to improve the care of hospital patients who had experienced heart disease or stroke.
- Get with the Guidelines – Coronary Artery Disease is a program with a best-practice set of standards for treatment, medication and lifestyle counseling for patients with heart disease.
- Applying Get with the Guidelines standards helps reduce the number of new heart attacks as well as disability and death in patients who have been hospitalized for heart disease.
- The Cardiovascular Health Program funded training, provides regular technical assistance to hospital staff and pays the annual fee for the Patient Management Tool needed to participate in the Program.

Impact

- More than 140 staff members from 57 hospitals were trained in the first statewide program. Twenty-six hospitals in rural and metropolitan areas of the state were added.
- Hospitals now have established standards to ensure appropriate medications are used and vital lifestyle counseling is provided to prevent a recurrence of heart attack & stroke.
- Participating hospitals are now evaluated to assess the effectiveness of their treatment & discharge instructions for heart disease and stroke patients. Reductions in illness and death from heart disease and stroke are expected.

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MASSACHUSETTS DEPARTMENT OF HEALTH STATEWIDE STROKE PREVENTION & CONTROL

Getting stroke patients to the right hospital within the vital 3-hour treatment window

Public Health Problem

- People in Massachusetts wait an average of 22 hours from the time they experience stroke symptoms before seeking medical care.
- Stroke causes approximately 10 deaths every day in Massachusetts, the third leading cause of death in the state.
- It was unclear which Massachusetts hospitals could meet standards for acute stroke care.

Program Example

- The Massachusetts Stroke Advisory Group reviewed the Recommendations for Primary Stroke Centers and met with hospitals to identify their potential to become a designated stroke center, including barriers to achieving this state designation.
- Two years of open forums, surveys, planning, and development, were needed to get stakeholders to agree on a MDPH draft of an amendment to state regulations creating a license for hospitals with primary stroke services.
- Massachusetts hospitals able to treat acute stroke within the recommended three hour time window are now designated by the Department of Public Health, required to meet treatment recommendations for Primary Stroke Centers, will educate their public and professional communities on stroke recognition, prevention and treatment, and must collect data on their delivery of acute stroke care.

Impact

- The Division of Health Care Quality developed a performance measurement system to assure quality and regular quality improvement in the hospitals.
- The Office of Emergency Medical Services developed a rigorous plan to direct individuals experiencing stroke symptoms to a designated facility.
- The MDPH Heart Disease and Stroke Prevention and Control program created a community outreach plan, training program, and partnered with the American Heart Association to deliver professional development opportunities in Massachusetts.
- A regulated hospital standard of stroke care was developed for the entire state, increasing internal hospital coordination.
- Data on improved treatment times, patient outcomes, decreased hospital costs and inhospital mortality will be collected beginning in Summer, 2005.

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MAINE PROFESSIONAL EDUCATION CONFERENCE IMPROVES QUALITY OF CARE FOR HEART DISEASE, STROKE & DIABETES

Teaching health professionals how heart disease, stroke and diabetes overlap

Public Health Problem

- Over sixty percent of Maine hospital charges for heart disease and stroke, at least \$437 million a year, are paid by Medicare or Medicaid (called MaineCare).
- More people with diabetes are hospitalized for heart diseases and stroke than people without diabetes.
- Heart disease, stroke and diabetes share many risk factors and people with one of these conditions are often at risk for developing another.
- Clinical training is frequently restricted to just one condition, limiting care-givers knowledge and contributing to fragmented and less effective treatment.

Program

- The Maine Cardiovascular Health Program and the Maine Diabetes Prevention and Control Program developed a professional education workshop, Bridging the Gap: Merging Diabetes and CVD Management with the help of a steering committee of clinicians and educators from cardiology, diabetes, and nutrition.
- The goal of the workshop was better collaboration among professionals to achieve improved patient care. Physicians, nurses, cardiac rehabilitation, certified diabetes educators and other health professionals attended.
- Topics included treatment guidelines and care standards for heart disease, stroke, high blood pressure and diabetes; decision support; self-management techniques for patients; and community resources.
- A workshop activity assigned participants from different health disciplines to teams representing eight regions of the state to practice solving problems using case studies. Meeting and working with colleagues from the same region of the state was designed to help the professionals in their future work to coordinate patient care across disciplines.

Impact

- Participants gained knowledge of guidelines for heart disease, stroke and diabetes care.
- Action steps developed by participants on integrating diabetes and CVD care include:
 - Take a team approach to discussing mutual patients weekly.
 - Reinforce patient teaching related to the interdependence of diabetes and cardiovascular health goals.
 - Apply common self-management principles and techniques to managing heart disease, stroke and diabetes.

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IMPROVING HEART ATTACK AND STROKE AWARENESS AND TREATMENT

Maine project reaches hospitals and communities

Public Health Problem

- Heart disease and stroke are leading causes of death in Maine.
- Almost half of all heart attack and stroke deaths occur before the ambulance arrives or before the victim reaches the hospital
- Prompt recognition of the signs and symptoms associated with heart attack and stroke, immediate access to emergency services and timely medical treatment are all crucial to save lives, prevent future events, and reduce medical costs and disability.

Program

- The Maine Cardiovascular Health Program collaborative projects to improve prevention, identification and treatment of heart attack and stroke include:
 - A statewide campaign that described warning signs of stroke and emphasized the importance of prompt use of 9-1-1 when a stroke is suspected used the theme “Time lost is brain lost.” Awareness materials and reminders were distributed through hospitals, healthcare providers, Emergency Medical Services, other partners and in radio spots. TV public service announcements also shared the moving story of a local news anchor who had survived a stroke.
 - Healthy Maine Partnerships grants helped local groups promote awareness and prevention by implementing health risk appraisals and interventions in workplaces and incorporating signs and symptoms information on heart attack and stroke into local YMCA, hospital wellness, adult education, Chamber of Commerce and worksite health programs.
 - Partnered with State and Regional Emergency Medical Services (EMS) offices to implement HeartSafe Communities in Maine, giving recognition to EMS and community partners working to improve heart disease and stroke survival and recovery rates and enhance partnerships, resources and services to improve cardiovascular health.

Impact

- Almost half of respondents from the state-wide campaign follow-up survey could list at least one warning sign of stroke, and a majority said they would call 9-1-1 if they suspected someone was having a stroke.
- Pre/post data from local Healthy Maine Partnership initiatives showed increases in knowledge of risk factors and signs and symptoms of heart attack and stroke. A majority also responded that they would call 9-1-1 if they suspected someone was having a stroke.
- Over sixty Maine towns and cities are now Maine HeartSafe Communities, evidence of improved capacity to prevent and treat heart attack and stroke.

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EMPLOYER STRATEGIES FOR HEART DISEASE AND STROKE PREVENTION

Maine partners with employer associations and others to implement workplace health programs

Public Health Problem

- More than three fourths of Maine adults have one or more risk factors for heart disease and stroke, such as overweight, obesity, diabetes, high blood pressure, high blood cholesterol, inactivity, or smoking.
- Research shows that comprehensive workplace health promotion and disease prevention programs are effective in reducing health risks and health care costs while increasing productivity and reducing absenteeism.

Program

- The Maine Cardiovascular Health Program developed a project to help Maine workplaces implement low- or no-cost, easy to apply policy and environmental change strategies that specifically apply to the many Maine workplaces with small numbers of employees.
- Successful, real-life examples from Maine employers, listed by name, motivate and inspire workplaces to implement the strategies.
- Initial work with partners such as wellness councils, the Chamber of Commerce and other employer and public health groups provided experience to support expanding this pilot to additional workplaces. The project developed the Good Work! Resource Kit which highlights information on the link between employee health and the business 'bottom line,' as well as key strategies.

Impact

- Changing the workplace environment to reduce heart disease risk factors now benefits more than 6,500 employees in 33 workplaces. Partnerships with business groups exposed hundreds of employers with several thousand employees to the successful practices developed during the project pilot.
- The Good Work! resource kit is now available for all workplaces to print and use – even those in other states – and provides guidance feasible for all types of employers at:
www.healthymainepartnerships.org/MCVHP/resource_good_work_manual.aspx
- A sample of successes for just two participating employers:
 - The University of Maine at Augusta has seen a dramatic increase in the number of employees participating in health-related activities such as walking groups and weight control groups, and reports blood pressures, cholesterol levels, and weights are down.
 - At Millinocket Hospital, almost half the employees achieved the walking goal of 10,000 steps a day, accumulating 14,850,875 steps altogether.

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MISSOURI SCREENING PROGRAM IDENTIFIES INNER-CITY RESIDENTS AT RISK FOR HEART ATTACK AND STROKE

Health and Fire Departments partner to provide screening and education programs

Problem

- For Missouri residents, heart disease is the leading cause and stroke is the third leading cause of death.
- In 2003, hospitalization costs for heart disease and stroke totaled over \$3.15 billion.
- More than a third of Missouri residents have high blood cholesterol and more than a quarter have high blood pressure – both risk factors for heart disease and stroke.

Program

- The Department of Health and Senior Services' Heart Disease and Stroke Prevention Program partners with the St. Louis City Fire Department to provide screening and education to inner-city residents.
- Residents receive blood pressure, cholesterol and other screening tests, with onsite counseling and recommendations for treatment if needed.
- Program staff contact individuals who have abnormal test results, describing necessary preventive measures they can take immediately before costly complications develop. They also receive lists of health centers, local hospitals and private healthcare providers that can provide treatment.

Impact

- From October 2003 to September 2004, the St. Louis Fire Department screened more than 3,000 inner-city residents for heart disease & stroke risk factors. Nearly half were referred for medical treatment, and 25% of those referred actually sought treatment.
- One participant provides a dramatic example of program impact. A woman screened by the program had blood pressure and cholesterol readings so high that she was told to see her doctor within the next two to three weeks. Later, when she awoke with a tight, burning sensation in her chest, she remembered what the paramedic had said and went immediately to the hospital. She learned that one of her coronary arteries was 95% blocked. While there her heart stopped beating, requiring urgent care to save her life. Had she not been warned by program staff that her test results put her at risk of having a heart attack, she “would have brushed my symptoms off as indigestion or asthma,” she said.

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MISSOURI IMPROVES EMERGENCY RESPONSE FOR HEART ATTACK VICTIMS

Defibrillator registry and training for first responders enables life-saving treatment

Public Health Problem

- Heart disease is the leading cause of death in Missouri, accounting for 30% of deaths.
- A shock to the heart within five to seven minutes of cardiac arrest can improve the chances of survival for the victim by as much as 49%.
- Placing devices to shock the heart (call AED, or automatic external defibrillator) in public places makes them readily available to a first responder in an emergency.
- Many rural Missouri communities did not have AED equipment available

Program

- The Missouri Heart Disease and Stroke Prevention Program, funded by CDC's Division of Heart Disease & Stroke, worked with the state Office of Primary Care & Rural Health, the Bureau of Emergency Medical Services and local health departments to create a statewide registry of AEDs, allowing emergency responders to quickly locate an AED when needed.
- This group also developed a strategic plan for placing additional AEDs in rural counties where they were not readily available.
- Federal Office of Rural Health funding allowed the distribution of approximately 400 AEDs over a two-year period to qualifying first response agencies.
- The Missouri Heart Disease and Stroke Prevention Program, the Office of Rural Health, Missouri Emergency Medical Services Association and the Center of Educational Development at University of Missouri Health Center collaborated to train firstresponders to operate an AED.

Impact

- In just 12 months, 39 emergencies required the use of these AEDs saving 9 lives.
- Over 4000 first responders have been trained in conjunction with the placement of 400 AEDs in rural communities, some of which have no 911 emergency service.
- First response staff in eligible rural counties must now be trained before receiving an AED for their area, ensuring best use of the equipment.
- Communities that previously had only enough funds to buy refurbished equipment with questionable reliability, now have up-to-date AED equipment provided by this project as well the availability of trained staff.

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RAISING PUBLIC AWARENESS OF STROKE SIGNS & SYMPTOMS

Montana project combines paid media and community-based outreach to communicate awareness of stroke signs and symptoms and the need to call 911

Public Health Problem

- Stroke is the fourth leading cause of death in Montana accounting for more than 6% of the state's deaths in 2003.
- Effective treatment exists for many stroke patients who reach a treatment facility within 3 hours of the onset of symptoms.
- Those at high risk are often unaware of the signs and symptoms of stroke and the need to call 911.
- Quick attention to symptoms is needed due to Montana's rural nature and often long travel times to stroke treatment facilities.

Program Example

- The Montana Cardiovascular Health Program, in partnership with the Montana State University, developed TV, radio and print ads on stroke signs and risk factors.
- A brochure and poster were created to reinforce the stroke-related campaign messages. With the assistance of Benefis Healthcare and Great Falls Fire and Rescue, materials reached residents via pharmacies, clinics, parish nurses, senior centers, and worksites.
- The 12-week project was piloted in Great Falls in 2004. The ads aired again in that community for 10 weeks in 2005. Newly revised ads are airing in Fall 2005.
- Evaluation uses pre/post-intervention telephone surveys conducted with residents aged 45 years and older who live in Great Falls and with a comparison community not exposed to campaign materials.

Impact

- There was a significant increase in the percentage of patients with mini-stroke or the most common type of stroke who arrived by Emergency Medical System transport, an indication that residents understand the importance of calling 911, a project objective.
- In the intervention community of Great Falls, stroke message recall was higher than in the comparison site. (Definition: having seen TV, radio or print ads in the past 3 months)
- Results on respondents' intent to call 911 prompted revised messages for Fall 2005 since intent did not significantly increase in the post-intervention survey.
- In conjunction with this project, Great Falls Fire and Rescue successfully implemented a pre-hospital stroke screening tool based on the Cincinnati Stroke Scale.

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STROKE EDUCATION PROGRAM TARGETS NEBRASKA RESIDENTS

Awareness of stroke signs and symptoms and the importance of seeking emergency help quickly

Public Health Problem

- More than 80% of the state's adults have at least one risk factor for stroke and heart attacks, including physical inactivity, being overweight or obese, and having high blood pressure.
- Almost half of stroke deaths happen before the victim is admitted to the hospital.
- Recognizing the signs and symptoms of stroke and seeking early emergency treatment increases the chances of a positive outcome and lowers the risk of permanent disability.

Program

- The Nebraska Cardiovascular Health Program and the Nebraska Stroke Foundation partnered to implement Strike Out Stroke®, a campaign designed to raise awareness of stroke signs and symptoms among children and adults.
- Minor league baseball games provided opportunities to educate attendees, to share strokesurvivor recognition and to allow a first pitch thrown by a stroke survivor. Nebraska residents were reached through similar events at community baseball and softball events.
- A Strike Out Stroke® educational curriculum for elementary and middle school students has been developed, at the request of teachers in the state.
- Video interviews featuring two teenage Nebraska stroke survivors are provided to schools.
- A campaign website gives information on the signs and symptoms of stroke, stories from stroke survivors, and a list of statewide Strike Out Stroke® community events.

Impact

- 10,000 Nebraska residents have been reached with potentially life-saving information on the signs and symptoms of stroke.
- Participant insights on the benefits of the campaign are reflected in these comments: "I never really thought about having a stroke or what I should do if it happens." "I've learned that a stroke happens in the brain, not some other part of the body." "Seeing a 17 year old stroke victim throwing out the first pitch at the ball game makes me realize it's not just an old person's disease."

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HEART DISEASE AND STROKE PROGRAM TAKES THE MYSTERY OUT OF CALLING 911

Saving lives means raising awareness of signs & symptoms of heart attack and stroke

Public Health Problem

- Almost half of stroke deaths occur before victims can be hospitalized.
- More people die from heart disease and stroke than from all cancers and three other leading causes of death, combined.
- People having strokes and heart attacks often don't recognize the signs or they mistake them for something less serious. Some won't call 911 because they fear they'll tie up emergency medical services for a minor problem.
- The yearly cost of heart disease and stroke in Pennsylvania is estimated at over \$13 million including hospitalization, physician care, drugs, lost productivity, lost earnings, and home health and nursing home care.

Intervention

- The Pennsylvania Heart Disease and Stroke Program partnered with the Department's Bureau of Emergency Medical Services and the American Heart Association, to educate residents on heart disease and stroke risk factors, signs of a heart attack or stroke, when to call 911, and what to expect once the call is made. A total of 4,353 adults were reached.
- Ambulance providers in ten high-risk counties were trained and provided educational programs to the public at churches, malls, fire halls, granges, community centers and other community sites.

Impact

- One Pennsylvania woman's story highlights the important benefit to the community of this program: A 71-year old woman resident attended a presentation by the Danville Ambulance Service at a local senior center. The next day she called 911 to report personal stroke signs of dizziness and weakness. That very ambulance service transported her to Geisinger Medical Center where she was treated immediately for a stroke. After a few days at the local Rehabilitation Center, she is living back in her own home.

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TEXAS RAISES AWARENESS OF HIGH BLOOD PRESSURE RISKS

Screening and education target seniors, ethnic minorities and employees to help prevent heart disease and stroke.

Public Health Problem

- Heart disease is the leading cause of death in Texas, accounting for more than one-fourth of the state's deaths. Stroke is the third leading cause of death.
- Together, heart disease and stroke are the largest drain on the state's health care resources.
- One-fourth of the state's adults have high blood pressure, a major risk factor for heart attack and stroke. Many do not know they have high blood pressure and are not receiving treatment to lower their blood pressure and reduce their risk of a stroke or heart attack.

Program

- The Texas Department of State Health Services (DSHS) conducted a campaign to increase awareness of the risks of high blood pressure and the importance of finding and treating people with high blood pressure during High Blood Pressure month in May.
- The Cardiovascular Health and Wellness Program at DSHS offered free High Blood Pressure Awareness starter kits to local health departments, state agencies, universities, healthcare providers, faith-based groups and nonprofit organizations to facilitate the organization of events throughout the state. Kits contained resources, incentives, ideas for awareness activities, and educational materials on healthy eating, high blood pressure and stroke.
- DSHS also organized screening and awareness events for state employees including blood pressure screening and presentations on nutrition, physical activity, stroke and tobacco prevention. Those completing risk appraisals received free health incentives to improve their health, such as self help manuals, blood pressure records, and information about the DASH diet for blood pressure control. Future events will target the establishment of environmental supports and health-promotion policies at worksites.

Impact

- Almost 4200 people at 56 events in 36 Texas cities were reached with blood pressure awareness, screening and education activities.
- Many of those reached were in the important target populations of seniors, Hispanics and African-Americans, groups with a higher risk of developing high blood pressure, heart attack and stroke than other age and ethnic groups.
- Scheduling activities where large groups were already gathered maximized the use of state, local and community resources.

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TEXAS CITIES ENHANCE HEART HEALTH

Awards recognize communities that support residents in reducing risk factors for heart attack and stroke

Public Health Problem

- Heart disease is the leading cause of death in Texas, accounting for more than one-fourth of the state's deaths. Stroke is the third leading cause of death.
- Together, heart disease and stroke are the number-one drain on the state's health care resources.
- Texas cities will create environments that promote cardiovascular health when they are encouraged and recognized for their effort.

Program

- The Texas Department of State Health Services' Cardiovascular Health and Wellness Program developed the Heart and Stroke Healthy City Recognition Program in cooperation with representatives from healthcare, business and education.
- Ten community-based indicators signifying a reduced burden of heart disease and stroke are used to evaluate cities around the state. Indicators include accessible physical activity areas, moderate-to-strong city smoking ordinances, coordinated health and physical activity programs in public elementary schools, AED placements in communities, EMS response times to heart attack and stroke calls and implementation of nationally recognized clinical guidelines for heart disease and stroke prevention and care.
- Texas cities are assessed every three years on a rotating basis. The Program collects information and assigns points based on how well the indicators have been met.
- Cities earn Gold, Silver, Bronze or Honorable Mention Awards which are presented at a full city council meeting.

Impact

- Thirty-two cities were assessed over the last 2 years.
- In the six metropolitan areas reassessed to determine progress there was a 50% increase in supportive environmental changes and policies to promote heart health and stroke prevention. For example, in Austin a 100% smoke-free city ordinance was adopted. El Paso developed a city-wide prevention program implemented in all hospitals. Get Moving Houston is a city initiative designed to raise fitness and prevention awareness levels of Houstonians. The city of Dallas implemented a quality improvement program for primary and secondary prevention at nine health care sites. San Antonio instituted smoke-free municipal worksites while Fort Worth made city smoking ordinances stronger.
- A program implementation guide, in development by the Cardiovascular Health and Wellness Program will help cities set supportive heart-healthy policies.

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PROMOTING HEART HEALTH IN EAST TEXAS

“Search Your Heart” program reaches African-Americans to reduce death rates from heart disease.

Public Health Problem

- Heart disease is the leading cause of death in Texas.
- Heart disease death rates are more than 40% higher for African-Americans than for Caucasians.
- East Texas has a large African-American population as well as some of the highest heart disease death rates in the state.
- Faith-based lifestyle change programs are a proven way to reduce heart disease and stroke risk factors with the goal of lowering death rates.

Program

- The Texas Department of State Health Services (DSHS) Cardiovascular Health and Wellness Program partners with the American Heart Association (AHA) to promote the Search Your Heart Program in East Texas.
- Search Your Heart uses tested, culturally appropriate strategies and materials to motivate African-Americans to adopt healthy lifestyles and develop heart-healthy habits.
- Search Your Heart is designed for use in churches and other faith-based organizations and includes six modules covering topics such as nutrition, physical activity, stress reduction and risk factors.
- At least 10 African-American churches from each of five East Texas cities (Longview, Texas City, Galveston, Beaumont and Tyler) will receive training on establishing the program, a total of at least 50 churches.

Impact

- Thirty-five churches have been recruited, representing 70% of the participation goal. Twenty-two of these have already received training to get the program up and running.
- More than 4,400 church members are active participants in the program, increasing the skills they need to reduce their risk for cardiovascular disease.
- The partnership allows DSHS to augment services in regions with few AHA staff members for program implementation. Funding provided by DSHS for the purchase of Search Your Heart program kits enables community volunteers to carry out the project, a low-cost way to provide needed services to Texas residents.
- Volunteer task forces have been established in Longview and Tyler that will provide additional outreach to the African-American community on preventing and controlling disease risk factors.

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RED BANDANA PROJECT EDUCATES WYOMING WOMEN ABOUT HEART DISEASE AND STROKE

Educational series promotes awareness of heart disease and stroke symptoms

Public Health Problem

- Less than half of all women know that heart disease is the leading cause of death for women in the U.S. as well as in Wyoming.
- Women often do not take the risk of heart disease seriously, postponing treatment and prevention.
- Awareness of the difference in symptoms of heart attack between women & men can help assure effective treatment of women having a heart attack, potentially saving women's lives.

Program

- The Wyoming Department of Health Cardiovascular Disease Prevention Program partnered with United Medical Center, the Cheyenne Heart Center, and the Cent\$ible Nutrition Program to develop the Red Bandana Project designed to educate women about the risks of heart disease. The project name gave a local appeal to a set of national messages from the American Heart Association's "Red Dress" campaign.
- Over 60 women in the Cheyenne area were educated in group sessions about signs and symptoms of heart disease and stroke, cholesterol-lowering diet, physical activity, and the importance of cholesterol and blood pressure testing to identify risk factors.

Impact

- One pre-test and four post-test surveys showed that participants were more aware of the signs and symptoms of heart disease and how to plan a heart-healthy diet.
- Red Bandana Project kits were distributed to 120 interested community sites to facilitate statewide reach of the community awareness campaign.

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TRAINING SCHOOL NURSES TO PREVENT DIABETES COMPLICATIONS

Delaware program reaches more than half the state's school nurses with vital information

Public Health Problem

- Delaware, as the rest of the nation, has seen a rise in type 2 diabetes in school children.
- Keeping the child with diabetes healthy improves the child's learning environment and helps prevent long-term complications.

Program

- Delaware is unique among states in having school nurses in all public, vocational, and many private schools. School nurses are responsible for overall wellness and providing oversight for administering insulin, medications and timely blood glucose testing.
- In 2002, the Diabetes Prevention and Control Program (DPCP) created annual in-service sessions for school nurses throughout the state to provide current and necessary information about diabetes in children, including management of type 1 diabetes in the school setting. Continuing education credits were offered.
- All instructors were Certified Diabetes Educators with extensive clinical and educational experience in diabetes.
- Pre-and post-tests were administered and evaluated.
- Program staff were invited to present a summary of the Program and evaluation at the 2002 American Association of Diabetes Educators Annual Meeting.

Impact

- Pre- and post-tests confirm that school nurses learned new information.
- Attendance over three years remains constant, demonstrating continued interest in this important topic. In 2004, over 65% of the Delaware school nurses participated in the program.
- Evaluations of the sessions revealed consistent, positive attitudes toward the content and methods used.
- The Delaware DPCP anticipates that some cost reduction will be achieved as a result of a reduction in emergency department visits by children with poorly controlled diabetes and that school nurses will refer more high risk youth to medical providers for diabetes screening and use more primary prevention strategies at their schools.

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PERSONAL SUCCESS STORY:

Georgia woman loses 200 pounds and learns to control diabetes

CoCo's Story

- R.L. “Coco” Bright learned that she might have diabetes when a nurse at a Georgia health department screening event detected high blood sugar levels. Her doctor confirmed the diagnosis and sent her to a certified diabetes educator. Bright, a 48 year-old African-American woman “was in denial for the first six months following the diagnosis,” ignoring the exercise and nutrition plan provided.
- A year later, her weight ballooned to 385 lbs. and she developed high blood pressure, inflamed joints and sleep apnea in addition to diabetes.
- A local TV reporter learned of her struggle to pay for gastric bypass surgery and found a doctor to donate his services.
- After surgery, she lost 75 lbs. and no longer needed her three prescribed diabetes medications.
- With the help of diabetes education, Coco learned portion control, healthy eating, and made exercise an important part of her life. She began to walk – first to the mailbox, then to the corner, and eventually to the finish line of a 13.1 mile half-marathon.
- Today at age 56 and 200 lbs. lighter, Coco keeps her diabetes under control with healthy eating and physical activity. She helps the Georgia Diabetes Program spread the word about the importance of preventing diabetes and serves as a role model for clients.
- As she says, “Good health is not a final destination ... it’s a journey. Small steps can make a big difference.”

Public Health Problem

- More than 400,000 Georgia adults (about 7%) have diagnosed diabetes. Another 205,000 have the condition but don’t know it.
- The death rate from diabetes for African-American women in Georgia is more than twice as high as the rate for Caucasian women.
- The number of Georgians who are obese and/or physically inactive, both important risk factors for diabetes, increases each year.

State Program

- The Georgia Diabetes Control Program serves residents throughout the state.
- Education programs teach people with diabetes how to better manage their condition.
- Services such as nutrition counseling, blood tests, blood pressure screenings and foot exams minimize the risk of complications such as kidney disease, heart attack, high blood pressure and amputations.

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IMPROVING OUTCOMES FOR PATIENTS WITH DIABETES

Health department partnership with medical practices and clinics helps patients reach goals

Public Health Problem

- Idaho adults report having diabetes at the following rates: 6% of all adults 15% of adults receiving Medicaid benefits 16% of adults eligible for Medicare.
- The annual cost of diabetes in Idaho is estimated at \$658 million.
- Preventing life-threatening complications of diabetes requires controlling blood sugar and blood pressure, controlling other chronic conditions and regular monitoring by a health care professional.
- Self-management training to help patients control their diabetes prevents hospitalizations, cutting health care costs by up to \$8.76 for every \$1 invested.

Program Example

- The Idaho Diabetes Prevention and Control Program (DPCP) provided expertise, staff time, and financial support to create the Diabetes Preventive Healthcare Collaborative in partnership with the Medicare Quality Improvement Organization for Idaho, Qualis Health.
- Three learning sessions and an outcomes congress were held for physicians and other health professionals to implement the chronic care model.
- Teams of health care professionals from fourteen medical practices and clinics with more than 3700 diabetes patients learned how to improve health care delivery for their patients using computerized clinical information registries, implementing clinical practice recommendations, and using a proven model to guide diabetes care.

Impact

- The main goal of diabetes care is better blood sugar control. A measure of blood sugar control, called hemoglobin A1c, improved from 72% at baseline to 78% at follow-up after training sessions, a significant improvement.
- Percentage of patients with an acceptable blood pressure reading improved by more than thirty percent at follow-up.
- Percentage of patients with a documented self-management goal tripled.

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PARTNERS WORK TOGETHER TO FILL THE GAP IN DATA ON MARYLAND MEDICARE BENEFICIARIES WITH DIABETES

State monitors services that prevent disabling conditions and lower costs

Public Health Problem

- Diabetes contributed to 1,630 lower extremity amputations and 882 new cases of endstage kidney disease in 2002, costly and disabling complications of the disease.
- About \$3 billion was spent on direct & indirect costs of diabetes in 2002 in Maryland.
- Recommended preventive services for people with diabetes can reduce complications and suffering and save money.
- Maryland had limited data on the prevalence of diabetes and the provision of preventive services such as eye exams and blood sugar monitoring among Medicare beneficiaries in the state prior to this project.

Program

- A Memorandum of Understanding outlined a unique partnership between the Maryland Department of Health and Mental Hygiene and the Maryland Health Care Commission, which provided access to and analysis of the needed data.
- CDC funds available through Maryland's Diabetes Prevention and Control cooperative agreement were matched roughly 1 to 1 by Maryland Health Care Commission funds.
- The project analyzed Medicare data for Maryland beneficiaries, resulting in a detailed report on which preventive care services were provided and the extent of gaps in services.

Impact

- The resulting report highlights the needs of specific Medicare populations, allowing the Maryland Diabetes Prevention and Control Program and its partners to develop and implement interventions to increase provision of recommended services.
- The baseline data in the report provides a necessary tracking tool for Maryland Diabetes Prevention and Control Coalition partners to use in planning improvements in diabetes care and reductions in costly medical complications.
- The availability of federal money enabled the program to find matching funds to complete the project in a way that addressed all identified Medicare data needs.

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MANAGING DIABETES AT SCHOOL

Training school personnel improves knowledge about the needs of children with diabetes at school

Public Health Problem

- About 8,700 children with diabetes in Michigan spend almost half of their waking hours at school.
- School personnel have a poor understanding of diabetes according to studies.
- Parents of children with diabetes express concern about the ability of their child's teachers to help their child manage the disease at school.

Program Example

- In partnership with the Michigan Department of Health Diabetes Prevention and Control Program, the Michigan Organization of Diabetes Educators (MODE) developed Diabetes Management in the School Setting: A Tool Kit.
- Certified diabetes educators trained school personnel on aspects of diabetes in children and ways to assist children with diabetes at school.

Impact

- 150 employees in 6 schools have been trained in 2005.
- A significant increase in knowledge occurred in trained staff of the nine evaluated schools.
- A significant decrease in staff apprehension and increased awareness of the needs of the child with diabetes in the educational setting was also measured in the evaluation group.

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MINNESOTA DEPARTMENT OF HEALTH DEVELOPS COMPREHENSIVE DIABETES PLAN

State leadership stimulates and unifies diabetes control and prevention

Public Health Problem

- One in ten Minnesotans has diabetes or is at risk for developing it.
- 250,000 people in Minnesota have pre-diabetes, making them more likely to develop the disease.
- Each year between 500 and 800 Minnesotans lose their sight due to diabetes.
- Diabetes costs the state \$2 billion annually.

Program

- Creating the Minnesota Diabetes Plan 2010 required the Minnesota Department of Health to coordinate meetings across the state with over 350 members of the Minnesota diabetes community.
- This series of meetings resulted in consensus on the vision of “creating a healthier future for all people in Minnesota” by preventing and managing diabetes.
- The resulting comprehensive plan spells out the goals and strategies for collaboration and is a tool for motivating coordinated statewide action on diabetes.
- The complete Minnesota Diabetes Plan 2010 and the Year 1 Progress Report are available at www.health.state.mn.us/diabetesplancentral.

Impact

- The Minnesota Diabetes Plan 2010 supplies a cohesive and cost-effective approach to addressing diabetes. It has mobilized hundreds of stakeholders around common issues to make the most of their collective expertise and resources.
- Extensive media coverage of the Plan reached over 1 million people in the state.
- Across Minnesota, local programs are aligning their goals and objectives with the Plan, a major step in achieving statewide implementation.
- The Department of Health is currently evaluating progress toward reaching the Plan’s goals in areas such as marketing, coordinating local programs, achieving recommended outcomes, and reducing the public health impact of diabetes.

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MISSOURI COLLABORATIVE IMPROVES CARE OF PEOPLE WITH DIABETES

Proven care models encourage disease management and follow-up among patients and families

Problem

- Diabetes is the fourth leading cause of death for African Americans in Missouri and the fifth leading cause of death for all residents.
- Diabetes rates are higher in populations with less education and lower incomes such as those served by Federally-qualified health centers.
- More than \$147 million is spent every year in Missouri on treatment of diabetes and its complications such as blindness, kidney failure and amputations.

Program

- The Missouri Diabetes Prevention and Control Program, part of the Missouri Health Department, facilitates and funds the Missouri Diabetes Collaborative.
- Participating members are Federally-qualified health centers, the Missouri Primary Care Association, and the Missouri quality improvement organization as well as hospitals and private physician practices.
- Collaborative members form practice teams to improve their care of patients with diabetes using a proven model to manage disease.
- Patient registries, proven treatment services, cooperation among healthcare providers, and referrals to community resources for follow-up are just some of the tools that help Collaborative members provide improved care.
- The Missouri Diabetes Prevention and Control Program tracks quarterly progress and gives reports to partners in the Collaborative to help them assess and improve patient care.

Impact

- Fourteen measures of patient diabetes care in the group of collaborative patients have improved. For example, a measure of blood sugar control called HbA1c decreased an average of more than 3%. For every one-percent reduction in this value, there is an estimated 35% decrease in eye, kidney and nerve damage, and a 25% decrease in diabetes-related deaths. Also, more patients are receiving foot exams (17%) and eye exams (32%), helping prevent amputations and blindness.
- The Collaborative is helping the state achieve Objective #3 in the Missouri Diabetes State Plan by more than doubling the number of federally qualified health centers and satellite sites participating, and by improving preventive practices and testing associated with the management and control of diabetes.
- A greater proportion of the high risk population is getting improved diabetes care and reducing their risk of death and serious complications.

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HEALTHY MEAL PLANNING HELPS MANAGE DIABETES

Cooking school that teaches food preparation and menu planning skills to New Mexicans with diabetes has improved nutrition for these individuals

Public Health Problem

- Meal planning and healthy eating are key steps for controlling diabetes.
- Many New Mexicans with diabetes face barriers that make control of the disease difficult: they live in rural areas where: 1) health insurance is either too expensive or not available and 2) access to health professionals trained specifically in diabetes is difficult. As a result, patients often do not learn the tools of self-management, such as portion sizes, healthy food choices on a budget, and the importance of monitoring blood sugar values.
- Many people with diabetes have high blood sugar levels and don't realize how closely tied these levels are to the foods they eat.

Program

- The New Mexico Diabetes Prevention and Control Program developed "Kitchen Creations Cooking School," a four-class series designed to improve meal planning and food preparation skills of New Mexicans with diabetes.
- Classes are team-taught by a local Extension home economist and either a certified diabetes educator or a registered dietitian.
- Participants learn simple meal planning strategies and food preparation techniques, as well as tips for reading food labels. Hands-on activities and food samplings incorporate many local recipes.
- Cooking schools have been conducted in Spanish in many counties. The program has also been adapted for Native American populations.

Impact

- During the past four years, more than 2,800 New Mexicans with diabetes have participated in 156 cooking schools throughout the state.
- The proportion of participants using the Diabetes Food Guide Pyramid for meal planning has increased by 183%.
- There has been a 92% increase in participants eating whole grains or beans, and a 142% increase in those selecting two or more non-starch vegetables at meals.
- The practice of reading food labels has increased by 98%.
- The program received The Florence Hall Award at the 2004 National Extension Association for Family and Consumer Sciences Conference, given to exemplary programs that meet the needs of families.

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CONGREGATIONS ‘TAKE ON’ DIABETES

New York coalition helps churches attack growing problem of obesity

Public Health Problem

- The mostly African American and Latino neighborhoods of the southwest Bronx are among the state’s highest in rate of diabetes risk, cases of diabetes and deaths from diabetes.
- Each year almost half of people with diabetes in the Bronx will be hospitalized.
- The Medicaid program spends over 5 billion dollars on the care of people with diabetes in New York State annually
- Studies prove that promoting healthy eating, physical activity and needed weight loss in people at risk of diabetes can prevent the disease and reduce costly complications.

Program

- Using Public Health & Health Services Block grant funding, the New York State Department of Health, Diabetes Prevention and Control Program supports The Bronx Health REACH Coalition for Diabetes Prevention.
- The Coalition developed and implemented a faith- based health and fitness program called “Fine, Fit and Fabulous,” which empowers participants to reduce diabetes risk by increasing physical activity, making healthier food choices and using the positive reinforcement of prayer and scriptural references.
- Members of the congregation are trained as facilitators, enhancing program ownership and sustainability. Sixty parishioners have completed the program.

Impact

- Program graduates lost weight and increased regular physical activity.
- Two churches reported an increase in fruit, vegetable and other healthy food offerings at church-related events, extending benefits beyond individual participants.
- The experience of one church member highlights the success of this effort: Jeanne, an African American in her thirties, was obese, with high blood pressure and a family history of diabetes. Her extra weight damaged her knees and she used a cane. Her pastor encouraged her to join the “Fine, Fit and Fabulous” program where she learned simple exercises, and healthful eating habits. She lost 119lbs, her blood pressure is normal and she no longer suffers knee pain. She has maintained this weight loss for over six months with her motto “plan, pray and prepare.”

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NEIGHBORHOOD FORMS COALITION TO FIGHT DIABETES

New York involves the community in improving diabetes care

Public Health Problem

- Better treatment and prevention of diabetes in East Harlem, New York is needed, as shown by these alarming statistics— East Harlem has the - highest diabetes and obesity rates in New York City
 - highest rate of preventable hospitalizations
 - highest diabetes amputation rate
 - highest diabetes death rate
- New York City residents with diabetes report obstacles to taking important preventive care steps such as exercising regularly or eating a healthy diet or knowing their A1c levels, an indicator of blood sugar control that's essential to effective treatment of diabetes.
- Three hospitals and two federally qualified health centers that provide the majority of health care for East Harlem residents report major challenges reaching neighborhood residents to help them lower these high disease rates.

Program

- The NYS Department of Health, Diabetes Prevention and Control Program supports the East Harlem Diabetes Center of Excellence, established in 1997.
- Coalition members, mostly from Hispanic and African American neighborhoods in East Harlem, work tirelessly to engage the community in diabetes care efforts and to strengthen the community's relationship to local hospitals and health centers providing diabetes care.
- James De la Vega, a respected, local artist of Hispanic descent whose mother has diabetes, designed diabetes education materials highlighting important self care messages, making them especially meaningful to many people in East Harlem.

Impact

- A community food festival held as part of the Diabetes Detection Initiative educated more than 1,000 residents on diabetes risk factors and gave them the opportunity to taste healthier versions of traditional foods, a first step toward making a change in eating habits.
- The coalition is now implementing a self-developed diabetes peer education program, based on the Stanford Chronic Disease Self-Management Program which is proven to reduce costly complications and improve outcomes for people with chronic diseases like diabetes. The coalition ensures that the program meets the needs of local residents by researching the barriers to diabetes self-care among community members.

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NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

DIABETES PREVENTION AND MANAGEMENT TOOLKIT DEVELOPED

Providers and the public benefit from better understanding of recommended practices

Public Health Problem

- Diabetes is a major public health problem in New York state - over a million residents have diabetes, about 450,000 more have diabetes but don't know it, and an estimated 4 million more New Yorkers have pre-diabetes, a condition where blood sugar levels are approaching the level of a diagnosis of diabetes.
- Information from yearly managed care plan performance reports indicate that health care providers are not consistently following the Clinical Practice Recommendations established by the American Diabetes Association.

Program

- The New York State Department of Health, Diabetes Prevention and Control Program, in collaboration with the New York Health Plan Association, developed a comprehensive Diabetes Prevention and Management Toolkit for health care providers and for people with, and at risk for, diabetes.
- The Toolkit gives providers and patients up-to-date information on diabetes standards of care and self-management practices using American Diabetes Association Clinical Practice Recommendations as the standard.
- Prevention steps for children and adults are provided in guidance materials which were field tested by health care providers and people with diabetes and include National Diabetes Education Program educational materials.

Impact

- Toolkits were distributed on CD-ROM to nearly 27,000 health care providers in New York State.
- The toolkit gives health care providers ready access to diabetes standards of care that can help patients achieve better blood sugar control and fewer hospitalizations. The toolkits are available from the New York State Department of Health website <http://nyhealth.gov> or provided in hard copy at no charge.
- Patients now have easy access to information they can apply directly to managing their disease.

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DIABETES COALITION PROMOTES ACTIVITIES TO REDUCE THE NUMBER OF AMPUTATIONS

Two New York counties acquire volunteer services to fill the gap in insurance coverage

Public Health Problem

- Suffolk and Nassau counties in New York have toe, foot and leg amputation rates that are significantly higher than the state rate.
- Poorly controlled diabetes increases the risk of amputations, a costly and debilitating complication of diabetes.
- Foot exams and diabetes education can reduce the number of amputations by improving foot care and helping people with diabetes control their blood sugar.

Program

- A state-funded Diabetes Resource Coalition with over 50 active member organizations implemented aggressive strategies to reduce the high rate of amputations by recruiting podiatrist volunteers for screening and education.

Impact

- Volunteer podiatrists now provide significant, necessary services at no cost to residents receiving them or to the state.
- These free podiatry examinations and the related education provided help fill the gap in insurance coverage for these services that people with diabetes may have.
- Here's an example of the benefits of this effort to just one patient:
 - James, an unemployed man with diabetes, had no recent medical care because he lacked insurance coverage. At a coalition screening event a foot exam revealed his need for medical attention. Coalition personnel arranged clinic treatment and diabetes education services to help James avoid foot problems that could lead to amputation. The screening event connected this patient to the health care system where he received needed care.

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IMPROVED HEALTH CARE FOR PEOPLE WITH DIABETES

Computer tracking system that measures health care services for people with diabetes resulted in enhanced care and cost savings for health plans

Public Health Problem

- In North Dakota, 6% of the adult population has diagnosed diabetes.
- Diabetes affects nearly 30,000 people and is the sixth leading cause of death.
- Health care costs for diabetes total nearly \$400 million annually, including medical expenses and hospitalizations resulting from complications of the disease.

Program

- The North Dakota Diabetes Prevention and Control Program and Blue Cross Blue Shield of North Dakota (BCBSND) formed a cooperative partnership to design a system to measure the level of care for diabetes patients and track five annual health care services:
 1. office visits; 2. hemoglobin A1C testing; 3. dilated eye exams; 4. lipid profiles; and 5. nephropathy assessments. These services help prevent complications such as blindness, amputations, heart attack and stroke.
- These care system indicators are entered into computer registries for BCBSND members with diabetes and continuously updated using insurance claim data.
- Quarterly reports monitor the five health care services. Emergency visits, hospital admissions and complications are also tracked to help determine whether use of the selected services has had an impact. Information is reported by provider and health care network.
- Project outcomes and updates are shared through the North Dakota Diabetes Care Provider Report, newsletters, presentations and conferences.
- The registries now track 6,816 individuals served by 530 health care professionals and 130 health care systems.

Impact

- After implementation of the program, the frequency of office visits, A1C tests, eye exams, lipid tests, and nephropathy tests increased for members diagnosed with diabetes.
- Plan members with diabetes were less likely to have hospital admissions and emergency room visits following the start of the program.
- The program, which cost approximately \$300,000, saved an estimated \$9 million over three years – about a 30 to 1 return on investment.
- Quarterly reports help providers track their success rate in providing services that keep diabetes patients healthy and out of the hospital. Health care networks have also begun using their own clinic registries and tracking systems to evaluate the care they provide.

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UTAH PARTNERS WITH HEALTH CARE PROVIDERS TO DEVELOP DIABETES MANAGEMENT PROGRAMS

Participants learn to control diabetes through diet, medication, regular blood tests and physical activity – reducing the likelihood of complications

Public Health Problem

- Approximately 93,000 Utah residents (4% of the population) have been diagnosed with diabetes. About 40,000 more have diabetes but haven't been diagnosed.
- In Utah, diabetes contributes to over 1,000 deaths and more than 20,000 hospitalizations each year.
- People with diabetes who complete a diabetes self-management education (DSME) course are more likely to follow treatment recommendations and experience fewer complications such as heart disease, blindness, nerve damage and skin disorders. DSME programs teach people how to manage diabetes through diet, medication and physical activity.
- Nearly half of Utah adults with diabetes have never taken a DSME course.

Program

- The Utah Diabetes Prevention and Control Program, part of the Utah Department of Health, works with public and private health care providers to develop and manage DSME courses.
- Program staff provides state certification, ensures that DSME courses meet national standards, loans computers to educators and offers on-going technical support and training.

Impact

- Sixteen state-certified DSME programs are operating in Utah.
- People with diabetes who have completed one of the DSME courses show improved blood sugar control. Over 70% monitor their blood sugar levels regularly and correctly.
- Nearly two-thirds of the participants are following recommended meal plans.
- Nearly two-thirds of the participants report that they exercise regularly.

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ALABAMA COALITION IMPROVES QUALITY OF LIFE FOR PEOPLE WITH ARTHRITIS

Health Department partners to implement arthritis training and self-management programs

Public Health Problem

- A third of all Alabama adults have diagnosed arthritis. Almost two-thirds of those 65 and older have it.
- Many adults with arthritis say it limits their daily activity.
- Proven self-management programs that promote physical activity help people take control of their condition and are important for preventing other chronic diseases such as diabetes and heart disease.

Program

- The Alabama Department of Public Health (ADPH) Arthritis Control Program partnered with more than 250 organizations and individuals, including the Arthritis Foundation, to form the Alabama Arthritis Prevention and Treatment Coalition. Projects are:
 - Implementation of the CDC campaign Physical Activity: The Arthritis Pain Reliever in cooperation with several state universities, the Alabama Pharmacy Association and the Alabama Department of Senior Services, including distribution of educational materials.
 - Professional updates on early diagnosis and management of arthritis for providers, and training on establishing routine referral of patients to self-management programs.
 - Development of Taking Care of Yourself with Arthritis, an interactive, web-based program to help people with arthritis manage pain and become more active.
 - Establishing cooperative arrangements with public and private agencies, universities and faith-based organizations to bring arthritis management programs to the community.

Impact

- The ADPH video on arthritis management, with personal testimonials from participants, was shown in 350 centers providing meals to 40,000 people age 60 and older.
- The Alabama Department of Senior Services and the health department are collaborating to train 70 PACE (People with Arthritis Can Exercise) instructors, who will lead these evidence-based programs in 10 regions of the state.
- The Taking Care of Yourself with Arthritis website (www.adph.org/arthritis) receives more than 3,500 hits each year.

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ARIZONA PROMOTES ARTHRITIS SELF-HELP COURSE

Proven program helps patients manage pain to improve quality of life

Public Health Problem

- In Arizona, 26 percent of the population has doctor-diagnosed arthritis.
- This disease affects approximately 1,068,000 adults and is the number one leading cause of disability.
- Health care costs for arthritis totaled nearly \$86 billion dollars in 1997, including \$51 billion dollars in direct costs, and \$35 billion in indirect costs.

Program

- The Arizona Department of Health Services Arthritis Program, the Arthritis Foundation, Greater Southwest Chapter, and the University of Arizona Arthritis Center have formed a partnership to decrease the burden of arthritis in Arizona by increasing the number of Arthritis Self Help Course available, increasing the awareness of arthritis as a public health burden, and accurately identifying the true burden of arthritis in Arizona.
- The Arthritis Self Help Courses are a six-week course intended to improve a patient's participation in the management of their disease. It emphasizes pain management techniques, problem solving skills, and goal setting.
- There are currently more than 20 classes being conducted across the state of Arizona, with the majority of them in the Phoenix and Tucson metropolitan areas.
- Quarterly reports monitor the status of the courses and determine if there are additional areas that need to be considered to host a course.

Impact

- The Arthritis Self Help Course has been shown to have reduced pain, improved quality-of-life, and reduce utilization of medical services.
- The benefits of the Arthritis Self Help Course have been shown to last at least four years.
- The quarterly reports provided to the Arizona Department of Health Services Arthritis Program help the program to track their success rate in providing services that keep arthritis patients healthy and mobile.

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MAPPING IDENTIFIES TARGETS FOR ILLINOIS ARTHRITIS PROGRAMS

Data helps staff target areas where arthritis education and programs will effectively reach underserved populations.

Public Health Problem

- Nearly 23% of Illinois adults have been diagnosed with arthritis by a doctor; another 9% have chronic joint pain. The state ranks seventh in the country in the percentage of adults with doctor-diagnosed arthritis.
- One-third to nearly one-half of adults with doctor-diagnosed arthritis or chronic joint pain report that it limits their activities.
- Arthritis is the leading cause of disability in the United States and costs the economy more than \$86 billion annually in medical expenses and lost productivity.
- Because there is limited funding for arthritis interventions, proven public education and disease management programs must be targeted to those most in need of services.

Program

- The Illinois Arthritis Initiative Public Education Target Group Assessment used census data to identify characteristics such as age, race, gender and community type (rural or urban) of residents in each of the state's 102 counties.
- A mapping process was used to create maps showing where people with these characteristics live in the state.
- Community arthritis prevention programs are placed in the areas identified through the mapping process as having populations with the greatest need for arthritis services, including people with arthritis living in rural and inner city communities, minorities, and the underserved/uninsured.

Impact

- Program staff uses the maps to target arthritis interventions to specific populations or to counties.
- State and federal resources are maximized by the state health agency and its community partners when decisions about public education and disease management programs are targeted to populations with the greatest need for services.

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KANSAS AGENCIES PARTNER ON ARTHRITIS SELF-MANAGEMENT

Local health departments and Area Agencies on Aging recruit leaders for arthritis course

Public Health Problem

- One-fourth of Kansas adults have been diagnosed with arthritis by a doctor.
- Nearly half of the state's residents aged 65 and older have arthritis.
- Very few people with arthritis have ever taken a class to learn how to manage problems with their condition, such as joint pain and disability.
- Research shows that people with arthritis who attend evidence-based classes experience less pain, fewer doctor visits and improved quality of life.

Program

- The Kansas Arthritis Program of the Department of Health and Environment, partnered with the Kansas Department on Aging to implement the Arthritis Foundation Self-Help Program through Area Agencies on Aging and local health departments.
- This proven, evidence-based program is a series of behavior change classes that teach individuals how to manage arthritis pain.
- The partners educated attendees at the Governor's Conference on Aging on the benefits of this self-help program.
- Regional staff of the partner agencies, community volunteers and local health care providers was trained as Arthritis Foundation Self-Help Program leaders, the first step in providing the classes to state residents with arthritis.
- Each partner provides resources to make the classes available in the community. The Kansas Arthritis Program funds leader trainings and course materials; the Arthritis Foundation assists with class logistics and data collection; and community organizations provide in-kind support such as donated classroom space and staff time to serve as leaders.

Impact

- Participants reported decreased pain and fatigue, increased levels of physical activity, and improved ability to perform activities of daily living according to evaluation surveys.
- The number of trained leaders has increased from just two to a current roster of 21 trained leaders in eight counties. Three additional counties intend to implement the program shortly.
- In 2005, 14 classes were offered, with 147 participants completing the course.

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MARYLAND ARTHRITIS PROJECT PROMOTES SELF-MANAGEMENT AND AWARENESS

Individual benefits include improved mobility for people with arthritis

Public Health Problem

- A million Maryland adults report they have doctor-diagnosed arthritis and another 680,267 have chronic joint symptoms that could be undiagnosed arthritis.
- About 200,000 Maryland adults say their ability to work for pay is affected by arthritis.
- The direct and indirect cost of arthritis care in Maryland is estimated at \$1.5 billion.

Program

- The Arthritis Project, a program of the Maryland Department of Health and Mental Hygiene works with partners to reduce the burden of arthritis in Maryland by:
 - Maintaining surveillance related to individuals with arthritis
 - Developing a state plan to address the burden of arthritis
 - Promoting public awareness
 - Disseminating arthritis education materials to the public and resources to providers
 - Working to provide trained leaders for proven Arthritis Foundation self-management classes in the community
 - Grants to local health departments and area agencies on aging to provide self-help classes in the community.

Impact

- One hundred and twenty course leaders were trained to conduct self-help classes in the community over the past three years. In 2005:
 - Twenty-two of these leaders taught classes through grants to local health departments and area agencies on aging
 - 1,350 people participated in self-help classes proven to reduce pain and the number of doctor visits in people with arthritis.
 - Over 600 people in the community were reached through educational workshops to increase public awareness of this condition.
- Individual impact of these efforts is reflected in these participant results:

“I have been able to realize the following benefits from the program - less body aches and joint pain and weight loss.” Another participant, suffering from arthritis, diabetes, & overweight can walk better, put on clothing without difficulty and has “completely turned her life around” by participating in an arthritis self-management course.

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EARLY DETECTION OF JUVENILE ARTHRITIS

Identifying children with juvenile arthritis leads to appropriate treatment and prevention of disability

Public Health Problem

- About 7,000 children in Michigan are affected by arthritis and other rheumatic conditions.
- With prompt diagnosis and treatment, most of these children can be spared a lifetime of preventable disability.
- Recognizing arthritic conditions when symptoms first appear enables pediatricians, family physicians and other primary care providers to start treatment and prevent disability.

Program Example

- The Michigan Department of Community Health implemented the Juvenile Arthritis Initiative.
- A consensus process with medical professionals and others identified the critical elements of care for childhood arthritis and created a guidelines document for national distribution by the American College of Rheumatology.
- The guidelines were used in an extensive educational effort with Michigan physicians to relate the differences between child and adult arthritis and the correct diagnosis and treatment for the childhood condition, including Grand Rounds presentations at hospitals on pediatric rheumatology.

Impact

- Over 355 pediatric, family practice and other primary care providers in Michigan have been reached through the Initiative.
- The Initiative resulted in publication of juvenile arthritis updates reaching a combined circulation of 11,700 readers of the Michigan State Medical Society's monthly journal and the newsletter of the Michigan Chapter of the American Academy of Pediatrics.
- An Impact survey assessing the usefulness of the Critical Elements of Care document indicates the following desired outcomes:
 - More than half saved the Critical Elements of Care document for future reference
 - More than half reported that the Critical Elements of Care document was somewhat helpful for their area of expertise
 - Almost a third have referred a patient to a pediatric rheumatologist

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NEBRASKA ARTHRITIS PROGRAM EXPANDS REACH THROUGH LEADER RECRUITMENT

Campaign targets health care professionals in metropolitan and rural areas.

Public Health Problem

- Arthritis affects more than 350,000 people in Nebraska.
- Women are more likely than men to have arthritis, and almost two-thirds of people with arthritis are younger than 65.
- Arthritis costs Nebraska's economy over \$450,000,000 each year in medical expenses and lost productivity.
- The state was not able to provide proven programs due to a lack of instructors.

Program

- The Nebraska Arthritis Program partnered with the state Arthritis Foundation chapter to expand the availability of the Arthritis Foundation Self-Help Program (AFSH), a program which is proven to reduce pain and improve functional ability.
- More than 29,000 registered nurses, licensed practical nurses, physical therapists and occupational therapists in the state were targeted to receive a letter educating them on the importance of physical activity in arthritis treatment and inviting them to become trained program leaders.
- Three hundred health care professionals responded positively to the recruitment letter.
- The recruitment effort has allowed the funding and provision of new, free programs throughout the state, including offering them to 1200 clients with arthritis in the "Every Woman Matters" Program for low-to middle-income women ages 40-64 with limited or no health insurance.

Impact

- There are now 68 trained Arthritis Foundation Self-Help Program leaders in the state, ready and able to reach arthritis patients with programs proven to reduce pain and disability.
- An additional 250 potential leaders are available on a waiting list for future training as replacements for those leaders.
- Trainers (those who train the program leaders) available to conduct program training have tripled in number in one year.
- Thirty AFSH Program classes have been provided to 283 people with additional classes scheduled.

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UNIQUE PARTNER FOR NEVADA ARTHRITIS PROGRAM - TRIBAL COMMODITY FOOD PROGRAM DISTRIBUTION SITES

Physical activity interventions side-by-side with nutrition education to relieve joint pain

Public Health Problem

- Over a third of Nevada residents age 18 and older have arthritis.
- Costs associated with hospital-related arthritis treatment in Nevada were more than \$100 million in 2001.
- More than half of all Nevadans are overweight or obese, conditions that can make arthritis symptoms worse.
- Controlling weight and being physically active helps prevent disability from arthritis.

Program

- This unique program spans three Nevada State agencies, including the Nevada Bureau of Community Health Arthritis Prevention and Control Program, to bring nutrition and physical activity education to those receiving commodity foods from FDPIR (Food Distribution Program on Indian Reservations) and to their households.
- Access to tribal councils and elders was facilitated by the CDC Public Health Advisor's efforts to conduct an American Indian/Alaska Native Behavioral Risk Factor Surveillance System (BRFSS) survey on a representative sample of Nevada residents.
- Commodity food distribution days are used as an opportunity to work with tribal members to blend nutrition and physical activity messages with traditional ways of sharing and learning at 11 Indian Reservation sites.
- The Arthritis Prevention and Control Program promotes "People With Arthritis Can Exercise," a proven program, and distributes stretch bands for at home exercise – both of which can help reduce joint pain and disability related to arthritis.

Impact

- Maximizes the use of federal, state and local resources by joining forces with partners to enable the Arthritis program to expand its reach.
- Promotes program integration by targeting a high-risk population through joint planning, pooling funds, and providing career mobility to staff
- Reaches out effectively to alleviate disparities among American Indians/Alaskan Natives through support from tribal leaders who ask to extend the education beyond the initial tribal group receiving commodity foods.
- The planned continuation of the American Indian/Alaska Native BRFSS allows the addition of arthritis survey questions to capture data on the extent of the Nevada arthritis burden among Nevada tribal groups.

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NEW YORK VOLUNTEERS DELIVER EVIDENCE-BASED ARTHRITIS PROGRAMS

Trained community volunteers effectively teach programs that improve the quality of life for people with arthritis.

Public Health Problem

- Approximately 3.9 million New Yorkers – more than a quarter of the state’s adults – have been diagnosed with arthritis.
- Arthritis is the leading cause of disability in the state, and costs the state’s economy nearly \$6 million each year in medical expenses and lost productivity.
- Evidence-based programs that are proven to decrease pain, increase flexibility and improve quality of life require trained leaders and must be accessible throughout the state.

Program

- The New York State Arthritis Program partnered with the state’s Arthritis Foundation chapters, Area Agencies on Aging, rural health networks and other interested groups to:
 - Recruit and train volunteer leaders from local communities to serve as instructors for three evidence-based arthritis programs, the Arthritis Foundation Self-Help Program, Arthritis Foundation Exercise Program, and Arthritis Foundation Aquatic Program.
- The partners also recruited volunteers willing to lead the workshops to train additional program leaders and provide technical support to help leaders effectively implement proven programs.

Impact

- By recruiting trainers as well as leaders, the NYS Arthritis Program ensures the growth of the evidence-based programs, which will reduce disability caused by arthritis.
- The successful volunteer leader approach has:
 - Increased participation five-fold at the Lackawanna site, run exclusively by volunteers.
 - Resulted in such high demand for proven programs that the Eastern Adirondack Health Care Network in Plattsburgh had to set up a waiting list for its volunteer-led Arthritis Foundation Self-Help Course. Plans are underway to expand offerings of the land-based and warm-water exercise programs, also led by community volunteers.

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NORTH CAROLINA PROMOTES ARTHRITIS MANAGEMENT

Reducing, disability, activity limitation, social isolation and work limitation due to arthritis and other rheumatic conditions

Public Health Problem

- More than 2.4 million North Carolinians have been diagnosed with arthritis, about 30% of the population.
- Arthritis costs North Carolina residents more than \$2 billion in lost wages each year.
- Arthritis education has been shown to help reduce pain, but only 1 in 10 adults have ever participated in any type of arthritis program.

Program

- The North Carolina Arthritis Program of the NC Department of Health & Human Services improves the quality of life for North Carolinians living with arthritis by working with community partners to educate people about arthritis and provide tools to manage arthritis.
- The following evidence-based interventions are provided:
 - 1) Arthritis Foundation Exercise Program (AFEP) which uses gentle activities to increase joint flexibility and muscle strength.
 - 2) The Chronic Disease Self Management Program (CDSMP), which teaches successful management of arthritis to reduce disability.
 - 3) Physical Activity: The Arthritis Pain Reliever, a communications campaign that promotes physical activity which research has shown has beneficial effects on arthritis pain.
- The North Carolina Arthritis Advisory Board promotes public awareness, early detection and treatment and self-management of arthritis and other rheumatic conditions. The goal is to maintain quality of life, prevent disability and preserve independent living for the citizens of North Carolina.

Impact

- Fifteen community volunteers were trained in the Arthritis Foundation Exercise Program, resulting in nine class sessions being offered in fall 2005. Funding was provided by the CDD Healthy Aging minigrant.
- All program participants reported that they learned management techniques; that the exercises helped their arthritis stiffness and that they would recommend the program to others.
- Two of these AFEP instructors became the first Master Trainers in NC.
- To broaden the program's capabilities, the same 15 volunteers will be trained in the Chronic Disease Self Management Program during 2006.

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ARTHRITIS AWARENESS AND SELF-MANAGEMENT

Pennsylvania Department of Health partners to fund demonstration grants

Public Health Problem

- More than a third of Pennsylvania adults have arthritis.
- Regular physical activity helps people with arthritis move more easily with less pain.
- People with arthritis are often physically inactive, putting them at higher risk for obesity, and other chronic diseases.

Program

- The Pennsylvania Department of Health working cooperatively with The Arthritis Foundation funded seven community-based demonstration projects to reduce the arthritis burden in the state by promoting physical activity for arthritis patients.
- Grantees implemented both a marketing campaign and evidence-based programs for people with arthritis or arthritis symptoms. They were required to provide matching funds.
- With only \$11,795 Mercy Rehab Associates for example, implemented three evidenced based programs - exercise, self-help and aquatics - to increase low impact physical activity.
- From January 2004 to May 2005 the Mercy program alone had 6,715 encounters with individuals affected by or at risk for arthritis.

Impact

- 60% of participants in all of the funded programs intend to make changes to their arthritis care as a result of the program and close to two thirds strongly agreed that they were confident of their ability to do moderate physical activity.
- Participants reported that their ability to perform activities of daily living improved and their feelings of being able to manage their disease also increased.
- Funds available for arthritis awareness and self-management in Pennsylvania were doubled by the grant matching requirement.
- All program participants were satisfied with the program; 87% would recommend the program they attended to other individuals; and three-quarters of the participants were aware of the public health messages about arthritis.

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PARTNERING TO HELP PEOPLE WITH ARTHRITIS

Providing needed self-help courses in Tennessee by training more qualified instructors

Public Health Problem

- One out of three Tennessee residents has either been diagnosed with arthritis by a doctor or experiences chronic joint pain.
- Arthritis is a leading cause of disability, costing the national economy more than \$86 billion a year.
- Proven arthritis self-management courses can reduce pain and disability and increase the physical activity of participants, contributing to improved quality of life and prevention of other chronic diseases.

Program

- The Tennessee Department of Health Arthritis Program worked with the Tennessee Arthritis Action Committee to increase the pool of trained course leaders for the proven Arthritis Foundation Exercise, Self Help and Aquatic Program courses as follows:
 - Trained forty University of Tennessee Extension educators as course leaders for 25 rural areas that had limited course availability, in cooperation with the University.
 - Recruited and trained Occupational and Physical Therapy students at Belmont University as course leaders, at the same time helping them fulfill a community service requirement.
 - Partnered with Alpha Omicron Pi to coordinate a pool of statewide course volunteers.
- Website links to the Tennessee Department of Health Arthritis Program and the Arthritis Foundation Tennessee Chapter provided in partnership with Alpha Omicron Pi increase access to arthritis information and program offerings.

Impact

- The Arthritis Foundation courses offered in increased numbers in Tennessee have been shown in studies to reduce pain in 20% of participants, doctor visits by 40% and to significantly increase physical activity levels.
- The Tennessee Arthritis Program expanded the availability of proven courses by increasing the number of qualified instructors and reached 560 Arthritis Foundation Self Help Program participants, 20,987 Arthritis Foundation Exercise Program participants, and 98,139 Arthritis Foundation Aquatic Program participants.
- The partnership with Extension is an effective use of state resources for bringing arthritis education to targeted rural areas because Extension agents cover every county in the state.

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UTAH MEASURES THE REACH OF ARTHRITIS PROGRAMS

New tool allows the state to accurately track the number of participants in proven programs

Public Health Problem

- One in four Utah adults has arthritis, the second leading cause of disability in the state.
- People with arthritis often have pain, difficulty performing their daily activities, and feelings of depression and loss, all of which negatively affect their quality of life.
- Arthritis management courses proven to be effective in reducing pain and the number of doctor visits are offered in Utah but there was not an effective way to track the number of participants to see how well the state was meeting the needs of its residents with arthritis.

Program

- A data tool developed by the Arthritis Council of the National Association of Chronic Disease Directors and the Centers for Disease Control and Prevention, called REACH, standardizes the collection of participant data in arthritis management programs.
- The Utah Arthritis Program and the Utah/Idaho Chapter of the Arthritis Foundation modified the national tool to fit the state's specific needs and implemented plans to use it in all offered courses.
- The tool was introduced at leader trainings and at re-certification for existing leaders with the goal of training every arthritis course leader to use it in each Arthritis Foundation course offered. Leaders of Arthritis Foundation Self-Help Program courses and Arthritis Foundation Aquatic Program courses are fully trained in its use and those leading Arthritis Foundation Exercise Program courses will complete training shortly.

Impact

- All facilities offering the Arthritis Foundation Self-Help Program met the goal of REACH data tool use in just the 1st quarter of use. Facilities offering the two other Arthritis Foundation courses have established regular use of the tool in most courses.
- Future tracking and additional training will facilitate use of the data tool by all facilities.
- Data on use of these proven programs helps Utah plan and implement courses that help Utah residents with arthritis relieve pain and reduce disability.

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CULTURALLY APPROPRIATE ARTHRITIS INTERVENTIONS FOR THE HISPANIC/LATINO POPULATION OF UTAH

Report describes the burden of arthritis on the Hispanic/Latino population and ways to reduce health disparities in this growing population

Public Health Problem

- Hispanics with arthritis have more severe joint pain and a higher proportion of work limitations because of arthritis than non-Hispanics.
- A recent study showed that Hispanics are less likely to see a doctor for chronic pain than blacks or whites.
- The Hispanic/Latino population of Utah is growing twice as fast as the national average, making health disparities in this group an urgent public health issue for Utah.

Program

- The Utah Arthritis Program gathered state-specific data about the burden of arthritis to the Hispanic/Latino population and published a report recommending actions to reduce disparities in diagnosis and treatment.
- The report, *The Prevalence and Impact of Arthritis Among Utah's Hispanic/Latinos and Non-Hispanic/Latino Whites*, identified several risk factors for arthritis among the Hispanic/Latino population, including being female, older, and having hypertension or diabetes. (<http://health.utah.gov/arthritis/>)
- More than half of Hispanic/Latino adults reported that pain limited their activities for 15 to 30 days. They were also more likely to be physically inactive and to report fair or poor health.

Impact

- The report guides the Utah Arthritis Program in reducing health disparities among the State's Hispanic/Latino population and in implementing appropriate arthritis interventions to meet their needs, such as:
 - The Arthritis Foundation Self-Management course, available in Spanish, is proven to reduce pain by 20% and doctor visits by 40%. Leaders for the course are being recruited and trained in Utah to offer this course.
 - Educational brochures in Spanish are distributed and the Foundation website is available in Spanish.
- The Utah Arthritis Program and Hispanic /Latino communities are working to find the best way to reach the Spanish speaking community in Utah with arthritis awareness and control measures.

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PROJECT LEAN ENCOURAGES HEALTHY EATING IN SCHOOLS

Collaborative partnerships improve school nutrition policies and promote obesity prevention

Public Health Problem

- Two-thirds of all deaths in California result from four nutrition/fitness-related chronic diseases: heart disease, cancer, stroke and diabetes.
- For the first time in two centuries, the current generation of children in America may have shorter life expectancies than their parents due to the rapid rise in childhood obesity.
- Schools play a significant role in feeding children and influencing the dietary habits they will have as adults.

Program Example

- The Successful Students Through Healthy Food Policy Program developed by California Project LEAN (Leaders Encouraging Activity and Nutrition) guided school boards to develop and adopt nutrition policies that support healthy eating.
- The California School Boards Association and Project LEAN's ten regional groups jointly developed ways to help school boards create and implement healthy nutrition policies, including:
 - Providing a guide to changing school environments to allow students to develop and practice healthy eating habits
 - Providing a guide for community groups on working effectively with school boards to develop policies that support healthy eating habits
 - Implementing training for school board members and providing promotional materials on healthy schools

Impact

- About 4 percent of California's 1,000 school districts have developed or are developing healthier nutrition policies impacting over 1 million of California's 6.3 million students.
- School boards have nutrition and obesity prevention on their agendas more often.
- Nutrition and marketing expertise provided by California Project LEAN gives the California School Boards Association excellent tools to assist school boards in developing healthy nutrition policies.
- The project received the Secretary's Innovation in Prevention Award from the Department of Health and Human Services, Office of the Secretary.

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EDUCATING STUDENTS FOR DISEASE PREVENTION

Improving student knowledge of the relationship of diabetes, high blood pressure, and kidney disease may improve their lifestyle habits for long-term disease prevention

Public Health Problem

- Forty four percent of newly diagnosed cases of end stage kidney disease in Michigan are in people with diabetes.
- Kidney dialysis treatments and transplants for people with diabetes in Michigan cost an estimated \$331 million in 2002.
- Preventing diabetes and high blood pressure can reduce chronic kidney disease rates
- One in nine adults have chronic kidney disease, and most don't know it.

Program

- The Michigan Diabetes Prevention and Control Program partnered with the National Kidney Foundation of Michigan (NKFM) and Michigan public and private schools to develop and implement two programs, Kids and Kidneys and KICK (Kids Interested in the Care of Their Kidneys)
- Both programs provide age-appropriate information on kidney function and kidney disease and on healthy lifestyles as a way to prevent disease.
- The Michigan Diabetes Prevention and Control Program provides funding to NKFM for education done in conjunction with Henry Ford Health Systems School Based Health Clinic which reaches 70 middle school children with the Making New Decisions class. Students participated in eight elective classes on physical activity and nutrition. Every sixth grader participated in a peer-led daily physical activity session (120 students).

Impact

- Kids and Kidneys has been used to educate 150,000 students in Michigan schools and currently reaches 50,000 students a year. KICK has educated 630,000 students, reaching about 80% of Michigan tenth graders.
- NKF affiliates in New York and the Republic of Palau have adapted and used the course materials.
- Kids and Kidneys evaluations regularly show a twenty percent overall increase in student knowledge of kidney disease, diabetes, physical activity and nutrition. KICK evaluations show a 45% gain in knowledge regarding diabetes, hypertension and kidney disease.
- Teacher evaluations for both Kids and Kidneys and KICK were overwhelmingly positive.
- The Making New Decisions class increased knowledge of physical activity/nutrition and chronic disease prevention by 21%, increased physical activity levels and positive nutrition choices by 5 to 6%.

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PREVENTING AN OUTBREAK OF MENINGOCOCCAL INVASIVE DISEASE

Quick action in an outbreak of meningococcal invasive disease in rural Mississippi helped limit the spread of a potentially fatal infection

Public Health Problem

- In February 2003, six school-aged children in rural Mississippi were diagnosed with confirmed or probable meningococcal invasive disease.
- The bacteria causing meningococcal invasive disease can invade the blood or spinal fluid of an individual, causing sepsis (blood infection) or meningitis. Even when appropriate treatment is administered, 5-15% of people diagnosed with this disease will die. Survivors may have permanent hearing loss, neurological damage, or loss of a limb.
- Each year, 25 to 50 cases of meningococcal invasive disease are reported in the state. Most occurrences are unrelated. When a cluster of cases breaks out, quick action is necessary to limit the spread of the disease.

Program

- An immediate public health response was coordinated using funds from the Preventive Health and Health Services (PHHS) Block Grant and other sources. Health Department and local personnel, including 74 public health nurses, 125 clerical staff, 7 physicians, and 3 epidemiology surveillance staff were mobilized in the effort.
- Because meningococcal vaccine can take up to two weeks to work, medical personnel administered antibiotics immediately to approximately 1,800 students, staff, and others at risk in the three schools where the outbreak occurred.
- Students and staff in all six schools in the district (more than 6,000 people) were vaccinated within just one week of the initial decision to vaccinate.

Impact

- Block Grant funding gave the Mississippi State Department of Health the flexibility to respond to this disease outbreak quickly, minimizing the serious consequences of further infection.
- Limiting the severity of the outbreak by vaccinating potential victims allowed schools to quickly resume classes.

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NEW YORK ACTS TO IMPROVE STUDENT'S HEALTH

Linking schools with nutrition professionals promotes wellness of children

Public Health Problem

- Schools play a critical role in promoting student health and preventing childhood obesity, both related to nutrition and physical activity.
- Students make healthful choices when school policies and guidelines create a supportive school environment.
- Federal law requires school districts participating in the National School Lunch and/or Breakfast Program to establish a local wellness policy by the beginning of the 2006-2007 school year.

Program Example

- SPIN (Schools and Professionals in Nutrition: Partnering for Healthier, Successful Students) is a broad group of member organizations* working together in NY to develop and strengthen school guidelines and practices related to federally-mandated local wellness policies.
- Nutrition professionals are trained to help the school community assess school environments using CDC's School Health Index (SHI) and to apply the results.
- Over 40% of professionals receiving training signed an agreement to be linked to a specific school.
- A completed SHI and a wellness plan positions schools to receive funding for implementation, an important step to improving children's health.

* New York State Department of Health, New York State Action for Healthy Kids, Statewide Center for Healthy Schools, Student Support Services Network, Cornell Cooperative Extension, New York State Education Department – Child Nutrition Program, New York State School Food Service Association, New York State Congress of Parents and Teachers, Inc., New York State Dietetic Association, New York State Association of Physical Education Health Recreation and Dance and American Cancer Society-Eastern Division.

Impact

- 281 nutrition professional volunteers are trained and ready to work with schools in their community.
- Over 60 schools have requested linkage with a trained nutrition professional or further information about the program.
- 33 PTA groups requested a presentation on healthy school environment from the nutrition professional members of the speaker's bureau.
- 740 superintendents and district health coordinators have received information marketing the program.

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OREGON SCHOOLS BECOME MORE ASTHMA FRIENDLY

Coordinated school health approach helps identify and monitor students with asthma

Public Health Problem

- Approximately 63,000 Oregon children have asthma which can be controlled with appropriate care.
- Each year, students miss 14 million school days because of asthma nationwide, making it the leading cause of school absences.
- The LaPine school staff believed that estimates of the number of students with asthma in their rural schools did not explain the significant number of asthma signs and symptoms among its students, such as school absences, extended respiratory infections, and decreased physical activity. Their students also had limited access to health care services.

Program

- The LaPine schools were the first in the state to take part in the Asthma Friendly Schools Demonstration Project, funded by the Centers for Disease Control & Prevention through a partnership between the Oregon Department of Education and the Oregon Asthma Program in the Department of Human Services.
- Using a Coordinated School Health approach the LaPine school system implemented an Asthma Friendly Schools action plan to improve the identification, monitoring and tracking of students with asthma, to foster better communication between schools, providers, and families, to reduce the presence of asthma triggers, and to increase awareness and understanding among staff and students about asthma.
- Central Oregon Independent Health Service, the local Medicaid health plan, Deschutes County Health Department, and Craig Jones, M.D., a national leader in school asthma management, were key partners in supporting asthma services for the LaPine schools.
- In order to sustain the efforts to implement asthma services for students in LaPine, the school and community researched sustainable models and planned a school-based health center to provide both the monthly asthma clinic already in place as well as services for other acute and chronic physical and mental health conditions. The State provides on-going base funding, which is matched locally with three to four dollars for every dollar of State funding.

Impact

- The LaPine K-12 school campus now has a financially stable school based health center staffed by health professionals and operating 20 hours per week.
- LaPine schools have identified 12% of their students as having asthma.
- LaPine now has an established process for identifying students with asthma at the time of enrollment and ensuring implementation of an individual asthma action plan for each student.
- Teachers are better educated about asthma and are more able to support students with asthma.

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NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

UTAH SCHOOLS ACHIEVE GOLD MEDALS IN 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 Utah Department of Health with other public and private partners created A Healthier You – The Gold Medal Schools Award Program. The program has three major themes: eat healthy, be active and stay tobacco-free.
- Schools move through Bronze and Silver levels to achieve the Gold level by meeting specific criteria, such as:
 - Establishing a student walking program
 - Scheduling 90 minutes of structured physical education each week
 - Offering healthy choices in the school cafeteria
 - Implementing staff wellness programs.
- When each level's criteria are met, schools receive cash awards for purchase of physical education equipment, nutrition resources or tobacco cessation materials.

Impact

- Over 1000 nutrition, physical activity and wellness policies have been implemented.
- Overall, most school districts participate, reaching approximately 86,000 students and 3,500 teachers.
- Half of the participating schools are Title 1 schools reaching the most at-risk students.
- More than half of the 190 elementary schools participating have achieved the top (Gold) level.
- Students have collectively walked approximately 5 million miles.
- Program success attracted funding sponsorship of \$1.5 million from Intermountain Health Care.

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COALITION MAKES COMPREHENSIVE TOBACCO PROGRAMS HAPPEN

Tax revenues fund comprehensive tobacco control at recommended level for success

Public Health Problem

- Tobacco use is the leading cause of preventable death in Colorado, responsible for more than 4,200 deaths a year.
- The more states spend on comprehensive tobacco control programs, the greater the reductions in smoking—and the longer states invest in such programs, the greater and faster the impact.
- The State Tobacco Education and Prevention Partnership’s funding was well below the CDC Best Practices recommended level of \$24.5 million that would allow implementation of all nine components of comprehensive tobacco control programs.

Program

- The “Citizens for a Healthier Colorado” Coalition educated the public and state legislators about the healthcare and budget impact of tobacco use.
- Coalition members included the American Heart Association, the American Lung Association, the American Cancer Society, Children’s Hospital, healthcare groups, physicians, and patients who had smoking-related diseases.
- The Colorado Department of Public Health and Environment, Tobacco Control Program educated coalition members on the components of effective comprehensive tobacco control programs – what is needed and how residents of the state could benefit.
- A Constitutional amendment to raise the cigarette excise tax and increase the tax on other tobacco products was proposed.
- A media and direct mail campaign by the Coalition educated voters on the benefits of the tobacco tax increase.

Impact

- The amendment passed by an overwhelming majority in November 2004, increasing tobacco taxes to provide revenue for prevention programs.
- Revenues from this tax of at least \$25 million are designated each year for comprehensive tobacco prevention and treatment programs, bringing Colorado to the CDC-recommended Best Practice level for achieving maximum reductions in smoking.

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YOUTH SMOKING RATES REDUCED IN MICHIGAN

Coordinating communication and advocacy strategies enhances partner effort

Public Health Problem

- Tobacco use is the number-one cause of lung cancer and the leading cause of all cancer deaths in Michigan.
- Michigan's health care expenses and productivity losses caused by smoking top \$6 billion annually.
- At the start of this program, 35% of Michigan youth smoked.

Program

- The Michigan Cancer Consortium (MCC), a statewide partnership of public and private organizations, including the Michigan Department of Health, made reduced youth smoking a priority seven years ago.
- Partners in the Consortium contributed their time, experience and expertise to change policies at local and state levels to:
 - reduce sales of cigarettes to minors
 - increase smoke-free regulations and ordinances in schools and childcare centers
 - limit tobacco billboard advertising
 - increase tobacco taxes
- The Michigan Cancer Consortium's communication network will continue to work at local and state levels to promote policies that impact youth smoking.

Impact

- The Michigan youth smoking rate has dropped to 23% since reduced youth smoking became a priority of the Consortium.
- Because of its success, MCC has set a new goal to lower the youth smoking rate to 16% by 2010.
- The Michigan Cancer Consortium planning process was enhanced by combining it with the statewide tobacco plan for a more coordinated effort to develop additional effective strategies for youth smoking reduction, for collecting data and for evaluating activities.

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NEBRASKA COALITION RESTORES FUNDING TO TOBACCO CONTROL PROGRAM

Personal stories, education are the key to improving funding for “Tobacco Free Nebraska.”

Public Health Problem

- More than 2,300 people die each year in Nebraska due to the consequences of smoking.
- The more states spend on comprehensive tobacco control programs, the greater the reductions in smoking—and the longer states invest in such programs, the greater and faster the impact.
- According to CDC’s Best Practices funding recommendations, in order to have the greatest impact on reducing smoking rates, Nebraska should spend at least \$13.3 million annually on its comprehensive tobacco control program.
- Annual funding for tobacco control interventions in Nebraska had decreased to a low of \$405,000 in 2003 due to a difficult budget situation.

Program

- Tobacco Free Nebraska and SmokeLess Nebraska are coalitions of individuals and organizations dedicated to reducing tobacco use and eliminating exposure to secondhand smoke.
- Coalition members educated the public and legislators about the costs and health consequences of tobacco use to Nebraska’s residents.
- Coalition members shared personal stories of smokers and their families and those who had benefited from tobacco control programs. Young people and community members who had no financial interest in the funding request were particularly effective speakers.
- Through personal meetings and mail/telephone campaigns, the coalition expressed the concern that years of infrastructure and progress made in tobacco control could be lost.

Impact

- In 2004, the state legislature increased funding for Tobacco Free Nebraska to \$2.5 million, using Master Settlement Agreement money. Statutory language earmarks this funding for comprehensive tobacco control programs.
- This level of funding is five times the previous year’s level and will help Nebraska reduce tobacco use.

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NORTH CAROLINA TOBACCO-FREE SCHOOLS PROJECT

Help for local school boards to pass and successfully implement a 100% tobacco-free policy.

Public Health Problem

- About 30% of NC's high school students, and almost 10% of middle school students report using tobacco products within the last month.
- Many school systems allow adult tobacco use on school campuses and at school events.
- School systems that limit all tobacco use on-campus (100% Tobacco-Free) often lack the financial resources to adequately publicize their policy.
- Comprehensive school tobacco use policies combined with community and media efforts can prevent or postpone smoking onset by up to 40% among teens according to the U.S. Surgeon General.

Program Example

- North Carolina's 100% Tobacco-Free Schools (TFS) project coordinates local efforts to establish policies prohibiting tobacco use on school grounds and during school-sanctioned events.
- The NC Tobacco Prevention and Control Branch coordinates the TFS program as part of a statewide teen tobacco use prevention and cessation effort funded by the NC Health and Wellness Trust Fund.

The project provides:

- local trainings and forums for school and community health advocates;
- media and strategic planning assistance
- a full-service website, with research, talking points, model policy at www.nctobaccofreeschools.com
- compliance training for school systems that have passed 100% TFS policies
- peer networking to link school personnel with their colleagues across the state
- promotional materials which are free to schools adopting 100% TFS policies

Impact

- There has been a ten-fold increase in the number of schools with comprehensive 100% Tobacco-Free policies – from only 5% in 2000 to 54% in 2005 – as a result of this project.
- Tobacco-free school policies are now a regular part of school health plans developed by local and state school system personnel.
- Because of the success of the 100% Tobacco-Free policies in schools communities are also adopting tobacco-free policies for parks, hospitals and county buildings, spreading the smoke-free environment across the state.

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VIRGINIA COALITION BOOSTS TOBACCO CONTROL FUNDING

Increasing excise taxes on tobacco products enhances comprehensive tobacco control

Public Health Problem

- Virginia has over 9000 deaths every year attributable to smoking.
- Seven in ten adult smokers in the U.S. say they want to quit smoking.
- Virginia's cigarette excise tax was the lowest in the U.S. and the state's tobacco control program was funded at a per capita level well below that recommended by CDC as a Best Practice for achieving the greatest reductions in tobacco use.

Program

- "Virginians for a Healthy Future" was founded in 2002 to improve the health, education, and welfare of the state's residents by reducing the use of tobacco products.
- Members included representatives from the Virginia Education Association, the American Association of Retired Persons, the American Cancer Society, the American Heart Association and the American Lung Association.
- The Virginia Department of Health, Tobacco Control Program educated coalition members on the components of effective comprehensive tobacco control programs – what is needed and how residents of the state could benefit.
- Using the theme "2.5 Cents to Common Sense," the coalition worked to educate the public and state legislators about the benefits of raising the cigarette excise tax from 2½¢ to a figure closer to the national average of 75¢, and of taxing other tobacco products.

Impact

- The cigarette excise tax increased to a high of 30 cents a pack in July 2005. A 10% excise tax was added to other tobacco products.
- Tobacco product tax dollars go into the Virginia Health Care Trust Fund and are used for health services, including prevention.
- Virginia is now closer to the CDC Best Practices spending recommendation of \$38.9 million a year necessary to achieve the greatest reductions in smoking.

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CALIFORNIA SKIN CANCER PREVENTION PROGRAM TARGETS YOUTH AND OUTDOOR WORKERS

Educational programs and legislative efforts improve the use of sun safety techniques.

Public Health Problem

- Skin cancer is largely prevented by practicing sun safety techniques such as using sunscreen or staying out of the sun during peak hours.
- Californians don't routinely protect themselves from the sun's harmful rays. For example, 78% of adults don't use sunscreen routinely, and almost as many don't wear protective clothing. More than half of young people don't use sunscreen and nearly one-quarter were sunburned in the past year.
- Over 127,000 new cases of skin cancer are expected in California this year.

Program

- The California Skin Cancer Prevention Program (SCPP), a statewide initiative supported by Preventive Health and Health Services Block Grant funds, promotes sun safety techniques.
- SCPP provided educational modules for 900 child care facilities, schools and outdoor worksites.
- A media campaign, with newspaper articles and radio interviews, promoted sun protection techniques.
- Program staff provided extensive technical assistance for State Senate bills requiring public elementary school students and state outdoor workers to get annual instruction on skin cancer protection.
- SCPP took the lead role in obtaining a grant from the Environmental Protection Agency to create two sun-safety videos for use in elementary schools.

Impact

- Over 20,000 children in child care facilities and preschools received education on skin cancer prevention.
- 8,000 outdoor workers received on-the-job sun-protection education. Almost half of these employees adopted at least one new sun-safety technique at work. Overall use of sun safety practices increased at worksites.
- SCPP drafted a sun-safety resolution that was adopted, with modifications, by the California State Parent Teacher Association.
- Hundreds of individuals have contacted SCPP to learn more about preventing skin cancer or advocating for sun-safety measures.

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RAISING AWARENESS OF BREAST & CERVICAL CANCER TO REACH MORE WOMEN

Michigan increases number of low-income women served through a targeted media campaign

Public Health Problem

- Services under the Michigan Breast & Cervical Cancer Program (BCCCP) are under-utilized. Only about 15% of eligible women have ever been served.
- Informing women of their risk for these cancers, the benefits of prevention and treatment and the existence of free services can improve screening rates and ultimately save lives.

Program

- The Michigan Department of Community Health (MDCH) Cancer Prevention and Control Section and the American Cancer Society (ACS) joined forces to develop a publicity campaign, Free2Be, designed to increase the number of women enrolled in the program.
- Working with a media consultant they created an original, culturally appropriate logo and slogans (Free to be YOU, Free to be HEALTHY, Free to be CANCER-FREE). A toll-free telephone number and description of BCCCP services were a part of every message.
- Cancer Society volunteers were specially trained to answer Free2Be calls and transfer eligible callers directly to local BCCCP offices while logging the number and nature of Free2Be calls received.
- The Detroit mayor, BCCCP Program Coordinator, ACS, and a breast cancer surgeon launched the campaign at the state capitol.
- 775,000 Medicaid clients statewide received Free2Be project flyers in the mail.
- 7,700 health care providers throughout the state received information promoting the BCCCP.
- Public service announcements appeared on radio statewide along with a breast cancer radio tour. Billboard ads with the logo, slogan, and toll-free number were placed in high density markets.

Impact

- The campaign received extensive free media coverage by a Detroit TV anchorwoman who also visited Detroit churches to promote the program.
- Mailings resulted in dramatic increases in volume of calls to the ACS call center. Overall, the campaign generated 2,850 calls to the special toll-free number.
- 404 eligible women newly enrolled in the program as a direct result of the campaign.
- HEDIS measures will help the program analyze the campaign impact on the breast and cervical cancer screening rates among Michigan women in general.

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NEW YORK DEVELOPS COLORECTAL CANCER SCREENING PROGRAM

Diverse partnership creates a flexible statewide program that saves lives

Public Health Problem

- Nearly 12,000 New York residents are diagnosed with colorectal cancer each year, with more than 4,000 deaths.
- A simple screening test done annually has been shown to decrease the risk of colorectal cancer death by 33% in people over fifty.
- Follow-up tests, such as a colonoscopy, to detect and remove polyps can actually prevent the disease.
- In addition, colorectal cancer has a high survival rate when found at an early stage.
- Only about half of all New Yorkers have had an appropriate screening test for colorectal cancer.

Program Example

- The New York State Department of Health created a state-funded colorectal cancer screening program to screen men and women aged 50 and older with inadequate health insurance.
- Screening kits are distributed to eligible individuals through local partnerships involving county health departments, American Cancer Society chapters, hospitals, physicians, health care clinics, and individual health care workers. The diversity of the partnerships allows great flexibility for reaching the target population.
- People with a positive test receive a complete colon exam, including a colonoscopy, funded by the state.
- Program eligibility was expanded in 2003 to allow screening colonoscopies for people at elevated risk for colorectal cancer per American Cancer Society guidelines.

Impact

- Of the 44,000 tests completed, almost 1,800 people with positive results required followup since the start of the program in 1997.
- Nearly 1,300 of these individuals received a complete colon exam.
- An additional 630 individuals received screening colonoscopies because of personal or family risk factors for colorectal cancer.
- Polyps were found and removed in a significant number of people, decreasing their risk of getting colorectal cancer.
- Diagnosis of colorectal cancer in 67 people allowed them to quickly enter treatment, increasing their survival chances.
- The success of the program has allowed expansion to 42 counties from the original 25.

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CANCER SURVIVORS NEEDS MET THROUGH STATE-SUPPORTED PROGRAM

Funding for services is increased as state develops a community-based cancer support services initiative

Public Health Problem

- About 90,000 New York adults and 900 children are diagnosed with cancer every year.
- Cancer survivors are people who have been diagnosed with cancer as well as the people in their lives who are affected by the diagnosis, including family members, friends, and caregivers.
- Because of advances in early detection and treatment, the population of cancer survivors is growing and they are facing physical, emotional, social, spiritual, and financial issues that public health professionals must address. For example cancer treatment can increase the risk for other health problems, increasing the need for health and respite services.

Program

- The New York State Department of Health's Cancer Services Program developed a community-based cancer support services initiative to distribute \$1,500,000 in state funds to provide 25 grants for adult support services, training, respite and counseling services over a three-year period.
- The initiative was later expanded to offer seven additional state-funded grants for similar services to children affected by cancer, totaling \$420,000.
- Another \$500,000 in state funding is provided yearly by the Cancer Services Program to six agencies providing legal services for those affected by cancer. These services include planning for long and short term legal, financial, and medical needs; estate planning; development of advance directives; child custody and guardianship; and designation of health care proxies.
- A survivorship curriculum developed by the Cancer Services Program for medical providers in collaboration with survivors and provider partners in the medical community enables providers to better understand and promote utilization of needed cancer support initiatives.

Impact

- This New York State Department of Health Cancer Services program is one of the first in the country to recognize the need for and provide state funding for vital support services to adult and child cancer survivors.
- Program funding is helping the many residents who live with, through, and beyond cancer to improve their health and quality of life.

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RURAL OREGON COMMUNITIES TAKE ACTION AGAINST CANCER

Forums raise awareness of cancer control plans and local resources

Public Health Problem

- Cancer accounts for nearly one-fourth of Oregon deaths each year.
- Certain rural counties in the state have more cancer cases and higher death rates than the state average. This may be because of a higher rate of risk factors such as obesity and smoking, or because fewer residents have cancer-screening tests.

Program

- The Oregon Partnership for Cancer Control developed the Call to Action Program to promote discussion on the impact of cancer on rural communities.
- Community forums in three rural communities convened by local health departments and cancer programs brought together healthcare providers, cancer survivors and other interested community members. The six forums reached 115 participants.
- Participants discussed the state's comprehensive cancer control plan, learned about the impact of cancer on their community, and shared data on screening rates and risk factors.
- Additional cancer forums were directed to members of the health care community.
- Local media coverage encouraged public input to the state's cancer control plan and promoted community participation. In one city, a cancer resource panel appeared on a local cable station, featuring representatives from the public health department, a cancer treatment center, the American Cancer Society, hospice agencies, as well as cancer survivors.

Impact

- New partnerships formed between public health departments, hospital cancer programs, voluntary agencies and cancer survivors help improve community awareness of local cancer resources.
- A local Clean Air Coalition expanded its spring education campaign to widely distribute information on cancer risk factors, screenings and death rates.

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COLLABORATION TO IMPROVE EMPLOYEE HEALTH

Washington State Health Department joins Prevention Research Center to improve cancer interventions

Public Health Problem

- Cancer and other chronic diseases are part of the cost of health care and health benefits for both employers and employees and they affect other business costs such as workers' compensation, life insurance, employee replacement costs and workplace productivity.
- A very large number of employed & insured people do not have adequate access to the clinical preventive services that offer the greatest value for improved health outcomes and cost-effectiveness.
- Less than half of employed, insured Washingtonians receive appropriate colorectal cancer screening which can save lives by detecting cancer early.
- Prevention Priorities: Employers' Guide to the Highest Value Preventive Health Services lists colorectal cancer screening as a high-value, high-impact service and ranks it among the top 8 of 30 services evaluated.

Program

- The Washington State Department of Health gives financial and administrative support to the Washington Comprehensive Cancer Control Partnership ("the Partnership").
- Three groups worked together - the Department of Health, the Partnership, and the University of Washington Prevention Research Center's Alliance for Reducing Cancer, Northwest to:
 - Assess primary care providers' knowledge, attitude and behavior regarding colorectal and prostate cancer screening and make recommendations based on this assessment
 - Analyze behavioral risk factor and insurance claims data
 - Fund community projects to increase colorectal cancer screening and promote informed decision-making about prostate cancer, based on assessment results
 - Evaluate funded interventions using PRC expertise to ensure the use of proven practices

Impact

- Publication of Employment-Based Prevention of Chronic Disease in Washington State in October 2005 outlining what is known about Washington employment-based health promotion activities and pointing to opportunities for action.
- Establishment of two colorectal and one prostate cancer community project.
- Access to evaluation expertise from the Prevention Research Center's Alliance to improve service delivery in health department projects
- Partnership adoption of evidence-based practices in Washington communities.

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COMMUNITY WALKING PROGRAM HELPS ALASKA ADULTS LOSE WEIGHT

10,000 Steps program targets residents with heart problems and diabetes

Public Health Problem

- Nearly two-thirds of Alaskan men and women are overweight or obese.
- Only one-quarter of Alaska adults are moderately physically active on a regular basis
- Obesity, partly the result of inactivity, is a major contributor to heart disease & diabetes
- Economic barriers, such as inability to pay membership fees, can keep residents from participating in organized health and fitness programs.

Program

- The Alaska Department of Health & Social Services awarded a two-year \$30,000 grant using Preventive Health and Health Services Block Grant funds to the Central Peninsula General Hospital (CPGH) to implement a free walking program.
- Patients from the cardiac rehabilitation, diabetes education, and other hospital programs were invited to participate.
- Each participant promised to work toward walking 10,000 steps per day; keep a daily step record; submit step, weight and blood pressure reports; and attend quarterly program events and screenings. Participants were given step counters and instructions for use.
- Program staff contacted participants regularly by e-mail and telephone.
- Program partners included the Kenai National Wildlife Refuge, Tsalteshi Trails Association, Soldotna Middle School, private healthcare practitioners and local media.

Impact

- CPGH expected 100 participants during the first year of the program, but had to set up a wait list due to overwhelming interest. Eventually 265 people registered.
- Program participants walked 304,336,058 steps, equivalent to 152,168 miles, by the end of the first year,
- Half of the participants completed the 10,000 Steps program.
- Nearly two-thirds of participants who reported results lost weight, contributing to a group loss of 766 pounds.
- Sixty-two percent of participants reporting said they are now exercising for at least 30 minutes on three or more days each week.

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RESOURCE KITS PROMOTE GOOD HEALTH IN COLORADO COMMUNITIES

Workplaces and schools use effective strategies to encourage physical activity and good nutrition.

Public Health Problem

- The number of overweight and obese Colorado children and adults has increased steadily over the past ten years.
- Obesity increases the risk of developing chronic diseases such as heart disease, diabetes, and cancer. It plays a role in more than a third of premature deaths in Colorado each year.
- Most Coloradans don't meet recommended guidelines for physical activity and healthy eating that could help prevent obesity.

Program

- The Colorado Physical Activity and Nutrition (COPAN) Program of the Colorado Department of Public Health and Environment developed resource kits with strategies and activities to promote physical activity and healthy eating in worksites and schools.
- The kits were available through the COPAN website and were showcased at statewide school and worksite training programs where participants learned how to use the resource kits. Grants of up to \$1,000 were awarded to 7 school sites and 11 worksites to implement resource kit activities.
- A Boulder elementary school used a grant to purchase heart rate monitors to give students and teachers feedback on physical activity intensity during physical education classes.
- The City of Northglenn used its funds to establish a “StairWELL to Better Health” program to encourage workers to use the stairs. This successful worksite effort has become a model that is promoted at trainings and conferences.

Impact

- COPAN distributed 600 resource kits in year one of the program.
- The resource kit program has helped schools and worksites build capacity to promote physical activity and good nutrition and sustain changes in behavioral, environmental changes (e.g., After the mini-grants the improved stairwell remains in the Northglenn building and the Boulder teacher continues to use the purchased equipment with new classes.)
- The heart rate monitors allow overweight students to focus on exercising within their target heart rate zone and takes attention away from trying to keep up with their peers.
- COPAN has expanded the program to include resource kits that address physical activity and nutrition for breastfeeding mothers, young children, college students and older adults. One thousand resource kits have been distributed in year 2 and grants have been awarded to 63 organizations, reaching nearly half of Colorado's counties.

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ILLINOIS ADOPTS PROVEN PROGRAM TO IMPROVE CHILDREN'S HEALTH

Goal is preventing chronic disease by changing activity and nutrition habits of children and parents

Public Health Problem

- Type 2 diabetes and overweight is increasing in Illinois children and adults.
- Almost 40 percent of Illinois third graders are either overweight or at risk for being overweight, according to survey of 99 schools done by the Healthy Smiles, Healthy Grow program of the Illinois Department of Public Health (IDPH).
- The scientifically-proven Coordinated Approach to Child Health (CATCH) Program has demonstrated that changing the school environment can lead to improvement in student eating and physical activity behaviors.

Program

- Teams are trained to use the evidence-based CATCH program.
- Participating schools receive a \$5,000 grant from IDPH to implement the curriculum, purchase necessary equipment and promote activities and program philosophy.
- Each school completes the School Health Index, a Centers for Disease Control and Prevention tool that helps schools identify strengths and weaknesses in existing health programs and develop action plans and wellness policies for improving students' health.
- Trained observers determine the level of activity in physical education classes to evaluate effectiveness of increasing activity.

Impact

- Follow-up evaluation shows that students in CATCH physical education classes are more active during class time. Moderate to vigorous physical activity during class increased by 32 percent and the time students were very active during class more than doubled.
- The CATCH curriculum and physical education activities are now aligned with the Illinois State Board of Education learning standards for physical development and health for grades 3 to 5.
- About 100 CATCH Team members have been trained, reaching about 6,000 elementary school students. About 275 students, family, school and community members participated at each of the 19 schools.
- Integrating CATCH with the IDPH obesity program and collaborating with the Consortium to Lower Obesity in Chicago Children will expand the Department's efforts.

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SUMMER SCORECARD ADDS UP FOR KENTUCKY YOUTH

Innovative campaign to increase physical activity takes advantage of national campaign

Public Health Problem

- Kentucky children are not physically active at recommended levels for good health.
- Almost a third of the state's high school students are already overweight or at risk of becoming overweight.
- Overweight increases the risk of developing Type 2 diabetes, high blood pressure, sleep apnea, heart disease and other conditions, even in children.

Program

- The Lexington Fayette County Health Department organized the Tweens Nutrition and Fitness Coalition, dedicated to improving the health of youth ages 9-13.
- The coalition developed the VERB Summer Scorecard, building on CDC's national VERB™ campaign which encourages youth to be physically active every day.
- Trained high school students conducted focus groups with local youth to learn what would make the program appealing to them.
- Youth tracked their physical activity using a wallet-sized scorecard. Each time they visited a Summer Scorecard Site, such as a pool, bowling alley or skating rink, their scorecards were stamped. Many program sites offered special deals such as free or reduced admission and sports clinics. Parents could also initial a square each time their children played for an hour or more. Completed cards were entered in a drawing for prize.
- The coalition hosted the "Longest Day of Play" on June 21, the day with the most hours of sunlight. Special fitness events took place throughout the community.
- During the Grand Finale youth and their families played at game stations and received fitness-related gifts from local sponsors.

Impact

- One mother explained the benefit of the Scorecard campaign this way: "I never thought about if my kids exercised or not. The Scorecard made me think about it every day. And now I'm still checking."
- Youth made more than 2,000 visits to program sites, completed more than 350 scorecards and partially-completed many more.
- Over 1000 children and adults participated in the Grand Finale event.
- Youth, parents and businesses were overwhelmingly positive about the program and all business sponsors said they would participate again.
- Lexington County is developing the scorecard campaign into a year-round project to provide incentives for participating kids to be regularly active.

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NATIONAL ASSOCIATION OF
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TAKE 10! PROGRAM GETS KENTUCKY YOUTH MOVING

School administrators and teachers implement classroom-based physical activity

Public Health Problem

- Kentucky children appear to have higher rates of overweight than the U.S. overall.
- Less than twenty percent of Kentucky 14 to 18 year olds have daily physical education classes.
- Regular physical activity is necessary for achieving and maintaining a healthy weight in children as well as adults.

Program

- Northern Kentucky Health Department worked with Cline Elementary School to implement *TAKE 10!*, training school staff to implement the classroom-based physical activity program in 2nd and 3rd grade classrooms.
- *TAKE 10!* provides teachers with ideas for including physical activity in classroom learning and ways to use physical activity as a reward for accomplishment in class. Teacher evaluations noted a positive change in the physical activity behaviors of some overweight students and reported that students were more alert during the day.
- Health department staff also worked with school administrators to implement a long range plan to improve school & student health by implementing *TAKE 10!* in all Cline elementary classrooms and expanding *TAKE 10!* to additional schools.

Impact

- Results from Cline Elementary include:
 - An increase in student participation in physical activity of 75-100 minutes a week
 - Expansion of the program to all elementary classrooms
- Five additional schools in the school district have implemented this successful program improving the physical activity of 1500 children.

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FRUIT AND VEGETABLE CHALLENGE CHANGE EATING HABITS

Free media helps spread the message of improving diet for good health

Public Health Problem

- Less than 20% of Kentuckians eat even the minimum number of servings of fruits and vegetables recommended for good health.
- Diets low in fruits and vegetables are associated with greater risk of chronic diseases such as heart disease and cancer.
- People who eat a diet with plenty of fruits and vegetables are more likely to be at a healthy weight, an important step in controlling the obesity epidemic.

Program

- The Barren River District Health Department conducts an annual community wide “5 A Day Challenge” to get residents of the eight-county district in south central Kentucky to eat at least five servings of fruits and vegetables every day.
- People are asked to eat five or more servings of fruits and vegetables for seven days in a row, record their consumption on an entry form, and mail it to the health department by a specified date.
- Community partners donate a portion of the cash and other incentives used to motivate participants changes in eating habits.
- The Challenge is publicized using free media, a website, and through events in schools, worksites, and community settings. Contest publicity educates the public about the benefits of eating produce.

Impact

- Challenge participants reported eating more produce and trying new fruits and vegetables as a result of the contest.
- The personal impact of the campaign on one participant shows that the contest: “...caused me to realize I was not eating as well as I used to and got me back on the path. Also, I notice when I eat so many fruits and vegetables (I was trying for 9 a day), I don’t have room for so much fattening food.”
- The health department raised “indirect” dollars to disseminate this important public health message by providing local media with an interesting, human interest story broadcast to a large geographic area at no cost to the state.

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PUBLIC-PRIVATE PARTNERSHIP TO IMPROVE CHRONIC DISEASE RISK FACTORS

WorkWell program results in healthier employees

Public Health Problem

- Nebraska has the least active population in the U.S.
- Cigarette smoking results in 2,400 premature deaths and \$419 million in health care costs every year in Nebraska.
- Almost two-thirds of the population is overweight or obese, putting them at risk for many chronic conditions.

Program

- WorkWell, a wellness council, was established by the Lincoln-Lancaster County Health Department, funded one-fourth by Preventive Health & Health Services Block Grant funds and three-fourths by participating businesses and local health department funds.
- Health department WorkWell staff provides materials and assistance to businesses in developing a wellness plan for their employees with measurable goals using best practice ideas.
- 90 businesses employing more than 55,000 workers are offered health risk appraisals, education and training by WorkWell and financial incentives provided by their employer to achieve smoking cessation and weight control goals.
- About 40% of the companies using the health risk appraisal in 2004 were blue collar industries where more minority and low-income people at high-risk of developing chronic diseases are employed.

Impact

- After seven years of WorkWell interventions, the 2004 health risk appraisals showed an obesity rate less than half the comparable state and local rate in the general population.
- Almost half the participating WorkWell employees were getting recommended amounts of physical activity on a regular basis.
- Smoking rates among WorkWell participants dropped from 24% to 12% after 5 years of the program.

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COLLABORATING TO IMPROVE PHYSICAL ACTIVITY OPPORTUNITIES FOR PEOPLE WITH DISABILITIES AND OLDER ADULTS

Working with the YMCA strengthens Steps to a HealthierNY program in Broome County

Public Health Problem

- Close to two-thirds of Broome County, New York residents are overweight or obese increasing their risk of developing many chronic diseases, such as diabetes and heart disease.
- Few Broome County adults get recommended amounts of even moderate physical activity – an important lifestyle factor in the development of chronic disease.
- Many Broome County adults report being having disabilities (over 20 percent) making it more difficult to find opportunities for physical activity.

Program

- The Steps to a HealthierNY program formed a unique partnership with the Broome County YMCA to increase opportunities for disabled and older residents to be physically active for better health.
- It can be difficult for individuals with disabilities and older adults to find physical activities that suit their abilities. The partners worked together to purchase and install two upper body strengthening bikes at the YMCA facility. These “arm bikes” allow a person to sit in a chair or wheelchair and pedal using just the arms. They are a good exercise for everyone, but especially for those who can’t use a regular exercise bike or have knee, ankle or hip pain with exercise.
- In the past, use of the swimming pool was a major challenge for individuals with disabilities and older adults in Broome County. The partners were able to arrange the installation two swimming pool chair lifts at the YMCA facility making it easy for those with physical disabilities to enter and exit the pool.

Impact

- The Steps to a HealthierNY and YMCA partnership improved health for older adults and people with disabilities by improving access to facilities and exercise equipment they can use for needed physical activity.
- Over 25 individuals with disabilities are now able to participate in aquatic programs in Broome County that can lessen pain, reduce disease risk, and improve quality of life.

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NEW YORK EDUCATES SCHOOL PERSONNEL ABOUT CHILDHOOD OBESITY

Technology increases opportunities for health-related professional development

Public Health Problem

- Childhood obesity is a significant public health problem strongly associated with the development of type 2 diabetes in children.
- Teachers and other school personnel can learn to take actions that help children reach and maintain a healthy weight, but release time for professional education is very limited in most schools.

Program

- Two New York State Department of Health programs, Steps to a HealthierNY and Diabetes Prevention and Control, partnered with the New York State Education Department and the University at Albany School of Public Health to produce a professional development program for school personnel entitled “Preventing Type 2 Diabetes in Children: Making the Case for the Healthy Schools Approach.”
- The program features a DVD with personnel from two award-winning New York State schools discussing their successful use of the Healthy Schools Model to increase physical activity and improve nutrition – important steps to preventing diabetes.
- A CD-ROM toolkit completes the training package which has been distributed to all 7,500 public and non-public schools throughout New York State as well as school nurses at the annual New York State Regional Health Update series. The training is also available via the internet at: <http://tinyurl.com/d9lnj>

Impact

- School personnel are provided with an easily-accessed, effective training program that provides continuing education units they need along with information on improving the eating and activity environment in their school.
- Over 1,000 out-of-state requests for copies and information have come to the New York State Department of Health, Bureau of Chronic Disease Services demonstrating a need for timely and convenient training on this topic.
- Trained school personnel are encouraging students to practice healthy behaviors. A school with many Title I students has added daily fresh fruit & vegetable trays in the cafeteria to increase healthy food offerings and teachers at another school set an example for students by taking time before school to take a walk.

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CHAUTAUQUA COUNTY COLLABORATES TO IMPROVE COMMUNITY HEALTH

YMCA partnership with Steps to a HealthierNY increases resources available to community

Public Health Problem

- Many Chautauqua County residents are overweight or obese, including a significant percentage of children.
- Almost 8 percent of county adults have diagnosed diabetes which can be controlled or even prevented by achieving & maintaining a healthy weight.
- Few county adult residents meet physical activity recommendations for good health and weight control.

Program

- In Chautauqua County the Steps to a HealthierNY initiative is building a strong relationship with a non-traditional partner - the Jamestown YMCA.
- To facilitate the partnership, the YMCA was chosen to house the Steps Program Coordinator, allowing Steps and the YMCA to work closely together, maximize resources used to increase resident's physical activity, and avoid duplication of effort.

Impact

- The Steps to a HealthierNY/YMCA partnership has increased county resources for improving resident's physical activity opportunities in the following ways:
 - The YMCA created and supplies funds for a membership and marketing director position to improve community outreach and participation in community physical activity programs, supplementing the Steps community outreach efforts.
 - The YMCA signed a pledge as an "Activate America" YMCA to show their commitment to devoting YMCA resources to making healthy living a reality for county residents.
 - The YMCA's partnership with Steps changed the organization's values – they now have a greater desire to achieve community-wide change related to physical activity and to reach beyond their building walls to impact the community.

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MISSION MELTAWAY PROGRAM HELPS ADULTS LOSE WEIGHT

Steps to a HealthierNY partners with Office of Aging to promote lifestyle change

Public Health Problem

- In Broome County New York, close to two-thirds of residents are overweight or obese, a strong risk factor for developing diabetes and other chronic diseases.
- The county death rate for diabetes is 50% higher than the rate for New York State as a whole.
- Few Broome County residents consume even minimum recommended amounts of fruits and vegetables daily, a factor in high rates of overweight and obesity. Residents are also not meeting recommendations for physical activity.
- Weight loss of as little as 7% of body weight and an increase in physical activity can prevent or delay a diagnosis of diabetes. Weight loss also helps people with diabetes control their blood sugar.

Program

- The Broome County the Steps to a HealthierNY program worked with the Office for Aging, to field test the Mission Meltaway program in senior centers and expand it the to other community sites.
- Mission Meltaway is a free, eight-week healthy lifestyle program that uses a group approach to weight loss and maintenance and builds on the concepts of the National Diabetes Education Program called “Small Steps, Big Rewards.”
- Volunteer, trained facilitators adapted Mission Meltaway to successfully meet the needs of specific community groups in worksites, faith-based settings, primary care sites, schools, public and non-profit organizations.

Impact

- As a result of the Mission Meltaway program:
 - o Over 1,100 participants lost an average of more than 5 pounds; average waist measurement was reduced also, indicating improved weight status.
 - o Body mass index, an indicator of body fatness, was lowered and some participants reduced their disease risk related to weight.
 - o Participants report eating a healthier diet, including more servings of fruits & vegetables and less fast food, baked goods, fried foods, processed/prepared foods, candy, and chips.
 - o Participants report being more physically active
 - o 34 sites established a maintenance program, some jointly with another program site, to enhance and maintain healthy behavior changes and weight loss.

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STEPS TO A HEALTHIER NY CREATES HEALTHIER SCHOOLS AND COMMUNITIES

Integrated approach to chronic disease prevention impacts four New York counties

Public Health Problem

- Many deaths and most serious illness, disability, and tremendous health care costs are attributable to chronic conditions such as obesity, diabetes, and asthma.
- Physical inactivity, poor nutrition, and tobacco use increase New York resident's risk for these chronic conditions.
- Changing these lifestyle behaviors to reduce the risk of disability, illness and death requires public health strategies combined to address common risk factors.

Program

- The New York State Department of Health and four New York counties (Broome, Chautauqua, Jefferson, Rockland) have Centers for Disease Control and Prevention funding to implement Steps to a HealthierNY.
- The goal of the program is to reduce the burden of obesity, diabetes, and asthma by addressing the three related risk factors – physical activity, nutrition, and tobacco use.
- Each of the selected communities is implementing interventions using evidence-based public health strategies addressing school, community, and work environments. These interventions are designed to lead to sustainable changes in policy, systems, and the environment.

Impact

- Highlights from the results of using an integrated Steps approach in four communities in New York State are:
 - Eleven schools added healthy food items to their menus and removed high fat and high sugar items.
 - Restaurants now highlight healthier menu items (115 so far).
 - Corner stores are stocking a wider variety of healthy foods (26 so far).
 - Over 46,000 residents engaged in community-wide physical activity programs.
 - Health care providers received needed training in diabetes care, tobacco cessation, and weight management (over 1,500 so far).
 - The CDC School Health Index, a tool that helps school identify ways to improve their school environment for better health, has been completed in 64 schools.
 - School Health Advisory Committees are established in 100 schools enabling long-term attention to school health improvements.

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CHANGING OHIO COMMUNITIES TO CREATE HEALTHIER ENVIRONMENTS

A public-private partnership promotes healthy behaviors in Ohio workers

Public Health Problem

- Heart disease, stroke and other chronic diseases cost employers more than \$500 billion annually in employee absences, diminished productivity and increased health care costs, according to MetLife Insurance Company.
- As a major manufacturing state, Ohio has a vested interest in keeping its workers healthy and productive.
- A statewide study of Ohio adults indicates that three-fourths of them have poor diets, over a quarter of them smoke cigarettes, and almost two thirds are overweight or obese -- all strong contributors to heart disease and stroke risk.

Program

- Ohio's Preventive Health and Health Services Block Grant (PHHSBG) funds Community Heart Health Projects in 21 communities where the health behaviors of residents are significantly worse than those of other Ohio residents and the U.S. as a whole. The project promotes innovative wellness programs that increase positive health behaviors to prevent chronic disease.
- In Henry County worksites, for example, employees frequently chose high-fat items from vending machines at work. In one PHHSBG-funded project, the Henry County Health Department partnered with Maumee Valley Vending Company to increase the number of healthy items in worksite vending machines, such as low fat snacks and more fruits and vegetables.
- The project also enabled employers to sponsor risk screenings and support groups, and provided educational materials to help employees maintain the positive health changes they made.

Impact

- Healthy vending choices made by employees increased by 80% in seven months (a total of 111, 686 improved vending selections made).
- All employees were aware of the project and 50% used it to help them make better nutrition choices outside the workplace.
- The PHHS Block Grant provided funding for the pilot of this project which leveraged private funding to expand the program to thousands of employees in 143 worksites.
- Results show that people will choose to be healthy if their environment is supportive of a healthy lifestyle.

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OREGON STATE EMPLOYEES WALK FOR WELLNESS

“Walking Well” Program encourages participants to increase their daily physical activity

Public Health Problem

- More than half of Oregon adults are obese or overweight, increasing their risk of heart disease, stroke, diabetes, arthritis and other chronic diseases.
- Since 1990, the prevalence of obesity has almost doubled in Oregon.
- Inactivity is a contributing factor in the development of overweight and obesity.
- Half of Oregon adults do not get minimum recommended levels of physical activity.

Program

- The Oregon Public Employees Benefits Board (PEBB), which manages health benefits for state employees, and the Oregon Physical Activity and Nutrition Program developed the Walking Well Program to encourage worksite wellness.
- The program was piloted in four agencies with offices located in both urban and rural areas.
- Employees completed online health risk assessments before registering for the program.
- Registered participants set personal health goals and received a pedometer and educational materials on walking for wellness. PEBB provided motivational messages and recognized successes throughout the program.
- More than 600 employees registered for the program and 38% of them completed a follow-up survey that measured progress toward achieving goals.

Impact

- More than two thirds of those completing the follow-up survey increased their physical activity and plan to continue.
- The number of participants meeting the CDC recommendation for moderate or vigorous physical activity increased by 24%.
- Nearly two-thirds of the participants reported making progress toward meeting their personal health goals.
- The Walking Well program will be offered to other state agencies, with additional activities to promote worksite wellness.

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PARTNERING TO CHANGE CHILDREN'S FOOD HABITS

Good choices early in life can lead to better health now and in the future

Public Health Problem

- About 18% of Pennsylvania youth are overweight, and the incidence of Type 2 diabetes is increasing in this population. These two conditions threaten to increase the rate of chronic disease, especially heart disease and stroke.
- Learning how to choose healthy foods and be physically active at an early age increases the likelihood that children will make these behaviors part of their lives as they grow up.

Program

- The Pennsylvania Department of Health partnered with the Pennsylvania Departments of Education and Public Welfare to train over 300 childcare professionals in daycare, Head Start and Family Literacy programs to teach healthy behaviors to children.
- Childcare professionals trained in the initial pilot reached approximately 12,000 young children in five Pennsylvania counties.

Impact

- The Preventive Health and Health Services Block Grant provided start-up funds for the successful pilot of this project. Funds leveraged from other sources allowed expansion of the project to childcare workers in 12 additional counties.
- Almost 100% of the participating childcare workers reported changes in their own attitudes about the importance of teaching these healthy behaviors to children. All will continue to use the program to educate the children in their care.
- As a result of the pilot project, one-half to two-thirds of the participating children can identify more fruits and vegetables, are willing to eat more healthy foods, and are enjoying or are excited about physical activity.
- Parental knowledge and behavior changes are expected from a forthcoming evaluation.

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PROVEN TEXAS PROGRAM HELPS PREVENT CHILDHOOD OBESITY

CATCH supports Texas students in improving eating habits and physical activity

Public Health Problem

- Childhood obesity has more than doubled in the past 20 years.
- Overweight and obesity rates for Texas fourth-graders are almost double the national average for the same age group.
- The obesity rates for Latino/Hispanic and African-American children in Texas are among the highest in the nation.
- Overweight increases the risk of developing high blood pressure, type 2 diabetes, kidney problems, heart disease and certain types of cancer.

Program

- The Texas Department of Health, the American Heart Association's Texas Chapter and the Center of Health Promotion and Prevention Research at The University of Texas Health Science Center at Houston implemented CATCH – A Coordinated Approach to Child Health.
- This proven school program includes a curriculum, physical education and healthy eating components and parent involvement. Examples of program activities are:
 - Physical education classes are designed to promote lifelong physical activity by blending fun and fitness.
 - School cafeterias prepare foods lower in fat and sodium, using “Eat Smart Guidelines” and child-tested recipes.
 - Teachers use a curriculum that promotes health habits known to prevent chronic disease, such as healthy eating, daily physical activity and tobacco avoidance.
 - Parents reinforce health messages at home through fun, interactive assignments. Family Fun Nights hosted by the schools involve the entire family in developing healthy lifestyles.

Impact

- Nearly 1800 elementary schools have adopted the CATCH Program, impacting over 900,000 students.
- CATCH interventions have been demonstrated to significantly improve students' eating and physical activity behaviors and decrease the fat content of school lunches.
- The Texas Education Agency certifies CATCH as meeting requirements of Texas Senate Bill 19 requiring all elementary schools to implement a coordinated school health program by 2007.

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ARIZONA CHRONIC DISEASE PLAN COORDINATES THE STATEWIDE PREVENTION APPROACH

Plan integrates common elements and risk factors of chronic diseases to guide intervention and funding

Public Health Problem

- Chronic diseases are seven of the ten leading causes of death in Arizona.
- The number of chronic disease programs has doubled over the past several years in the Public Health Services Division of the Arizona Department of Health Services but these programs functioned independently, partly due to funding requirements.
- The state's public health leaders saw the need to develop an integrated approach to chronic disease prevention that considered the overlap in risk factors for these diseases.

Program

- The Chronic Disease Team of the Arizona Department of Health Services developed the Arizona Chronic Disease Plan in 2005 integrating six disease- and risk factor-specific plans into one comprehensive model with common elements of each.
- Funding for community groups and local health departments to implement an integrated approach to grassroots chronic disease prevention is now available from the Arizona Tobacco Tax Health Education Account/Chronic Disease Fund which addresses 5.

Impact

- The Plan is used to guide funding priorities for a portion of the Arizona Tobacco Tax and Health Care Fund – Health Education Account to address prevention and early detection of heart disease, cancer, stroke and lung disease, the top four causes of chronic disease deaths in the state.
- Progress toward reaching the Plan's statewide objectives will be tracked by the Chronic Disease Team.
- Funded community projects will be evaluated using a set of performance measures and deliverables based on the Plan and built into the funding contracts.
- The Chronic Disease Team will assure progress and guide Plan revisions over the next three years.
- Read the Arizona Plan at: http://www.azdhs.gov/phs/oncdps/pdf/chronic_disease_plan.pdf

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CALIFORNIA RAISES OSTEOPOROSIS AWARENESS THROUGH PERSONAL STORIES

A new book shares the challenges of men, women and children who live with the condition

Public Health Problem

- Osteoporosis is a preventable, treatable condition that affects at least 5 million Californians and costs the state's economy more than \$2.4 billion a year in direct healthcare costs.
- Osteoporosis affects all age groups, genders and races although many people believe that only post-menopausal women get osteoporosis.
- Most people don't know they have osteoporosis until they break a bone.

Program

- The California Osteoporosis Prevention and Education Program, part of the California Department of Health Services, funded Faces of Osteoporosis, a book documenting the stories of people living with this chronic condition.
- Author Amelia Davis relates inspirational stories with photos of men, women and children of all ages and ethnicities who are meeting the challenges of osteoporosis.
- The book educates readers on treatment options such as medication, diet and exercise.
- The California Osteoporosis Prevention and Education Program partners with the University of California, San Francisco and the Foundation for Osteoporosis Research and Education to publicize the book and its key health education messages.
- A media event featured Elaine Alquist, a California state legislator who authored Assembly Bill 161 establishing California's osteoporosis program.

Impact

- The California Osteoporosis Prevention and Education Program developed this book project as a way to implement strategies from the California's Action Plan to Prevent Osteoporosis, a document describing the steps California must take to tackle the growing public health problem of osteoporosis.
- "After reading this book, you will no longer see osteoporosis in the face of a stooped, older woman who walks with a cane. These profiles of osteoporosis are a compelling reminder that osteoporosis can affect anyone," says Senator Elaine Alquist.

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COLORADO VOTERS AMEND STATE CONSTITUTION TO FUND CHRONIC DISEASE PROGRAMS

Tobacco taxes will support cancer, heart and lung disease prevention and treatment programs

Public Health Problem

- Chronic diseases such as heart disease, stroke and cancer account for nearly 70% of Colorado deaths each year and these deaths are projected to increase sharply as the state's population ages.
- Chronic disease prevention and control programs save lives and limit disability. Funding these programs is a challenge due to budget demands faced by state legislatures.
- In Colorado, chronic disease preventive services were not receiving adequate funding, and the state was losing opportunities to provide critical programs such as cancer screenings.
- State budgets continue to face shortfalls that negatively impact public health capacity to implement, sustain, or enhance chronic disease prevention and control activities.

Program

- Colorado's share of tobacco settlement funds was up for re-allocation, providing an opportunity to help support badly needed chronic disease services.
- With the help of staff from the Colorado Comprehensive Cancer Program, the Colorado Cancer Coalition, a consortium of organizations and individuals working to prevent and control cancer, produced an updated strategic action plan to demonstrate how new revenues would help reduce the burden of cancer in the state.
- Evidence-based action plans such as the Colorado Cancer Plan were instrumental in garnering public support for Amendment 35 which steered revenue from a tobacco tax increase to health programs.

Impact

- In November 2004, Colorado voters approved Amendment 35, a citizens' initiative that added "Tobacco Taxes for Health Related Purposes" to the state constitution. The statewide Colorado Cancer Plan will be used to guide expenditures of the revenues from this new source of funds.
- Sixteen percent of new revenue from a 64-cent tobacco tax increase, available in July 2005, is earmarked for prevention, early detection and treatment programs for cancer, cardiovascular and pulmonary diseases.

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CHRONIC DISEASE SELF MANAGEMENT PROGRAM DECREASES HOSPITAL STAYS

Living Well workshops provide an added benefit to regular treatment

Public Health Problem

- Chronic diseases such as arthritis, heart disease and diabetes are the leading causes of death & disability in every state.
- Seventy-five percent of all health care costs are the result of chronic disease.
- For the many people with more than one chronic condition, disease management education has been shown to improve outcomes and lower the cost of treatment.

Program

- The Kentucky Departments for Public Health and Medicaid Services and the University of Louisville Department of Family and Geriatric Medicine and local health departments partnered to provide the Chronic Disease Self-Management Program developed by the Stanford University Patient Education Research Center to patients in community settings such as senior centers, churches, libraries and hospitals.
- Trained facilitators implement this free, highly interactive program, in mixed groups of people with a variety of chronic health problems, focusing on building skills, sharing experiences, and providing support.
- This Program has been evaluated and shown to be effective in lowering costs of treatment.

Impact

- Evaluation studies at Stanford and the University of Louisville show that patients in this program spent fewer days in the hospital, with a trend toward fewer outpatient visits and hospital admissions, yielding savings of about ten times the program cost.
- Participants also had significant improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations when compared to those who did not participate.
- The Chronic Disease Self-Management Program enhances regular treatment and the effects persist for as long as three years.

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KENTUCKY UNINSURED GET FREE MEDICAL CARE AND PRESCRIPTIONS

Block grant funding helps in recruiting providers and maintaining services

Public Health Problem

- Many of Kentucky's 576,500 uninsured residents are overweight and have diabetes and high blood pressure, making regular medical care and prescriptions a necessity to prevent death and disability from chronic diseases.
- Over a third of the uninsured have no regular source of medical care and many use the emergency room for their medical needs, an expensive and inconsistent source of care.
- Uninsured people may also lack the money to buy needed prescription medicines and be unable to decipher the complicated pharmaceutical company Patient Assistance Program information resulting in a failure to benefit from these programs.

Program

- Preventive Health and Health Services Block Grant funds supplied to Health Kentucky, Inc., a nonprofit charitable organization, help them coordinate a statewide network of volunteer providers called the Kentucky Physicians Care program.
- Using these funds supplied by the Kentucky Department for Public Health, Health Kentucky, Inc. works with public and private organizations to help meet the healthcare needs of the poor and uninsured, by recruiting volunteer providers to provide services and free prescription medicines.

Impact

Examples of the program benefits to eligible clients are:

- Free services were provided by participating physicians, dentists and pharmacies through 2,507 referrals from the toll free Kentucky Physicians Care Hotline.
- Almost 100,000 free prescriptions were filled at participating pharmacies with a value of over \$9 million.

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REDUCING CHILDHOOD ASTHMA TRIGGERS IN LOUISIANA

Louisiana Asthma Program aims to reduce the death rate and high economic cost of childhood asthma in the state, starting with Orleans Parish.

Public Health Problem

- The asthma death rate in Orleans Parish is significantly higher than rates for the rest of Louisiana and the U.S.
- According to the Asthma and Allergy Foundation of America, childhood asthma costs in Orleans Parish are nearly \$7 million per year – tops in the state.
- New Orleans’ humid climate and the large number of old, musty homes which often have dust mites and mold create a high concentration of major asthma triggers.

Program

- In 2003, Louisiana launched a statewide asthma program with in-home education activities that reduce indoor asthma triggers.
- “Healthy Environments and Living Places (HELP) For Kids” targets parents and caregivers of New Orleans children age 12-16 with asthma. Respiratory therapists teach participants to assess and manage asthma risks and provide tools to measure each child’s progress in managing the disease.
- The Asthma Coalition of Louisiana, formed in 2005, links more than 50 public health professionals, physicians, people with asthma and caregivers to support surveillance, clinical interventions and community outreach.

Impact

- The Asthma Program partnered with the American Lung Association of Louisiana to maximize and supplement federal funding and resources for the HELP For Kids Program.
- Twelve trained, volunteer respiratory therapists provide services in more than 100 New Orleans homes.
- Program staff anticipates that reduction of asthma triggers in these homes will decrease the incidence of asthma attacks and corresponding costs to the state.

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IMPROVING OSTEOPOROSIS SURVEILLANCE

Maryland task force leads the nation to promote state osteoporosis data collection with the BRFSS

Public Health Problem

- Costs for osteoporosis-related fracture care are roughly \$18 billion a year in the U.S.
- The Maryland Osteoporosis Prevention and Education Task Force, staffed by the Maryland Department of Health & Mental Hygiene, needed state-specific information on this condition to describe the burden of osteoporosis on their population and to evaluate proposed activities.
- States like Maryland have had only limited estimates of disease rates from private sources to use in describing the extent of the osteoporosis problem.
- Osteoporosis is the only major chronic disease that was not covered in the BRFSS, a survey used to collect state and national data on public health conditions.

Program

- The Maryland Osteoporosis Prevention and Education Task Force developed and tested questions to create a new osteoporosis question module comparable to those used to monitor other chronic diseases.
- Seven standardized osteoporosis questions covering prevention, screening, diagnosis and treatment of the disease, were the result of this lengthy, rigorous development process.
- The finalized set of seven osteoporosis questions was proposed to the national BRFSS coordinating group for approval as an optional module for inclusion in the 2005 national BRFSS survey.

Impact

- State BRFSS coordinators voted their overwhelming support of the Maryland proposal to include the question module they developed in the BRFSS.
- Beginning with the 2005 BRFSS survey, states will have tested questions available for use in gathering important information about this public health problem.
- Maryland, Pennsylvania and Utah are adding all seven questions to their 2005 (MD), 2006 (UT) and 2007 (PA) survey giving them the capacity to collect standardized state-specific data on osteoporosis for the first time.

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MAKING EVIDENCE-BASED PRACTICE A REALITY

Developing a course that improves capacity of states to apply science to public health practice for chronic disease prevention & control

Public Health Problem

- Effective chronic disease prevention program managers need specific skills and knowledge, such as the ability to design programs based on good scientific evidence.
- Programs based on evidence of effectiveness are more likely to result in risk factor changes and to increase access to preventive services that improve health status and reduce disease.
- Few state public health agency managers have a strong background in evidence-based chronic disease prevention resulting in a failure to incorporate the latest evidence about what works or to apply lessons learned from their experience with program impact.

Program

- The Saint Louis University School of Public Health's Prevention Research Center, the National Association of Chronic Disease Directors, the Missouri Department of Health and Senior Services, and the Centers for Disease Control and Prevention, worked together to develop a training course, Evidence-based Public Health: A Course in Chronic Disease Prevention.
- The course applies scientific principles to public health practice, with a strong focus on chronic disease issues such as healthy eating, obesity, and tobacco and practices such as program development and evaluation.
- The target audience is mid- to senior-level program managers with responsibility for state health department chronic disease programs.
- Real-life scenarios and active learning exercises, along with computer labs and literature searching techniques guide participants to develop skills in applying evidence to health programming.

Impact

- Since 2000, 345 practitioners representing 45 states have attended training at Saint Louis University, conducted by their faculty.
- From follow-up surveys and interviews of participants:
 - Two thirds of those surveyed have used the EBPH materials in planning a new program and a similar percentage have taught others how to apply the information from the course. Almost this many have used the material in evaluating a program.
 - 14 respondents have designed and delivered an EBPH course themselves.
- The pioneering course has been adapted to CD-ROM and is the basis for a published book, (Brownson RC, Baker EA, Leet TL, Gillespie KN Evidence-Based Public Health, Oxford University Press, 2003) extending the course information to a much wider audience.
- The New York State Health Department and the Illinois Department of Public Health have adapted the course to enable local health department staff to develop similar skills without the cost of traveling out-of-state.

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ADAPTING AN EVIDENCE-BASED COURSE FOR STATE PROGRAM MANAGERS

New York uses cost-effective approach to extend the reach of national training

Public Health Problem

- Effective chronic disease prevention programs call for managers with specific knowledge and skills, such as the ability to design programs based on proven practices.
- Chronic disease programs may fail to incorporate the latest evidence about what works and to target populations effectively since few state program managers have a strong background in evidence-based chronic disease prevention and health promotion.
- Providing trained replacements for directors lost as the public health workforce ages demands cost-effective, widely-available, evidence-based public health training.

Program

- The New York State Health Department in partnership with the State University of New York at Albany's Prevention Research Center adapted a nationally-recognized public health training course to enable cost-effective training for local health department staff.
- The national course, a pioneering effort by the Saint Louis University School of Public Health's Prevention Research Center, the National Association of Chronic Disease Directors, and the Centers for Disease Control and Prevention, is called Evidence-based Public Health: A Course in Chronic Disease Prevention.
- NY created Evidence Based Public Health for Local Health Practice, a course incorporating the Core Competencies for Public Health Professionals, a set of skills, knowledge, and attitudes necessary for the practice of public health that have been reviewed by more than 1,000 public health professionals.

Impact

- 100 local health department staff across the state of NY received vital training at a much lower cost than training at an out-of-state location.
- Well over half of those trained say they will use evidence-based decision-making in most or all of their future project decisions compared to only 10 percent prior to taking the course. Most of the participants plan to share the course information with others and over three-fourths said it would help them perform their jobs more effectively.
- Growing interest in the course is demonstrated by the fact that there's a waiting list for each course offering.
- Addition of an online version of the New York course, From Evidence to Practice, using case studies to help participants develop analytical skills at a comfortable pace will further extend the reach of this important skill-building course.

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EDUCATING PROFESSIONALS ON THE INTEGRATED APPROACH TO CHRONIC DISEASE PREVENTION

Satellite broadcast is an effective way to reach local public health agency staff

Public Health Problem

- Seven of ten deaths in the United States are attributed to chronic diseases, a significant public health problem.
- Public health professionals may not be aware of effective ways to prevent chronic diseases.
- Satellite broadcasts can effectively reach large numbers of public health professionals, improving the capacity of their programs to prevent chronic diseases.

Program

- Steps to a HealthierNY developed an educational program called “An Integrated Approach to Chronic Disease Prevention: the Steps to a HealthierNY Model”.
- The program was broadcast by satellite as part of the Third Thursday Breakfast Broadcast, a monthly video program that provides continuing education opportunities for public health and human services professionals.
- Four New York county examples highlighted the benefits of using an integrated approach to chronic disease prevention and showcased the Steps to a HealthierNY initiative. The broadcast can be viewed at the convenience of the learner at: <http://www.albany.edu/sph/coned/t2b2steps.htm>.

Impact

- The broadcast was rated highly by almost all participants, whose evaluations also showed that most of them:
 - Gained knowledge that will help them perform their job more effectively
 - Will use the ideas to integrate chronic disease prevention strategies into their own programs
- Steps to a HealthierNY reached large numbers of public health professionals and improved their capacity to deliver needed chronic diseases programs using a cost-effective satellite broadcasting method.

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NORTH CAROLINA CHRONIC DISEASE MANAGEMENT COLLABORATIVE

Chronic disease registries improve disease management and prevent costly complications

Public Health Problem

- Heart disease, cancer, stroke, and diabetes are four of the top five leading causes of death in North Carolina.
- More than 500,000 state residents have diagnosed diabetes and over 500,000 have a history of heart disease or stroke. Over the next year, 40,000 new cases of cancer will be diagnosed in North Carolina.
- Primary care settings are better designed for acute care than chronic problems.

Program

- North Carolina's Chronic Disease Management Collaborative provides a means for action to make rapid changes in delivery of chronic disease care by primary care practices.
- The Collaborative key partners are the NC Division of Public Health, Chronic Disease and Injury Section; the NC Community Health Center Association; and Medical Review of NC, the State's quality improvement organization. In addition to CDC funding for categorical state chronic disease programs, funding is provided by the Robert Wood Johnson Foundation and the Kate B. Reynolds Charitable Trust. Partners pledge scholarship money and donate large amounts of in-kind time to the project.
- The Collaborative promotes the development of disease registries to track the care of patients with diabetes, cardiovascular disease, and, in 2006, will track cancer screening and prevention.

Impact

- Over 30 practice teams participate in the Collaborative.
- Over 5,000 people with chronic disease are followed in practice registries developed as a result of the Collaborative, seventy-five percent of whom are in higher risk African-American or Hispanic ethnic groups.
- Tracking patient care has resulted in improvement in the delivery of services necessary to prevent the complications of chronic disease, such as blood sugar monitoring, eye exams, vaccinations, and blood pressure measurement and control.
- For example, average A1c levels (a measure of blood sugar control) decreased by an amount that is predicted to result in an 8% reduction in diabetes deaths, a 6% reduction in heart attacks, a 5% reduction in stroke, a 17% reduction in amputations, and a 10% reduction in renal failure.
- The three year gross cost savings estimates for a sample of 2745 patients are \$957,493.
- The U.S. Bureau of Primary Health Care designates the Collaborative as "equivalent" meaning that federally qualified community health centers participating in the state-based Collaborative are credited as if participating in the federal collaborative, a requirement for reimbursement.

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