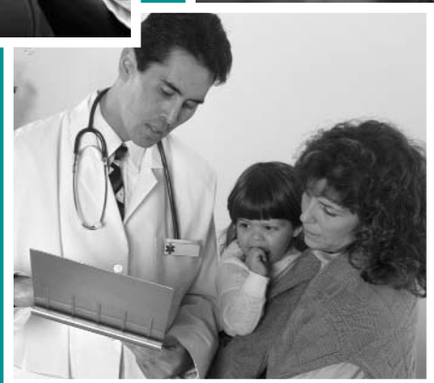
State Programs *in action*

CDC
Chronic Disease Prevention



Exemplary Work to Prevent Chronic Disease and Promote Health

2005

U.S. Department Of Health and Human Services
Centers for Disease Control and Prevention
SAFER • HEALTHIER • PEOPLE™

State Programs in Action

Exemplary Work to Prevent Chronic Disease and Promote Health

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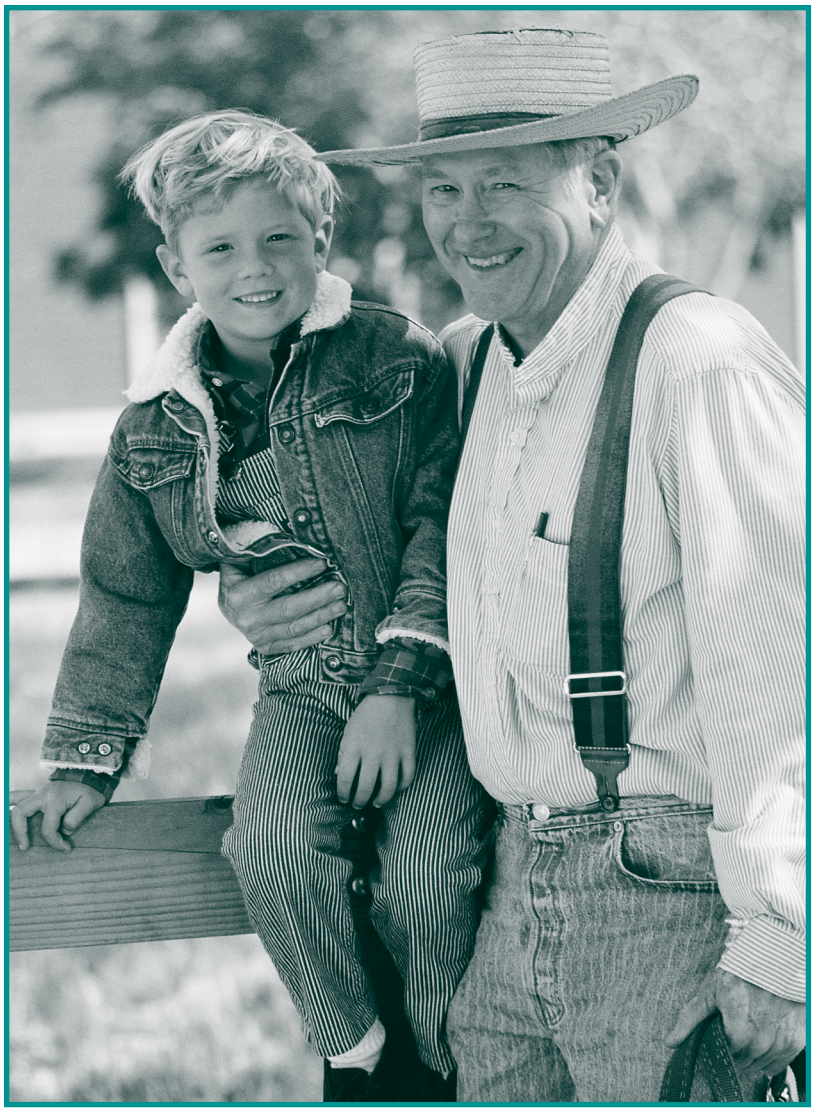

For more information about CDC's healthy aging program,
visit www.cdc.gov/aging/

Arkansas

Building a Healthy Aging Initiative With Mini-Grants Program Funds

Producing Results

The Mini-Grants Program continues to develop activities that promote healthy aging behaviors. The Arkansas governor announced that his office will spearhead a Healthy Arkansas initiative focused on physical activity, good nutrition, and smoking cessation for all age groups, and this blueprint will likely become a model for other states that choose to promote healthy lifestyles across the life span.

Public Health Problem

According to several indicators, Arkansas has one of the least healthy populations in the United States. The risk and burden of chronic disease in Arkansas are directly linked to a lack of physical activity, poor eating habits, and poor lifestyle choices, including the use of tobacco products. Arkansans aged 65 years or older - approximately 14.5 percent of the state population - share a great deal of this burden since 30 percent are overweight; 20 percent are obese; and 38 percent do not participate in any form of physical activity. A growing body of evidence suggests that programs promoting physical activity, adult immunizations, and prevention of falls can provide tangible benefits for older adults.

Taking Action

In FY 2003, the Arkansas Department of Health and Division of Aging and Adult Services received $10,000 from the CDC and the Public Health and Aging Mini-Grants Program of the Administration on Aging (AOA) to create a partnership between the public health and aging services networks. The infusion of the mini-grant funds into Arkansas' fledgling healthy aging initiative catalyzed a groundswell of activities. These activities included: 1) leveraging of funds from the state's tobacco settlement for use in development of a coalition on healthy aging and in developing a health fair, and 2) successful competition for hiring a CDC public health prevention specialist to work on issues of aging.

(continued on next page)

Contact Information

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Phone: 501-280-4055 www.healthyarkansas.com
http://www.cdc.gov/nccdphp/exemplary

Arkansas

Building on these first-year efforts, Arkansas again successfully competed for a CDC/AOA mini-grant in FY 2004 to implement the Peer Exercise Program Promotes Independence (PEPPI) initiative in 10 senior centers that are part of the Central Arkansas Area Agency on Aging (CareLink). Energized by this partnership, CareLink has doubled the number of programs offered, making PEPPI available every day in 20 of its senior centers. This evidence-based program is now available to even more older Arkansans, and these achievements have been accomplished with only $14,000.

Implications and Impact

In May 2004, Arkansas Governor Mike Huckabee announced that his office would spearhead an initiative focused on physical activity, good nutrition, and smoking cessation to encourage all age groups in Arkansas to have a healthy lifestyle. Because of the planning and implementation efforts already funded by mini-grants, the Department of Health and the Division of Aging and Adult Services were poised to help the governor create strategies to promote healthy living for older adults. The Healthy Arkansas Blueprint will likely become a model for other states that choose to address issues related to healthy lifestyles across the life span.

Contact Information

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Arthritis

For more information about CDC's arthritis program,
visit www.cdc.gov/nccdphp/arthritis

Tennessee

Arthritis Self-Help Course Expanded to Underserved Communities

Producing Results

The Arthritis Self-Help Course has improved quality of life among people with arthritis, and more widespread use of the course can save money and reduce the burden of arthritis. In 2004, Tennessee successfully expanded availability and participation in this self-help course to underserved areas that previously had no participation.

Public Health Problem

Arthritis is among the most common health problem in the United States. During 2002, physician-diagnosed arthritis affected about 1 in 5 U.S. adults (21 percent). In Tennessee, approximately 29.5 percent of the adult population reported physician-diagnosed arthritis in 2002, exceeding the national estimate. Inadequate access to health information is a major barrier to arthritis intervention and treatment in Tennessee.

Research has shown that the pain and disability associated with arthritis can be minimized through early diagnosis and treatment, including appropriate self-management. The Arthritis Self-Help Course, developed at Stanford University, teaches patients necessary self-management skills. This course, taught in a group setting, has been shown to reduce arthritis pain by 20 percent and physician visits by 40 percent, even four years later.

Taking Action

With CDC support, Tennessee has partnered with the University of Tennessee's Agriculture Extension Services (UTAES) to expand the availability of the Arthritis Self-Help Course in 25 rural areas where access to health care is severely limited. Forty UTAES educators in the 25 targeted regions have been trained to be instructors for this self-help course. Additionally, discretionary funds were used to provide financial support and incentives to participants. Before this partnership, 377 metropolitan participants completed the Arthritis Self-Help Course, and no residents of the 25 identified underserved areas had taken the course. In 2004, 642 participants completed the course. Of those participants, 449 completed the Arthritis Self-Help Course in metropolitan areas and 193 attended courses offered by the UTAES educators.

Implications and Impact

The Arthritis Self-Help Course had been proven to improve quality of life among people with arthritis. Nationally, less than 1 percent of people with arthritis who could benefit from self-management programs, used them; more widespread use of this course would save money and reduce the burden of arthritis. This partnership demonstrates the importance of identifying and implementing strategies to increase the use of this course in rural, underserved communities. Such collaboration, aimed at implementing community-based projects responsive to the needs and culture of the community, can serve as a model for reaching underserved populations in other states as well.

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New York

Partnering With Offices on Aging to Improve Quality of Life for People With Arthritis in Underserved Areas

Producing Results

Newly trained leaders for the Arthritis Self-Help Course offered courses in hospitals and senior centers where arthritis-specific interventions had not been available. New York's strategy to expand availability of the Arthritis Self-Help Course by working with senior centers, health systems, and county offices on aging may serve as a model for other states, to increase the availability of interventions.

Public Health Problem

In 2002, the national estimate for the prevalence of physician-diagnosed arthritis was nearly 21 percent (43 million adults), making it among the most common health problems in the United States. In New York, 26.5 percent of adults (approximately 3.6 million) reported that a physician had told them they had arthritis, including 1.3 million persons aged 65 years or older.

Taking Action

With CDC support, the New York State Department of Health collaborated with the New York State Office for Aging and chapters of the Arthritis Foundation to offer evidence-based interventions in six underserved counties in the state. Along with the Arthritis Foundation chapters, the two New York State agencies identified urban and rural areas that were medically underserved. Data from the Index of Medical Underservice were used to determine the target counties for implementation of the Arthritis Self-Help Course. Nine partners representing senior centers, county offices on aging, and a health care network participated in this effort.

Leaders for the Arthritis Self-Help Course were trained to serve in all six counties targeted. In spring 2004, the newly trained leaders offered courses in hospitals and senior centers where arthritis-specific interventions had not been available.

Implications and Impact

The Arthritis Self-Help Course has been proven to reduce the impact of arthritis by reducing pain and physician visits. Nationally, less than 1 percent of people with arthritis who could benefit from self-management programs used them. These interventions are especially scarce in rural settings. New York's strategy to expand the availability of the Arthritis Self-Help Course by working with senior centers, health systems, and county offices on aging may serve as a model for other states to increase the availability of interventions. More widespread use of evidence-based interventions could improve the quality of life among persons with arthritis and reduce direct and indirect medical costs.

Contact Information

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http://www.cdc.gov/nccdphp/exemplary

Block Grants

Preventing Chronic Disease

For more information about CDC's block grant funding,
visit www.cdc.gov/nccdphp/blockgrant

Alabama

Prevention of Waterborne Disease

Producing Results

In 2003, corrective action taken by Alabama's Department of Public Health averted outbreaks of waterborne disease by eliminating contaminants in well water that threatened health. Now 96 percent of the state's water systems meet the federal drinking-water standards.

Public Health Problem

Of the private well-water samples routinely tested by the Alabama Department of Public Health, approximately 40 to 50 percent were contaminated with fecal coliforms, nitrates, and pesticides. Percentages for contamination were even higher for privately dug shallow wells that are less than 30 feet in depth and for water sources in rural and coastal areas. Failing septic tanks placed about 340,000 low-income persons in rural Alabama who use well water at risk for waterborne disease. During 2003-2004, Alabama received national media coverage when three low-income families were forced to live in tents in rural Lowndes County because a shared septic system failed. Significant costs are associated with the investigation and management of outbreaks of waterborne disease and with the medical treatment and lost productivity for those who become ill.

Taking Action

The Alabama Department of Environmental Management regulates and funds the protection of large municipal and community wells for drinking water and of persons who drill the wells, but it does not have funds to protect private wells that provide drinking water. Approximately $109,000 of the state's PHHS Block Grant was used to develop a statewide monitoring system that enables the state to identify problems and take corrective action for both community wells and private wells. During 2003, program professionals undertook a number of steps, including: investigating and evaluating more than150 failed septic tanks in sensitive areas statewide; working with each owner to repair every septic tank in accordance with the standards for sewage discharge; and conducting continuing education programs with the Alabama Onsite Wastewater Association, training more than 500 septic tank installers, pumpers, manufacturers, engineers, and surveyors in the proper installation of on-site sewage systems.

Implications and Impact

Alabama established a goal of no more than two outbreaks of waterborne disease per year. PHHS Block Grant funds enabled the state to investigate private wells and to review in real time the pathology findings for all samples of well water (both private and community) that were analyzed in the state clinical laboratories. This approach facilitated timely investigation and corrective action. The results included: no outbreaks of waterborne disease in 2003; and realizing a cost savings of $280,000 per year for chemicals to treat the 780 community water systems. Above all, the citizens of Alabama were given the assurance that their health is a priority that is being protected.

Contact Information

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Mississippi

Outbreak of Invasive Bacterial Meningitis Controlled

Producing Results

Careful monitoring and quick action, including timely and judicious administration of antimicrobial drugs and vaccinations to all close contacts of persons who had a confirmed or probable diagnosis of invasive bacterial meningitis, contained a serious outbreak of the disease. There were no fatalities, and no secondary cases were identified.

Public Health Problem

Within a nine-day period in February 2003, in a small town in Mississippi, six children aged 7-14 years had a confirmed or probable diagnosis of invasive bacterial meningitis. An infection of the spinal cord and fluid that surrounds the brain, bacterial meningitis is spread by exchange of respiratory and throat secretions. The disease has a fatality rate of 40 percent, and death often closely follows the onset of symptoms. In addition, bacterial meningitis profoundly affects the long-term health of survivors - 20 percent have permanent neurological deficits, including hearing loss, speech disorders, loss of limbs, mental retardation, and paralysis. Immediate identification and treatment of household members and persons who have had close contact with the patient are critical, because the risk of secondary transmission is 500-800 times greater for household members and close contacts than for the general population. .

Taking Action

The primary means of preventing secondary transmission of meningitis is timely and judicious use of antimicrobial drugs (antimicrobial chemoprophylaxis) by close contacts of infected persons. Mississippi's PHHS Block Grant provides $170,000 in funds for diagnosis and treatment of meningitis. In this instance, determination of the pattern of disease outbreak was critical. The medical investigation indicated the following important findings: 1) All six persons with a diagnosis of invasive bacterial meningitis lived in a small town in Mississippi with a population of 15,000; 2) four of the six patients attended the same middle school; and 3) three of the six cases were confirmed by laboratory culture as serogroup C.

(continued on next page)

Contact Information

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Mississippi

As a first step, the district epidemiology nurse, who started the investigation with the first patient, offered antimicrobial chemoprophylaxis to 85 close contacts. Rifampin was administered to 1,186 of the 1,384 students in the affected middle school and to 659 of the 786 students in affected elementary schools. After an additional four cases were detected through increased surveillance and after serogrouping was completed, meningococcal vaccine was obtained and offered to all students and staff in the affected school system.

Implications and Impact

Careful monitoring and quick action, including timely and judicious administration of antimicrobial drugs to all close contacts, and broad offering of vaccination throughout the affected school system, contained a serious outbreak. The case fatality rate was zero percent, and there were no secondary cases identified.

Contact Information

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Oklahoma

Health Insurance Claims and Risk for Heart Disease and Diabetes

Producing Results

OKHealth, a program for the management of health risk and disease, reduced the risk for cardiovascular disease by 20 percent, the risk for diabetes by 11 percent, and health insurance claims by 14 percent.

Public Health Problem

As of 2002, Oklahoma ranks third in the nation for deaths due to heart disease and eighth in the nation for deaths due to diabetes. In hospitalizations alone, this high morbidity of these diseases costs Oklahoma residents more than $2.5 billion annually for cardiovascular disease and $600 million for diabetes.

Oklahoma also has the eighth highest prevalence rates for both diabetes and high blood pressure in the nation. The government of Oklahoma is the largest employer in the state, and the Oklahoma Benefits Council is responsible for brokering the benefits packages available to state employees. Among state employees, the overall costs for treating cardiovascular disease exceed $50.5 million, and for diabetes, the costs are $13.3 million.

Taking Action

The OKHealth pilot project is funded by the PHHS Block Grant over a 2-year period at $150,000. OKHealth is a program for the management of health risk and disease that addresses the risks for developing cardiovascular disease and diabetes and manages the diseases to prevent further complications. The pilot project serves 969 state employees enrolled in the state health insurance plan.

As a first step, employees were assigned to groups that were stratified on the basis of disease diagnosis or risk factors. Using mentors and a Web-based, self-management program designed by a disease management company, participants entered the program to set and achieve goals for risk reduction and disease management based on a model for care of patients with chronic disease. Employee goals, outcomes, and health care standards were communicated to a health care provider to engage the provider in improving the quality of care. The desired outcome of the quality-improvement plan is to change the health benefits for state employees to address prevention of chronic disease and management of care for patients with chronic disease.

Implications and Impact

The results of this pilot project demonstrate improved health outcomes: the risk of cardiovascular disease was reduced by 20 percent, the risk of diabetes by 11 percent, and health insurance claims by 14 percent. The return on the investment was $77.40 per employee per year (21 cents daily). The pilot study proved the intervention hypothesis, and steps are being taken to present the results, impact, and cost to the state legislature to leverage for changes in health coverage.

Contact Information

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Utah

Elementary School Children "Go for the Gold"

Producing Results

Among participating schools, miles walked increased from 800,000 miles in 2001 to 2,692,429 miles in 2004 (equal to 5.4 round-trips to the moon). The percentage of schools in Utah with a policy of physical activity for 90 minutes per week for each child increased from 13 percent to 100 percent. Schools reported that the program was instrumental in decreasing violence on the playground, increasing attention in the classroom, and increasing interest in being physically active.

Public Health Problem

In Utah, as in the rest of the nation, approximately 25 percent of the children are overweight or at risk for being overweight (higher than the 85th percentile of standards on CDC's growth charts), and 12 percent are overweight (higher than the 95th percentile). Lack of policies and infrastructures to promote and support opportunities for physical activity and healthy nutrition are contributing to the epidemic of obesity among school-aged children. Utah used approximately $175,000 of its PHHS Block Grant funds to support the Gold Medal School Initiative for elementary school children.

Taking Action

The Utah Department of Health, the Heart Disease and Stroke Prevention Program, the State Office of Education, and local health departments created the Gold Medal School Initiative. This elementary school incentive program helps schools adopt a healthy culture by making policy and environmental changes to receive funding for physical activity equipment or salad bars. Changes encourage more opportunities for physical activity during the school day and better nutrition and healthier food choices.

Schools are given a menu of award criteria to achieve, including: establishing a Gold Medal Mile track on or near school grounds, and setting a goal for student participation (at least 1 mile per week for each child); setting a policy for at least 90 minutes of structured physical activity for each student per week; and offering salad bars, providing more nutritious food choices in school stores and in the cafeteria, and limiting choices in vending machines to healthy items. Evaluation of the impact on obesity will begin in year four of the initiative - the first three years were needed to develop policies and change the school environments.

Implications and Impact

During school years 2001-2004, the following accomplishments were achieved: 1) the number of schools participating increased from 50 to 138; 2) nonfood incentives and rewards have been offered to students by 3,039 teachers; and 3) schools report that new healthy policies and environmental supports (about 10 per school) have been instrumental in decreasing violence on the playground and waste of food and in increasing attention in the classroom, participation in school lunch, and interest in being physically active.

Contact Information

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http://www.cdc.gov/nccdphp/exemplary

Cancer

For more information about CDC's cancer control program,
www.cdc.gov/cancer

Alabama

Butterfly Project-Helping Incarcerated Women Have Access to the Alabama Breast and Cervical Cancer Early Detection Program

Public Health Problem

In Alabama, 49,419 women between the ages of 40 and 64 were eligible to participate in the Alabama Breast and Cervical Cancer Early Detection Program (ABCCEDP) in 2003. Typically, only 25 percent of those eligible women participated in the program. Reaching women in rural areas and recruiting eligible women who have never heard of the program can be difficult. In response to such low participation, a health educator with the HIV/AIDS Division asked ABCCEDP to conduct a health promotion class at both of the women's state prisons. After the success with the state prisons, the program was expanded to county facilities. This experience revealed that the majority of incarcerated women had never heard about the screening program, and thus had not participated.

Taking Action

In January 2004, a partnership was formed among ABCCEDP, the AVON Foundation Breast Care Fund, and the Alabama Sheriffs' Association. The partnership, known as The Butterfly Project, educates women about the importance of early detection of breast and cervical cancers. Working with the county sheriffs' departments and state correctional facilities, the project staff transport incarcerated women for breast and cervical cancer screenings at their county health departments. As a result, more than 700 women have been educated and screened. One incarcerated woman shared her appreciation with the program after she found a mass and was later diagnosed with breast cancer. She is currently in treatment and is extremely grateful that the program motivated her to take care of herself.

Implications and Impact

The Butterfly Project has received national attention in its first year through the American Jail Association's magazine American Jails. ABCCEDP was invited to share details of The Butterfly Project at the association's annual conference and has subsequently received telephone calls from other states interested in developing similar programs. In addition to providing breast and cervical cancer information for female inmates, health educators are developing a videotape to teach women how to perform a breast self-exam and to increase cervical cancer awareness. The video will be broadcast nationally through the American Jail Association's satellite teaching network. Participating correctional facilities can use the educational message to teach incarcerated women the importance of early detection. The message also gives these women a sense of self-worth and empowerment as they learn steps to take care of themselves.

Contact Information

Alabama Breast and Cervical Cancer Early Detection Program
P.O. Box 303017, Montgomery, AL 36130-3017
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http://www.cdc.gov/nccdphp/exemplary

Colorado

Colorado Advances Health Priorities by Constitutional Amendment

Public Health Problem

Chronic diseases, such as heart disease, stroke, and cancer, are the most prevalent, costly, and preventable of all health problems; however, securing resources to enable public health agencies to implement programs to prevent chronic disease is an ongoing challenge. State budgets continue to face shortfalls that limit the capacity of public health agencies to implement, sustain, and enhance chronic disease prevention programs. In Colorado, as in many other states, budget shortfalls have resulted in the re-allocation of funds from the Tobacco Master Settlement Agreement to support other needs. Because of diminishing resources, Colorado has been limited in its ability to fully implement public health programs designed to reduce the use of tobacco through prevention and cessation and to reduce the burden of chronic diseases through education and support of proven clinical preventive services for cancer and heart disease.

Taking Action

In November 2004, Colorado voters approved Amendment 35, a citizens' initiative that added "Tobacco Taxes for Health Related Purposes" to the State Constitution. As a result, on January 1, 2005, a new tax of 65 cents was added to the price of each pack of cigarettes. This new tax raises the Colorado tobacco excise tax to about the national average and generates about $175 million per year in new revenues. The Amendment specifies that all of these new monies are to be used for health purposes. Most of the money will be used to subsidize health care for the uninsured, but 16 percent (about $28 million per year) will be dedicated to tobacco control, and another 16 percent to cancer and cardiovascular disease prevention. The Amendment process assures that these new funds cannot be allocated for other purposes, so long-term strategies and programs can now be implemented to reduce the burden of cancer and cardiovascular disease in Colorado.

The Colorado Cancer Coalition, a broad consortium of organizations and individuals with interests in the prevention and control of cancer in Colorado, played an integral role in achieving this outcome. Working along with its partners, the state's Comprehensive Cancer Program supplied critical data to the Coalition for determining objectives, goals, and priorities in cancer prevention and control to reduce the burden of cancer in Colorado. Because a Colorado Cancer Plan had been developed and publicized, the drafters of Amendment 35 were able to specify earmarked funds (about $28 million per year) to support the implementation of the plan.

Implications and Impact

The Colorado Cancer Plan is the cornerstone of the Colorado Cancer Coalition. The vital role of the plan in the earmarking of new tobacco tax funds for cancer control in Colorado underscores the value of having a statewide action plan that is collaboratively developed and collectively supported. Equipped with a data-based state cancer plan, partners are better prepared to address their state's specific cancer problems as well as develop strategies to gather support for cancer control. Citizen-initiated constitutional amendment processes are possible in many other states, where cancer control programs could also be funded by designated new tobacco taxes.

Contact Information

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Assessing Quality of Life at the End of Life in Maine Veterans' Homes

Public Health Problem

In 2002, Last Acts, a national coalition to improve care and caring near the end of life, published Means to a Better End: A Report on Dying in America Today. This document rated each of the 50 states and the District of Columbia on eight criteria as a basis for assessing end-of-life care. The criteria included: 1) advanced care planning; 2) dying at home; 3) use of hospice care; 4) hospital-based palliative care services; 5) over-aggressive care; 6) pain management in nursing homes; 7) pain management policies; and 8) availability of trained palliative care staff. Maine received a "D" or lower rating in four of those eight areas, indicating that there was significant room for improvement in end-of-life care in Maine.

Taking Action

In 2003, the Maine Comprehensive Cancer Control Program, in conjunction with the Maine Hospice Council and the Maine Veterans' Homes (MVH), assessed the end-of-life care in MVH facilities relative to existing national data and palliative care standards. Retrospective chart audits were conducted at MVH facilities in which residents died with cancer diagnoses between 2000 and 2003. A standardized data collection instrument was used to assess indicators of quality of life (QOL), including resident demographic information, diagnosis, family issues, site of death, symptom management, and palliative care. Residents' wishes relating to Do Not Resuscitate orders were consistently respected. Invasive-type treatment was found in the last weeks of life in 35 percent of cases reviewed. Up to 67 percent of the study population reported experiencing some pain. Opioids for pain management were given to 87 percent of residents in the last 48 hours of life. Documentation of the religious and spiritual preferences of MVH residents was lacking overall. The number of documented clergy visits was very low. Only 14 percent of the total resident population reviewed were referred to local hospice programs.

Implications and Impact

The results show that there is much room for improvement in Maine for pain management, advanced directive/advanced care planning, clergy visitations, and documentation of patient religious and spiritual preferences, as well as for increased use of community-based hospice programs. Staff education and training in pain management, end-of-life care, and documentation of patient needs and preferences could be improved. Additionally, standardization of care practices in the art of providing excellence in end-of-life care may be useful. This project could serve as a model for all states that are working on end-of-life issues through their comprehensive cancer control programs. Not only does it serve as a model for assessing QOL at the end of life, it also creates opportunities to work with non-traditional partners, such as veterans' homes, the state hospice association, and community hospice agencies. QOL at the end of life is an important concern for many cancer patients. There is a huge opportunity to improve the systems and manner in which end-of-life care is given.

Contact Information

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Maryland

Korean Outreach Workers Reduce Screening Barriers for Korean Women

Public Health Problem

In 2004, an estimated 4,090 Maryland women will be diagnosed with breast cancer and approximately 760 women will die of the disease. About 220 women in Maryland will be diagnosed with cervical cancer in 2004. A community study of Korean-Americans found that only 10 percent of respondents aged 40 to 69 reported ever having a mammogram, and 54.8 percent of same-aged women in a corresponding study reported ever having a Papanicolaou (Pap) test. According to the U.S. Census, from 1990 to 2000 the Korean population increased from 2,369 to 6,188 in Howard County, Maryland, and from 4,893 to 5,249 in Baltimore County - increases of 161 percent and 7.2 percent, respectively.

Taking Action

Twenty-two local health departments and two hospitals are responsible for implementing the Maryland Breast and Cervical Cancer Program (BCCP). Of those, two local health department BCCPs demonstrate success in recruiting Korean women into the program by employing bilingual Korean outreach workers. Outreach workers that are from the specific population are effective in promoting screening for early detection of breast and cervical cancer by addressing the cultural and language barriers. A variety of factors, including cultural differences, language barriers, transportation barriers, and misperceptions about their cancer risk, contribute to Korean women never or rarely having been screened for breast and cervical cancer. The bilingual Korean outreach workers use a combination of strategies including one-to-one recruitment, public service announcements (PSAs) in a Korean newspaper, outreach to Korean grocery stores, and word of mouth within the Korean community. Additionally, Korean outreach workers translate during screening appointments, case management, and recall.

Implications and Impact

The BCCPs in Baltimore and Howard Counties demonstrate the impact of using bilingual Korean outreach workers to reduce cultural barriers and recruit Korean women for screening. In Baltimore County from January 1, 1992, to August 9, 2000, a total of 83 Asian women were screened, an average of about 9 per year. A Korean outreach worker was hired on August 10, 2000. From August 10, 2000, to April 4, 2003, 225 Asian women were screened, or about 90 per year. This is a ten-fold increase in the average per-year screening of Asian women. About 75 percent (168) were identified as Korean. In fiscal year 2003, 20.4 percent of patient visits in Howard County's Breast and Cervical Cancer Screening Program were for Korean women, compared to only 10 percent in 1997 before a Korean outreach worker was hired. The use of bilingual Korean outreach workers has demonstrated success in decreasing access barriers and enabled many high-risk Korean women to obtain breast and cervical cancer screening that they may not have received otherwise.

Contact Information

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http://www.cdc.gov/nccdphp/exemplary

Women's Health Screening Events in Southeast Missouri

Public Health Problem

Southeast Missouri is a large rural area with limited medical services. Low socioeconomic status, as well as high insurance premiums and deductibles, have prevented underserved women from receiving breast and cervical cancer screening and diagnostic services.

Taking Action

In 2004, four different events were held in eight rural locations in Southeast Missouri. BJH brought staff and a mobile mammography unit from St. Louis to work with local SMHW providers. These Women's Health Days were advertised through the media, church bulletins, flyers, and word of mouth.

A task force, which was created to help alleviate this burden, collaborated with Barnes Jewish Hospital (BJH) to help increase awareness about the availability of screening services through the state's Show Me Healthy Women (SMHW) program. The task force enlisted the aid of local church groups; the American Cancer Society; cancer support groups; local radio stations and newspapers; and Caring Communities, a grassroots coalition that provides resources for community members. Special women's health screening events, scheduled for one to three days each, were planned to assure free mammograms, free clinical breast examinations, free Papanicolaou (Pap) screening, and instruction in breast self-exams for SMHW-eligible women.

Implications and Impact

Through the women's health screening events, a total of 459 women have received screening mammograms, clinical breast examinations, and instruction in self-breast exams, as well as 157 Pap tests. All abnormal findings were followed, and clients were referred for care as needed. Eleven breast cancers were found and these women were enrolled in BCCPT. Data on follow-up screenings will be available next year when the project is continued. Outcomes from this project are being prepared to share with other SMHW case managers for use in other areas of the state. The Missouri Cancer Consortium (MCC), which is developing a statewide comprehensive cancer control plan, will use this program's materials, approaches, and evaluation methods as a model for promoting breast and cervical cancer control screening and diagnostic services for underserved women in Missouri.

Contact Information

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920 Wildwood, Jefferson City, MO 65109
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http://www.cdc.gov/nccdphp/exemplary

Nevada

Using Electronic Pathology Reporting to Improve Case Ascertainment

Public Health Problem

Having complete and accurate cancer data is important to understanding the burden of cancer. Prior to collecting and analyzing cancer morbidity and mortality data for the year 2000, the Nevada Central Cancer Registry (NCCR) was unable to provide complete reporting of cancer cases. Consequently, Nevada did not meet the completeness standards required for certification by the North American Association of Central Cancer Registries (NAACCR).

Taking Action

NCCR believed it had captured all the cancer cases that were diagnosed or treated in an inpatient facility (e.g., hospital), but fell short in identifying cancer cases that were diagnosed or treated in an outpatient setting (e.g., doctors' offices, surgi-centers). In order to capture cancer cases in the outpatient setting, NCCR electronically processed more than 10,000 pathology reports and was able to identify more than 2,000 new cancer cases. NCCR increased reporting of prostate, breast, melanoma, and bladder cancers by 12.2 percent. These are forms of cancer that are typically diagnosed and treated in an outpatient setting. Of the 1,512 breast cancers reported, 22.6 percent were reported from "path only" (i.e., the case was identified from a pathology report and no other source) cases accounting for an 8.7 percent increase in overall breast cancer reporting. Of the 435 cases of malignant melanoma skin cancers reported, 46 percent were from "path only" cases, accounting for an 89 percent increase in overall malignant melanoma reporting. Of the 1,319 prostate cancers reported, 22.4 percent were reported from "path only" cases. This accounted for an 8.3 percent increase in overall prostate cancer reporting.

Implications and Impact

By electronically processing pathology reports, NCCR was able to achieve more than 95 percent complete case ascertainment for 2000 and 2001 data and thus achieved "Gold" Certification from NAACCR. In 1997, NAACCR instituted a program that annually reviews member registries for their ability to produce complete, accurate, and timely data. The registry certification program then recognizes those registries meeting the highest standards of data quality with Gold or Silver recognition certificates for each data year. This achievement allowed the State of Nevada to produce Cancer Report on Nevada, which included epidemiological analysis that statewide cancer prevention and intervention programs can use to target appropriate services. Moreover, Nevada is now included in United States Cancer Statistics, which is produced and disseminated by the Centers for Disease Control and Prevention. Finally, NCCR was recently recognized as "Outstanding Program of the Year" by the State of Nevada Health Division and the program manager was awarded "Outstanding Employee of the Year."

Contact Information

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Phone: (410) 767-5281 Web Site: www.fha.state.md.us/cancer/
http://www.cdc.gov/nccdphp/exemplary

Wisconsin

Working With Wisconsin's Indian Health Service Clinics to Improve Race Classification on Cancer Reports for Native Americans

Public Health Problem

The Wisconsin Cancer Reporting System (WCRS) collects and maintains data on all Wisconsin residents who are diagnosed with cancer - approximately 26,000 new cases per year. Wisconsin's cancer morbidity and mortality rates are calculated annually to assess the state's cancer burden. Based on findings from studies conducted in other states that showed underreporting and misclassification of Native American/Native Indian (NA/NI) populations, WCRS was concerned that NA/NIs might be underreported or misclassified in its database, and consequently misrepresented in the burden assessments.

Taking Action

WCRS collaborated with CDC and the Indian Health Service (IHS) to link 17 years of registry data with IHS enrollment lists. The results showed that 37 percent of the cancer cases matched to IHS enrollees were misclassified as non-Native American. WCRS also participated in the Spirit of EAGLES Building Cancer Surveillance Capacity project, a collaboration among the Wisconsin Tribal Health Directors Association, the Great Lakes Inter-Tribal Council, the Mayo Clinic Cancer Center, the University of Wisconsin Comprehensive Cancer Center (UWCCC), and WCRS. Data on cancers diagnosed in 2001 at Wisconsin's 12 tribal clinics and one suburban clinic that serve the Native American population were collected directly from those facilities and matched against the WCRS registry. At the time of the study, only 50 percent of the cases had been reported by non-IHS facilities, and of those that had been reported, 25 percent were misclassified as non-Native American.

In light of those results, WCRS is now collaborating with UWCCC and Wisconsin's tribal clinics to collect data directly from those clinics on a routine basis, starting with 2004 cases, to ensure stable and accurate reporting of cancers to WCRS for the Native American population in Wisconsin. A simplified reporting form and protocols have been established and will be implemented later this year.

Implications and Impact

Accurate race reporting is crucial for monitoring health status and planning interventions for reducing cancer morbidity and mortality in Wisconsin. This collaboration will improve the data collected on the NA/NI population in Wisconsin, allowing for more accurate analysis of the cancer patterns within this population (type of cancer, how far it has spread within the body, types of treatments being offered, etc.). This model can be adopted by cancer registries in other states that may have similar challenges due to underreporting or racial misclassification.

Contact Information

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Diabetes

For more information about CDC's diabetes program,
visit www.cdc.gov/diabetes

California

Diabetes Prevention and Control Program

Public Health Problem

California is a large and diverse state with more than 2 million people with diabetes. There are more than 350,000 diabetes-related hospitalizations each year at a cost of $4 billion annually. Between 1994 and 1997, there was an average of 21,025 deaths each year directly or indirectly attributable to diabetes. In 2000, diabetes contributed to 24,520 deaths in the state. The direct and indirect cost of diabetes in California per year is more than $17.9 billion. Diabetes disproportionately burdens Latinos, African Americans, Native Americans, and Asian/Pacific Islanders.

Taking Action

The capital of California is Sacramento, home of many of the state's government agencies as well as home to about 2 million residents. The California Department of Health Services employs approximately 5,000 individuals with the majority of them located at the newly constructed east end complex in Sacramento.

The custodial staff at the east end complex is large, ethnically diverse, and includes mostly African American, Latino, and Asian men and women. In response to numerous individual requests for diabetes information, a diabetes forum was hosted specifically for the custodial staff. The event was planned between the day and evening shifts to maximize attendance. Prior to the diabetes presentation, custodians picked up health education literature, enjoyed a fresh fruit snack, and spun the Five-a-Day PowerPlay wheel for prizes that promoted eating fruits and vegetables. Custodians purchased raffle tickets to benefit the ADA and also were recruited to be on walking teams for America's Walk for Diabetes. A health educator gave an interactive talk about diabetes prevention and control and underscored the important roles that physical activity and nutrition play in preventing diabetes and its complications. Participants were encouraged to make a personal game plan using material from the NDEP. At the end of the event, raffle prizes were awarded, and each participant was given a pedometer and shown how to use it. Now, custodians regularly wear their pedometers at work to measure their steps, and they also serve as motivational models for all employees.

Implications and Impact

This program demonstrates the simple approach of reaching out to colleagues. Now, representatives from other government agencies have requested that the team make the same presentation to their custodial and security staffs. A series of presentations to government personnel have been planned and will involve other programs at DHS for events on numerous health topics such as cardiovascular disease, asthma, cancer, and arthritis. In Sacramento alone, there is the ability to reach more than 100,000 state employees who can serve as “healthy” civil servants in their own neighborhoods.

Contact Information

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http://www.cdc.gov/nccdphp/exemplary

Kentucky

Diabetes Prevention and Control Program

Public Health Problem

Daviess and Henderson counties are two adjacent counties of the Green River District in western Kentucky with populations of 91,545 and 44,829, respectively. The estimated number of adult Kentuckians diagnosed with diabetes in 2002 was 7.8 percent with an additional 3.9 percent having undiagnosed diabetes. Based on this data, estimations of adults with diabetes in Daviess and Henderson counties were 7,969 and 3,955, respectively (11.7 percent).

Taking Action

The Daviess and Henderson County Diabetes Coalitions were formed in 1995 and 1996, respectively, utilizing the "Diabetes Today" model as a CDC project with the Kentucky DPCP. Both coalitions were formed to examine issues and problems related to diabetes within their communities and formulate ongoing plans to decrease the diabetes burden.

The Daviess County Diabetes Today Coalition's accomplishments include: holding a diabetes expo and panel of experts for the eighth consecutive year with 200 to 300 in attendance annually; initiating a diabetes speakers bureau that gave 16 presentations to more than 350 persons in 2003; and developing and distributing a regional diabetes resource directory that is serving as a model for other regional and state directories.

The Henderson County Diabetes Today Coalition's accomplishments include: holding a "Diabetes Bash" for six consecutive years, netting anywhere from $12,000 to $16,000; receiving a listing as one of 31 "Models that Work" by the Healthy Kentucky Foundation in 2003; and conducting the Diabetes Panel of Experts Forum with 88 in attendance for three consecutive years.

Implications and Impact

A small group of passionate, committed partners for diabetes, formed as a CDC "Diabetes Today" project, truly have impacted diabetes in Kentucky. The coalitions were instrumental in local and statewide diabetes efforts to educate policymakers regarding diabetes control and prevention issues. Outcomes included: diabetes state funding being maintained and the passing of a law that mandated that specific diabetes questions be added to Kentucky death certificates. The coalitions also completed nearly 50 diabetes screenings and preventive education events with local hospital, health department, pharmacies, and others, with approximately 1,500 people being tested (more than 80 referrals).

Contact Information

Kentucky Department for Public Health - Diabetes Prevention and Control Program
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http://www.cdc.gov/nccdphp/exemplary

Minnesota

Diabetes Prevention and Control Program

Public Health Problem

There is an epidemic of diabetes in Minnesota. One in 10 Minnesotans currently has diabetes or is at risk for developing the disease. Diabetes is a leading cause of death and disability, and its prevalence and related complications are increasing dramatically. Although Minnesota is a recognized leader in diabetes activities, state activities were largely fragmented and uncoordinated.

Taking Action

Unified statewide action, involving all aspects of diabetes and the entire diabetes community, was recognized as essential. To begin building the infrastructure to support unification, a state strategic plan for diabetes was developed. Using a grassroots planning process, key members of the diabetes community were convened to identify key diabetes issues and needs, facilitated by the Minnesota Diabetes Program (MDP) and its advisory group, the Minnesota Diabetes Steering Committee. The result was the creation of the Minnesota Diabetes Plan 2010, released in October 2003. The plan is a call to action, urging everyone to get involved in achieving its vision by taking action on its far-reaching goals and recommendations. It provides the framework and baseline for coordinated population-based activities to prevent diabetes and its complications more effectively and to achieve Healthy People 2010 objectives.

Implications and Impact

The Minnesota Diabetes Plan 2010 provides a more cohesive and cost-effective approach to addressing diabetes by unifying direction and stimulating collaboration. Between October 2003 and April 2004, the plan mobilized hundreds of stakeholders around common issues, leveraging their collective expertise and resources. The MDP is now working to facilitate the plan's implementation by tracking and evaluating diabetes activities and improvements relating to the plan and reporting back to Minnesota stakeholders on this progress. The MDP also is identifying gaps and promoting targeted activities to ensure optimal population-based coordination and impact. Some of the early accomplishments related to the plan include: 1) creation by the MDP of a unique Web-based database (www.health.state.mn.us/diabetes/ plancentral) to facilitate plan evaluation and the sharing of tools, resources, interventions, and lessons learned for all those working to achieve plan goals statewide; 2) publication of an online quarterly newsletter, the Diabetes Plan Dialog, to facilitate ongoing discussion of the plan. As of April 2004, the newsletter has more than 200 subscribers; 3) television, radio, print, and Web coverage about the plan reached more than 400,000 Minnesotans in October 2003, 146,000 in January 2004, and another 255,000 in March 2004; and 4) health professional publications have highlighted the plan, including Minnesota Medicine (8,500 readers), Minnesota Physician (14,000 readers), the Center for Cross Cultural Health's Crosswinds (500 readers), and the local diabetes educators' newsletter (200 readers).

Contact Information

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Utah

Diabetes Prevention and Control Program

Public Health Problem

The Utah DPCP has continued its emphasis on increasing awareness of diabetes and diabetes control among Utahans, particularly among higher risk populations. Many Utahans diagnosed with diabetes are not aware of the recommended tests to prevent complications, what their diabetes test numbers mean, and how meeting recommended management targets can affect their overall health and delay or prevent complications.

Some populations are hard to reach, especially those who are isolated geographically or culturally, and traditional methods of disseminating information are not effective. Research has demonstrated that innovative approaches for delivering messages are needed to reach certain subgroups.

Taking Action

The Utah program created a bus wrap with a message in both Spanish and English. The messages from the NDEP, "You Are the Heart of Your Family" and "Control Your Diabetes. For Life," were used as the basis for the bus wrap message on two Utah transit authority buses. The buses traveled through four urban Utah counties between March 2004 and August 2004. A survey sampling 500 Utah adults was conducted when the bus wrap activity terminated. One of five respondents (20 percent) reported they had seen the bus wrap. Of those, 20 percent had seen it once, 46 percent had seen it two to three times, and 20 percent had seen it four or five times. Over half of the respondents saw the bus in Salt Lake City followed by Orem (16 percent) and Provo (11 percent). Almost half (47 percent) of the respondents reported that their first impression was that they liked the bus wrap. In addition to measuring awareness of the bus and message, respondents were asked if they had taken action: 1 percent of those who saw it called the Health Resource phone number posted on the bus wrap, 1 percent looked up the Utah DPCP Web site, 2 percent called their doctor, 3 percent got a screening, 9 percent started to exercise, 6 percent started to eat better, 3 percent tried to find additional information on diabetes, and 6 percent talked to other people about diabetes.

Implications and Impact

Diabetes messages increase knowledge of risk factors, symptoms, control methods, and prevention methods of diabetes. A large proportion of the Utah population in urban areas was reached by using innovative bus wraps to deliver a message. While increased knowledge does not lead necessarily to behavioral changes, the bus wrap message did appear to have an impact, albeit small, on motivating people to be screened for diabetes, to talk to their doctors, to learn more about diabetes, and to adopt healthier lifestyles.and 2002, network patients had declines in their absolute glycosylated hemoglobin values of 1.15% (13% relative reduction). Network patients also have significantly improved their physical activity and nutrition planning.

Contact Information

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Healthy Mothers Healthy Babies

For more information about CDC's reproductive health program,
visit www.cdc.gov/nccdphp/drh/index.htm

Massachusetts

ART Linkage Project

Public Health Problem

There are few opportunities to understand the influence of assisted reproductive technology (ART) on short-term maternal and infant health outcomes. In Massachusetts, the percentage of infants born using ART is expected to rise as new policies regarding coverage of infertility/ART treatment services are expanded.

Research indicates that linking vital records data with other health events can yield information to support public policy decisions regarding the scope and nature of clinical health services.

Taking Action

In 2001, CDC developed a collaborative project with the Massachusetts Department of Public Health to link the existing ART surveillance data for infants born to Massachusetts resident women who attended ART clinics in Massachusetts and Rhode Island. Data were obtained from state's birth and death certificate files. This project includes infants born to Massachusetts' resident mothers in 1997, 1998, 1999, and 2000.

Approximately 80,000 babies are born in Massachusetts every year. The 1997/1998 linked ART and birth/death data set, for example, consists of approximately 160,000 infants born in Massachusetts to Massachusetts resident mothers, of which approximately 2 to 3 percent are the result of ART.

The analysis of data yields information that can help CDC and the state assess trends in the number of infants conceived with ART, the potential adverse health risks associated with ART in Massachusetts, and the impact of ART on adverse maternal and child health outcomes.

Implications and Impact

Linkage of the ART surveillance data with Massachusetts linked birth and death certificate data will provide detailed information on short-term maternal and infant health outcomes. It is an example of how state public health programs, local clinicians/specialists, and CDC can partner to provide a model program to better understand a practice that may be widely adopted in the United States.

Contact Information

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Colorado

Enhanced Pregnancy Risk Assessment Monitoring System (PRAMS) Project

Public Health Problem

Understanding women's lives before, during, and after pregnancy is essential to developing programs, services, and public policy needed to reduce the burden of mortality and morbidity among women and their infants.

Taking Action

The Pregnancy Risk Assessment Monitoring System (PRAMS) has been very successful in achieving its objectives to collect state population-based data of high scientific quality on topics relating to pregnancy and early infancy. Colorado's success in using state-level data generated demand for an enhanced system that includes 1) local level PRAMS data on subpopulations and 2) the state's desire to be a site for testing enhanced linkages between PRAMS and other data sources used by public health planners and providers.

In 2001, PRAMS funding was expanded to enhance existing surveillance efforts to reach special population groups, to test new data collection or analytic methodologies related to pregnancy or infant health, and to gather additional information on specific topics from women or others. Colorado was chosen from among twelve states to developed enhanced program and survey activities.

Currently, Colorado is working to develop more complex PRAMS data survey and analysis services to meet the needs of local health departments. For example, Colorado is conducted a special survey of African American women in six local health department areas. In addition, Colorado linked Medicaid claims database with birth certificate records and added PRAMS data to the heath departments' web-based query system, Colorado Health Information Dataset (CoHID), http://www.cdphe.state.co.us/cohid. The CoHID system allows any individual to request specific health-related statistics from a variety of health department databases. The PRAMS module currently averages 370 queries per quarter. CoHID is also used to help public health professionals understand the use of data for planning public health programs.

Colorado is now working with Wyoming to develop a similar program. This will help provide Wyoming the data for the first time on many indicators of maternal and child health.

Implications and Impact

Colorado's model program provides examples for other CDC and state-based systems to collect and link information on women and infants. It also develops a model that others can use to complement PRAMS data services by involving local health departments, non-traditional partners in research/surveillance, and data users.

Contact Information

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Phone: (303) 692-2160 www.cdphe.state.co.us/hs/prams
http://www.cdc.gov/nccdphp/exemplary

Healthy Youth

For more information about CDC's adolescent and school health program,
visit www.cdc.gov/nccdphp/dash

Maryland

Reaching School Personnel Through Intensive Training and Professional Development

Public Health Problem

In 2002, youth ages 13-24 accounted for 11 percent (243 cases) of all newly diagnosed HIV cases and 4 percent (53 cases) of all newly diagnosed AIDS cases in Maryland. During the same year, there were 731 young people ages 13-24 living with HIV/AIDS throughout the state. In addition, there were 1,309 young adults ages 24-29 living with HIV/AIDS who likely began engaging in risky behaviors as adolescents that placed them at risk for HIV/AIDS.

Taking Action

The Maryland State Department of Education (MSDE) coordinates all comprehensive sexual education program components including HIV/AIDS, STDs, and teenage pregnancy prevention with the Maryland Department of Health/AIDS Administration's state-wide Community Planning Group (CPG). The involvement of the CPG ensures that feedback is received from a diverse group of community members from throughout the state on MSDE's workplan and future activities. MSDE also provides continuous updates to school personnel on newly published survey results through mailings or by posting information to Web sites.

The week-long "Positive Behavior Intervention Systems and Supports" (PBIS) conference was attended by more than 1,000 participants from more than 130 school-based teams. PBIS is a systems approach designed to enhance the capacity of schools to begin and to continue using effective practices for all students. It uses a team-based approach to problem solving and planning that focuses on determining the root causes of academic and health problems.

A second conference sponsored by the MSDE was the "No Counselor Left Behind" Conference, which provided information on HIV-prevention education programs that were shown to be effective at reaching high-risk youth. This one-day conference was attended by over 800 K-12 guidance counselors from all 24 school systems.

Implications and Impact

PBIS Conference as well as the "No Counselor Left Behind" Conference showed positive changes taking place after participants left the conference. As a result of attending the PBIS conference, a number of the school-based teams developed plans for improving their school environments. After implementing their plans, the schools self-reported less office referrals and an improved school climate. Follow-up site visits demonstrated an increase in positive behavioral interventions and an increase in the identification of students at risk for HIV infection. Similarly, attendance at the "No Counselor Left Behind" conference was followed by an increase in the services and programs offered to meet the needs of high-risk youth.

Contact Information

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http://www.cdc.gov/nccdphp/exemplary

Healthy Weight in Schools

Public Health Problem

Data from the 2003 Youth Risk Behavior Surveillance Study (YRBSS) indicated that, nationwide, 15.4 percent of students were at risk for becoming overweight and 13.5 percent of students were overweight. The most recent YRBSS data available from Michigan show that, in 2003, 13.8 percent of students were at risk for becoming overweight and 12.4 percent of students were overweight. Furthermore, 39.4 percent of Michigan students went to physical education (PE) classes on one or more days in an average week when they were in school, and 27.5 percent went to PE classes 5 days in an average week when they were in school. Even though the percentage of youth at risk for becoming overweight and those who were overweight in Michigan is less than the percentages seen nationwide, the rates for Michigan remain too high. Michigan also has one of the highest rates of overweight in the adult population.

Taking Action

The Michigan Model for Comprehensive School Health Education, a skills-based, sequential and comprehensive school health education curriculum, is being used voluntarily in 94 percent of Michigan's school districts. With funding from CDC, the Michigan Department of Education (MDE) increased its focus on promoting healthy weight in schools. They have partnered with the Michigan Department of Community Health (MDCH), the state Surgeon General, the United Dairy Industry of Michigan, Michigan Action for Healthy Kids and others to promote coordinated school health programs that focus on physical activity and health.

The MDCH has a Web site, www.mihealthtools.org, to help local schools complete an assessment using the Michigan Healthy Schools Action Tool (HSAT), which is a modified version of CDC's School Health Index.

Implications and Impact

Based on the systems put in place by the Michigan Department of Education and its partners, many significant changes have been implemented at the local school levels that affect physical activity and healthy eating. Some examples include: Altering a school's PE credit policy to eliminate the use of band or sport activities to meet physical education requirements; purchasing equipment and resources to enhance physical activity during recess time; adding healthy food options to the cafeteria offerings, vending machines and school activities; and offering nutrition lessons in K-5 classes. Finally, the MDE has passed state board of education policy to ensure schools create a supportive environment for healthy eating and physical activity, thus reinforcing the messages taught in the classroom.

Contact Information

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North Carolina

Schools Embrace Evidence-Based Making a Difference HIV Prevention Curriculum

Public Health Problem

In North Carolina, the 2003 Youth Risk Behavior Survey reported that 52.2 percent of high school students had ever had sexual intercourse. Of those students, 17.1 percent had had sex with four or more people. Also, in 2003, while just fewer than three percent of HIV disease reports were found among teenagers aged 13 to 19, the percentage increased to almost 12 percent of all cases when 20 to 24 year-olds were included. Additionally the rate for gonorrhea in 13 to 19 year-olds was 514.4 (per 100,000) and the rate for chlamydia in the same age group was 1327.3.

Taking Action

The North Carolina Department of Public Instruction, Healthy Schools Initiative funds the North Carolina Comprehensive School Health Training Center. The Center developed and provides training for Making a Difference, an evidence-based HIV-prevention curriculum. The curricula were aligned with the North Carolina Healthful Living Standard Course of Study and met the state basic education guidelines. During an eighteen month period starting in March of 2003, 31 of the 117 school systems in North Carolina participated in a two-day, Making a Difference Training. This represents 26 percent of the school systems in North Carolina. Fourteen of the school systems trained their entire middle school health teacher staff. Several school systems have received additional curricula training for their local boards of education, school administrators, and parents. An in-depth evaluation was conducted with one school system to look at implementation. Within three months of the spring training, 61 percent of the teachers had implemented the curriculum in their classrooms.

A research study of Making a Difference provided evidence that the curricula works. In the study, sixth and seventh grade African-American students were stratified by gender and age and randomly assigned to receive one of three, eight hour curricula. The participants who received the Making a Difference curricula were less likely than the control group to report having sexual intercourse in the three months after the intervention. The curriculum also delayed sexual experience among virgins. Adolescents who received Making a Difference believed more strongly that practicing abstinence would prevent pregnancy and AIDS.

Implications and Impact

A 2003 telephone survey of North Carolina parents of school-aged students found that 91.5 percent of parents surveyed supported teaching age-appropriate sexuality education in schools. Parents overwhelmingly supported including HIV/STD and teen pregnancy prevention as part of sexuality education. Through the implementation of the evidence-based HIV-prevention curricula, Making a Difference, North Carolina is meeting the expectations of its parents and preparing students to negotiate the pressures of having early sexual experiences, which could lead to HIV infection.

Contact Information

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http://www.cdc.gov/nccdphp/exemplary

Increasing Health Literacy and HIV Prevention to High-Risk Youth

Public Health Problem

According to the 2003 YRBS, 37 percent of Wisconsin's students in grades 9-12 had ever had sexual intercourse and 26 percent had had sexual intercourse within the past three months. Nine percent reported having had four or more sexual partners and 35 percent did not use a condom during their last sexual intercourse. Furthermore, as of June 30, 2004, there were 5,549 reported AIDS cases and 8,511 reported HIV cases in Wisconsin. Adolescents ages 13-19 accounted for 45 of the reported AIDS cases and 209 of the reported HIV cases.

Taking Action

The Wisconsin Department of Public Instruction (DPI) has utilized a variety of strategies to provide HIV prevention education to young people. These strategies consist of addressing the needs of high-risk youth, focusing on health literacy, involving the community and parents in prevention activities, and forming strong collaborations to address abstinence and sexual risk behaviors.

During 2003-2004, four groups of at-risk youth received focus: gay, lesbian, bisexual, and transgender (GLBT) youth; Native American youth; students attending alternative schools; and minority youth. A three-day peer education skills building event was attended by 70 GLBT youth and their advisors. Within the same time frame, a number of events were also held for the Native American community, including the HIV/AIDS and STI Youth conference, which was attended by 30 Native American youth and their adult advisors. Another training that focused on effective HIV-prevention instruction principles was provided to 15 alternative school staff. Training also was provided on two evidence-based HIV-prevention curricula to 67 staff from schools and minority community-based organizations.

Implications and Impact

The Wisconsin DPI has utilized these strategies to focus on high-risk youth ensuring that those youth most at risk for becoming infected with HIV receive accurate HIV-prevention education along with the skills needed to protect themselves. Targeting health literacy results in the effective use of resources by providing only those resources that are successfully designed for and understood by the intended audience. Promoting the involvement of the community and parents increases support for HIV-prevention education and also increases the number of sources from which young people will receive prevention messages. This type of collaboration effectively pools ideas and resources resulting in a more comprehensive approach to prevention.

Contact Information

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http://www.cdc.gov/nccdphp/exemplary

Heart Disease and Stroke

For more information about CDC's cardiovascular health program,
visit www.cdc.gov/nccdphp/cvh

Arkansas

Bringing State-of-the-Art Techniques in Chronic Disease Management to Patients in Federally Funded Health Centers

Producing Results

Arkansas increased the number of community health centers implementing techniques for care of patients with chronic disease, such as electronic data management and clinical information systems.

Public Health Problem

Heart disease is the leading cause of death in Arkansas, and the state ranks second in the country in deaths from stroke. Arkansas has a larger burden of disease than the rest of the nation, possibly because the state has higher-than-average rates for risk factors. BRFSS data indicate that 30 percent of people in Arkansas have high blood pressure (versus 26 percent in the nation); 26 percent smoke cigarettes (versus 23 percent in the nation); and 27 percent are physically inactive (versus 24 percent in the nation). These risk factors significantly increase the potential for heart disease and stroke.

Taking Action

The Arkansas Cardiovascular Health Program, through the Arkansas Chronic Illness Collaborative, is helping federally funded community health centers and area health education centers to develop electronic patient-management systems to support control of heart disease and stroke and diabetes. Such clinical information systems have proven effective in helping to improve quality of care and controlling heart disease and stroke risk factors (such as high blood pressure) among patients in federally funded health centers. The Arkansas Cardiovascular Health Program is helping federally funded health centers in the state to apply these proven interventions and is continually expanding the number of community health centers capable of implementing these disease management techniques. Other partners in the Arkansas Chronic Illness Collaborative include the Arkansas Diabetes Prevention and Control Program; the Bureau of Primary Care's Federally Qualified Community Health Centers of Arkansas, Inc.; and the Arkansas Foundation for Medical Care, the state's quality-improvement organization.

Implications and Impact

Improvements in control of risk factors for heart disease and stroke can significantly reduce risk for heart attack, stroke, coronary heart disease, and death from CVD. The Arkansas Cardiovascular Health Program is helping to bring state-of-the-art techniques in disease management to the vulnerable populations served by federally funded health centers in the state. Public health has a critical role to play in helping to bring these effective measures for prevention of heart disease and stroke to the places where vulnerable populations receive health care and in building the capacity of such clinics to implement these and other public health measures for heart disease and stroke prevention.

Contact Information

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Kentucky

Partnering With Hospitals and the American Heart Association in Secondary Prevention of Coronary Artery Disease

Producing Results

Twenty-six hospitals in major metropolitan and rural areas in all five regions of Kentucky have adopted a secondary prevention program proven effective to improve management of patient care.

Public Health Problem

In Kentucky, heart disease and stroke account for 37 percent of all deaths; 30 percent of people die of heart disease, and 7 percent die of stroke. According to the Kentucky State of the Heart 2000 report, about 40 percent of all hospitalizations in the state are due to heart disease and stroke, resulting in hospital costs exceeding $863 million in 2000.

Taking Action

The Cardiovascular Health Program of the Kentucky Department of Public Health partnered with the American Heart Association Kentucky Affiliate, the Kentucky Hospital Association, Healthcare Excel, and the American College of Cardiology to improve management of patient care. The partners used the American Heart Association's program, Get With the Guidelines - Coronary Artery Disease, to improve outcomes for patients in acute care settings. In April 2003, a statewide training program was launched in Lexington, and 142 people from 57 hospitals across the state participated. The state Cardiovascular Health Program provided funds, to cover the training costs and the annual fee for the Patient Management Tool, for hospitals starting the program by June 2003. Twenty-six hospitals in major metropolitan and rural areas in all five regions of Kentucky are conducting this secondary prevention program. Regular technical assistance is provided through telephone conference calls to the participating hospital teams by the American Heart Association, the state Cardiovascular Health Program, and the project's information technology manager.

Implications and Impact

These partners shared the vision of reducing deaths, disability, and recurrent heart attacks among patients with coronary artery disease and successfully collaborated to put in place secondary prevention guidelines in hospitals across Kentucky. By uniting and leveraging their strengths and resources, each organization contributed to the development of a hospital-based infrastructure for quality improvement that focuses on protocols to ensure that patients are treated and discharged with appropriate medications and lifestyle counseling. The impact of this intervention is being evaluated by assessing the compliance with secondary prevention measures. As more acute care hospitals across the state launch quality-improvement programs, illness and deaths from heart disease and stroke are expected to decline.

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South Carolina

Closing the Disparity Gap for Cardiovascular Disease in African American Communities

Producing Results

In efforts to close the disparity gap for cardiovascular disease, faith organizations in African American communities are implementing programs and organizational changes to address control of high blood pressure and high blood cholesterol and other cardiovascular risk factors.

Public Health Problem

Every year, more than one in four South Carolina residents have a diagnosis of some form of heart disease and stroke, and in 2000, almost 14,000 persons died of heart disease and stroke. Thirty percent of South Carolinians are African American, and they carry a disproportionate burden of cardiovascular-related deaths and hospitalizations. These illnesses also result in stroke rates that are higher than the national average, and they affect the quality of life, resulting in life expectancy 10 years less than that for the average South Carolinian. The Institute of Medicine has reported that many social, economic, political, and cultural factors are associated with health and disease and that changes in individual health behaviors alone are not likely to result in improved health and quality of life. However, environmental and policy changes affecting large segments of the population can affect the informational, physical, social, or economic environment to facilitate healthier behavior.

Taking Action

In 2002, the South Carolina Cardiovascular Health Program provided funding and training to eight health districts to implement cardiovascular health projects in collaboration with local community partners. Each of the eight districts has sponsored activities and training courses designed to create heart-healthy policies and environmental supports in African American communities. The Palmetto Health District: Promoting Healthy Congregations Project is one example. The project goals focus on increasing heart-healthy policy and environmental supports in faith-based congregations in the following ways: 1) develop a map to identify strengths, assets, and resources in the community; 2) create a community-wide media campaign (e.g., use of print and broadcast channels) to increase awareness of high blood pressure and the signs and symptoms of heart disease and stroke; and 3) implement CVH interventions to promote policy and environmental changes to help make the church a more heart-healthy organization. Churches and faith organizations select and implement policy and environmental strategies that are appropriate to their needs and that address control of high blood pressure and high blood cholesterol, prevention of tobacco use, increased physical activity, and improved nutrition.

Implications and Impact

In South Carolina, African Americans are at an increased risk for developing heart disease and stroke across all age groups and socioeconomic groups. Efforts to focus on this population through local community partners should result in strong social support for policy and environmental interventions that encourage and maintain heart-healthy behaviors.

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Promoting Quality Cardiovascular Care by Implementing Secondary Prevention Guidelines

Producing Results

Hospitals and community health centers adopted changes to better manage and control cardiovascular disease to decrease second events, disability, and deteriorating health from cardiovascular disease. Public health agencies and organizations played a key role in secondary prevention by propelling changes, providing tools, and assessing results.

Public Health Problem

Heart disease is the number one cause of death in Texas, and stroke is close behind at number three. Together, heart disease and stroke are the number one drain on health care resources in the state. Hospital charges in Texas for ischemic heart disease, hemorrhagic stroke, ischemic stroke, and congestive heart failure were an estimated $7.5 billion in 2002.

Taking Action

The Texas Cardiovascular Health and Wellness Program held forums with representatives of major health systems to develop strategies for an initiative to improve quality of care for the secondary prevention of heart disease and stroke in primary and specialty health care facilities and hospitals. Participants were from health plan organizations, the Texas Medical Association, the American Heart Association Texas Affiliate and its national office, hospitals, business groups, the state's quality-improvement organization, and other health care systems. Three strategies were identified by this collaborative effort, known as the Texas Cardiovascular Quality and Patient Safety Initiative: 1) Promote adoption of the guidelines for secondary prevention from the American Heart Association and the American College of Cardiology; 2) identify physicians who can be leaders and champions in promoting adoption of these guidelines; and 3) develop a program to recognize hospitals and health care providers that adopt and follow the guidelines.

Implications and Impact

The Texas Cardiovascular Health and Wellness Program provided electronic tools for hospitals to use in management of patient data to implement secondary prevention guidelines. This program will report improvement in quality of care among participating hospitals. The state program facilitated the development of the Texas Quality Recognition Program, which recognizes physicians and hospitals for providing quality care, on the basis of nationally recognized standards. Concerned about reaching underserved populations, the Texas Cardiovascular Health and Wellness Program is also collaborating with the Texas Association of Community Health Centers to improve cardiovascular health, especially by controlling high blood pressure among patients in five community health centers.

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Wisconsin

Improving Control of High Blood Pressure Through Partnerships With Health Plans

Producing Results

Among participating health plans, the percentage of patients who had high blood pressure controlled increased by nearly 30 percent from 2000 to 2003.

Public Health Problem

CVD, mainly heart disease and stroke, is the leading cause of death in Wisconsin. In 2001, the estimated annual total cost of CVD in Wisconsin was more than $5.2 billion. According to 2001 data from the Behavioral Risk Factor Surveillance System (BRFSS), 24 percent of people in Wisconsin have high blood pressure, 30 percent have high blood cholesterol, 23 percent are smokers, 58 percent are overweight, and 77 percent are physically inactive. These measures are all risk factors for CVD.

Taking Action

Wisconsin's Cardiovascular Health Program collaborated with a statewide group of HMOs and health systems, as well as other public and private health organizations, to increase the percentage of patients who have high blood pressure controlled. Participating HMOs represented 84 percent of people enrolled in HMOs in the state in 2000 and more than 98 percent of those enrolled in 2001 (nearly 1.5 million people). The Cardiovascular Health Program asked that the 20 participating health plans with commercial enrollees collect data on four measures of cardiovascular health, from the Health Plan Employer Data and Information Set (HEDIS). These data provided a baseline assessment for planning quality-improvement strategies within health plans. High blood pressure was controlled in only 48 percent of the patients in the participating health plans. On the basis of this information, the health plans put into place strategies to improve control of high blood pressure. As a result, by 2003, 62 percent of patients had high blood pressure controlled - a relative increase of nearly 30 percent over 3 years. In the first year alone, high blood pressure control increased by 21 percent. The Cardiovascular Health Program developed an initiative to reducing cardiovascular risk through control of high blood pressure and high blood cholesterol. Tools are being created to help HMOs and other health systems to implement guidelines and improve quality of care.

Implications and Impact

Wisconsin's achievements demonstrate the opportunity for state programs to serve as catalysts for improvements in the health system that lead to prevention of heart disease and stroke. Public health programs accomplish this goal by serving as a neutral entity for convening health system organizations, sharing data on improvement in the quality of care, providing a population-based perspective, and promoting health system changes that lead to better health outcomes and can maximize health care resources.

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Nutrition and Physical Activity

For more information about CDC's nutrition and physical activity program,
visit www.cdc.gov/nccdphp/dnpa

Colorado

Changing the Worksite Environment

Public Health Problem

In Colorado, the obesity rate among adults increased by 141 percent from 1990 to 2002. Today, nearly half of the state's adults are overweight or obese. Efforts to address this issue by promoting healthy eating and physical activity should focus on the environments where people spend a significant amount of their time, such as their places of employment. However, businesses and other organizations have generally lacked both resources and motivation to implement wellness projects themselves.

Taking Action

Colorado's Worksite Resource Kit provides employers with resources to implement worksite wellness initiatives, regardless of the size of the worksite. In developing this kit, the Colorado Physical Activity and Nutrition (COPAN) Program relied on survey data collected from 716 organizations around the state on physical activity, nutrition, and wellness programs available to employees. Divided into four sections - health education, physical activity, healthful eating, and worksite environment - the kit outlines for employers how to plan, assess, and successfully implement physical activity and nutrition interventions, including information on the importance of each step and the availability of additional information resources.

The Worksite Resource Kit Program was launched at the Colorado Worksite Wellness Summit in November 2003. Attendees representing 63 organizations from across the state received a kit and instructions on its use. A number of additional organizations have since received kits. In addition, mini-grant recipients are now implementing programs that include informational health meetings, preventive wellness screenings, healthy cooking demonstrations, and physical activity events. Other recipients have made stairway improvements to encourage walking and now provide private rooms for nursing mothers.

Implications and Impact

Successful nutrition and physical activity outcomes from this program, such as a high level of employee interest and/or satisfaction regarding worksite activities, could result in employees making positive changes in their lives and in those of their families. For their part, employers should increasingly see the kit and other workplace interventions as a way to address the economic cost of overweight and obesity - decreased productivity, increased absenteeism, lower morale, and higher health insurance claims.

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Massachusetts

Improving Children's Nutrition and Physical Activity Choices

Public Health Problem

Nearly a quarter of all high school students in Massachusetts are overweight or at risk of becoming overweight. Through school-based efforts to encourage better nutrition and increased physical activity among younger children, the problem of overweight and the related risk of chronic diseases can be addressed preemptively.

Taking Action

5-2-1 Go! (eat 5 servings of fruits and vegetables daily, limit screen time to no more than 2 hours a day, and get at least 1 hour of physical activity daily) is a school-based overweight prevention initiative in Massachusetts middle schools that aims to improve eating habits, increase physical activity, and decrease sedentary activities like watching TV - all through changes to core curriculum and existing school policies. The program has two main components that work together to make positive changes in both individual behaviors and organizational decision making. The first component is the School Health Index (SHI), a self-assessment and planning guide developed by CDC that involves teachers, parents, students, and the community in evaluating school policies on health and safety, and guides them in developing a plan to improve them. The second component is Planet Health, a curriculum program developed by the Harvard School of Public Health that weaves important health themes into physical education, language arts, math, science, and social studies.

Implications and Impact

Based on the positive response to 5-2-1 Go!, Blue Cross and Blue Shield of Massachusetts (BCBSMA) is offering a number of schools an enhanced version of its Healthy Choices after-school program, which now uses both the SHI and Planet Health, to improve nutrition and physical activity. Additional regional coordinators and an evaluator have been hired, and BCBSMA has awarded mini-grants to schools to support implementation of these enhancements.

In addition, the results of a recent evaluation of 5-2-1 Go! schools will help better target interventions that promote walking to school as a way to increase physical activity. Another evaluation of schools in the program showed that higher rates of vending machine and fast food restaurant use among students are associated with higher sugar-sweetened beverage consumption. These results can bolster the case for providing students with healthier food choices at school.

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Massachusetts

Women Help Each Other Follow a Healthy Path by Joining Social Support Group

Public Health Problem

OIn rural Ware, Massachusetts, women needed help improving their health at a price they could afford. They also needed health advice. The state's Women's Health Network, which offers WISEWOMAN services, created the Women's Health Support Group for network members.

Taking Action

Each month, women attend group meetings for health tips and help in managing blood sugar, blood pressure, and cholesterol. Meetings also offer hands-on activities such as swapping and tasting recipes and cooking healthy meals. Support group members who have weight problems or high blood pressure, cholesterol, or blood sugar levels are referred to the WISWOMAN Program, while WISEWOMAN participants who want additional support are also referred to the support group. The support group makes sure that the interests of the participating women drive the group's agenda. Together, WISEWOMAN and the Women's Health Support Group are helping to ensure that underserved women in Ware get the care and support they need to adopt healthy lifestyles.

Implications and Impact

The Massachusetts Women's Health Support Group is tailored to women's interests and needs and provides women with the tools they need to make healthy changes in their lives. It allows members to be leaders and role models for other women in the community. Many interpersonal benefits have resulted from the Massachusetts Women's Health Support Group. Women are motivated to make healthy changes as they are exposed to other women's success and encouragement. The willingness of members to share and help each other in a peer-led group promotes a setting where women can share. The support group and the Women's Health Network refer women to each other as a way of ensuring that underserved women in Ware can get the care they need to be healthy and fit. Each year, 250 women can be helped through the Women's Health Support Group, which serves Women's Health Network members including WISEWOMAN participants.

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North Carolina

Creating Healthier Child Care Centers

Public Health Problem

More than half of all adults in North Carolina are overweight or obese, and almost one-third of high school students are overweight or at risk of becoming overweight. Making positive changes in nutrition and physical activity behaviors among pre-school-age children is a way to preempt the growth of this epidemic in the state.

Taking Action

The Nutrition and Physical Activity Self-Assessment for Child Care (NAP-SACC) is a pilot intervention in child care centers aimed at improving nutrition and physical activity environments and practices through self-assessment and targeted technical assistance. The intervention, a crucial part of the North Carolina Healthy Weight Initiative and created in partnership with the Center for Health Promotion and Disease Prevention, University of North Carolina at Chapel Hill, was implemented in six counties throughout the state, with two additional counties serving as controls. After completing a self-assessment, the child care center director, with assistance from a Child Care Health Consultant (CCHC), identified at least three areas for improvement. The CCHC and the center worked together over six to nine months to improve and enhance their respective center's environment using a resource manual and continuing education workshops developed by the NAP-SACC team. Three 30-minute workshops were developed by NAP-SACC that covered childhood overweight, healthy eating, and physical activity. Then, both quantitative and qualitative evaluations were performed to gauge the effectiveness of the NAP-SACC intervention.

After the centers assessed their nutrition and physical activity environments, technical assistance was provided on ways to make positive improvements, such as enhanced access to physical activity through purchase of additional equipment or creation of additional indoor/outdoor play space. With regards to nutrition, these improvements included activities such as increasing the availability of fruit and vegetables, reducing use of fried foods, reducing use of sugar-sweetened beverages, and introducing overall nutrition polices in individual centers.

Implications and Impact

The NAP-SACC workshops were attended by 122 staff members from centers in six counties. An evaluation of the pilot concluded that NAP-SACC helps child care centers improve their nutrition and physical activity environments and policies, as demonstrated through the NAP-SACC self-assessment data as well as an analysis of interview and focus group data. The evaluation also suggested that nutrition and physical activity interventions benefit from parental involvement and linguistic inclusiveness.

Based on progress made through NAP-SACC, there are plans to establish the intervention in child care centers throughout the state, develop a large-scale evaluation of NAP-SACC to assess child-specific changes in behavior as a result of the project, and develop a similar project targeting infants.

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North Carolina

Healthwise Partnership Promotes Physical Activity for WISEWOMAN Participants in Winston-Salem

Public Health Problem

In many communities, underserved, at-risk women may not have opportunities to be physically active because of cost and access barriers to physical activity programs or facilities.

Taking Action

The Healthwise program, funded by the Kate B. Reynolds Charitable Trust and the WISEWOMAN Program, provides health education, counseling, and referrals to at-risk WISEWOMAN clients. As part of their counseling, clients are encouraged to become more physically active. Community partners collaborated to offer Young Women's Christian Association (YWCA) scholarships to help women in need become more physically active. The scholarships allow women to purchase membership at a substantially reduced cost. Participants may purchase a one-month membership for $5 versus the regular $30 cost. Scholarships are incentives that encourage WISEWOMAN participants to engage in physical activity, and they recruit women into the program.

WISEWOMAN clients have their blood pressure and cholesterol levels checked at the Forsyth County Department of Public Health. Women receive counseling about healthy diets, physical activity, smoking cessation, and stress management. An individualized physical activity plan is developed for each client by the Healthwise program coordinator. After clients answer health questions and obtain physician approval to participate in the physical activity programs, YWCA scholarships can be offered.

Women who receive YWCA scholarships must attend an orientation to learn about the exercise equipment or attend classes at the YWCA. At a minimum, participants are required to engage in physical activity at least twice a week for a six-month period. The Healthwise coordinator monitors attendance and provides feedback and motivation for women at follow-up visits. WISEWOMAN offers ongoing support and motivation and fosters a supportive environment among participants.

Implications and Impact

Through access to Healthwise and the YWCA, WISEWOMAN clients have opportunities to become more physically active, lose weight, increase their stamina, and better control their blood pressure and cholesterol levels. The program has removed cost and access barriers that were preventing underserved women in the community from being physically active. This outreach strategy has attracted more women to the WISEWOMAN Program. At the organizational level, partnerships were formed with other agencies and increased the chances that these services will be sustained in the community.

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Pennsylvania

Involving the Community in Reducing Overweight

Public Health Problem

A 2002 study conducted by the Pennsylvania Department of Health showed that 35 percent of a large statewide sample of eighth graders were at risk for being overweight or already were overweight. Recognizing that a significant percentage of students could be at risk for heart disease, diabetes, and other chronic conditions associated with overweight, the Pennsylvania Department of Health decided to update its longstanding growth screening program to more effectively measure students' growth patterns and their risk for overweight.

Taking Action

In fall 2003, the Department of Health conducted a pilot of this updated growth screening program in 10 public and private schools, based on anthropometric measurements collected by school nurses using CDC's 2000 growth reference. These pilot schools represented urban, suburban, and rural districts as well as various grade and enrollment levels. Each school nurse used an updated program manual and one of three tools to determine BMI: 1) a table from CDC (Calculated BMI Values for Selected Heights and Weights for Ages 2 to 20 Years), 2) a BMI wheel, or 3) one of two computer programs including NutStat, a part of the Epi Info public-domain software package. Newly revised gender-appropriate growth charts from CDC were provided for plotting BMI-for-age percentiles. Nurses also received a sample letter they could use to inform parents of screening results.

During the pilot, department staff visited participating schools to observe school staff who were obtaining height and weight measurements, determining BMI, and plotting BMI-for-age percentiles. Department staff also provided technical assistance and verified the accuracy of measurements and calculations.

Implications and Impact

The pilot screening program found that 38 percent of students tested were overweight or at risk of becoming overweight, which confirmed that overweight is a serious problem for the school-age population. In September 2004, the Department of Health announced that the revised growth-screening program would be implemented statewide. The revised procedures are voluntary for school year 2004-2005. Mandatory implementation will begin in 2005-2006 for grades K-4 and will expand to three additional grades each year until all 12 grades are included. Each school district and charter school will receive materials that provide guidance on proper height and weight measurement, calculation and plotting of BMI, and how to notify parents or guardians of screening results. This new screening procedure will help educate children and their parents about the risks of being overweight and bolster other initiatives promoting active lifestyles and healthy food choices.

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Washington

Building a Healthy, Active Community

Public Health Problem

Between 1990 and 2002, the obesity rate among adults in Washington State increased by 127 percent. Today, nearly three out of every five state residents is overweight or obese. Improved eating habits and increased physical activity are keys to reversing this trend, but in communities throughout the state, numerous barriers exist to making these healthful changes.

In Moses Lake, a small, central Washington city, there is a need for better access to healthy foods at home, at school, and in the workplace. In addition, Moses Lake, like other communities, needs additional resources to make physical activity safe and accessible for all its residents.

Taking Action

A series of interventions in Moses Lake, known collectively as Healthy Communities Moses Lake, encourages good nutrition and physical activity behaviors through environmental and policy change. Both Moses Lake and Grant County, where Moses Lake resides, have adopted an overall Healthy Communities action plan. Specifically, the city has adopted a master plan to replace a railroad that runs through the downtown area with a path for biking and walking. The county adopted a plan for creating walking and biking trails alongside irrigation canals. New zoning ordinances in both the city and county require wider sidewalks that will increase accessibility for pedestrians and cyclists.

The city has incorporated the community garden project into its parks and recreation department work plan. The project is building capacity through integration with county nutrition activities and youth wellness team projects in the community as well as the development of a community-based oversight and planning group for the garden. The garden project has forged links with local school groups and chefs to make the garden both a food source and educational tool for the community.

In addition, to encourage good nutrition from birth, Healthy Communities aims to inform residents about proper breastfeeding practices as well as create supportive environments for nursing mothers throughout the community. Planned activities include meeting with local business representatives to discuss breastfeeding policies in the workplace, daycare provider workshops and continued educational forums, and various community advertising and promotion efforts.

Implications and Impact

As a result of the positive steps Moses Lake is taking with regard to community nutrition and physical activity, the City of Mount Vernon has adopted a Healthy Communities action plan of its own as part of the City's comprehensive plan.

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Oral Health

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Arkansas

Preventing Tooth Decay by Strengthening the Community Water Fluoridation Program

Public Health Problem

Dental caries (i.e., tooth decay) is a multi-factor disease that affects 50 percent of children aged 5-9 years, 67 percent of adolescents aged 12-17 years, and 94 percent of adults aged >18 years in the United States. During the second half of the 20th century, a major decline in the prevalence and severity of dental caries resulted from the use of fluoride to prevent caries. Fluoridation of the public water supply is the most equitable, cost-effective, and cost-saving method of delivering fluoride to a community. In 2002, approximately 170 million persons in the United States (67 percent of the population served by public water systems) received optimally fluoridated water.

Water fluoridation, which is adjusting the natural fluoride level in drinking water to the right level to prevent tooth decay, has been shown to be effective both in adults and children. In 2001, two major reports reaffirmed the effectiveness of water fluoridation. The U.S. Task Force on Community Preventive Services reviewed the scientific evidence of effectiveness and issued a strong recommendation for water fluoridation. Another work group of fluoride experts convened by CDC concluded that water fluoridation be continued and extended to additional communities.

Taking Action

Arkansas has made significant progress in advancing community water fluoridation with a cooperative agreement from CDC. In 1999, prior to receiving CDC support, Arkansas had a one-person state oral health program, and only 49 percent of the state's population was receiving the benefits of water fluoridation. The state lacked the resources to regularly monitor fluoridation systems at the state level and provided limited community water fluoridation training, promotion, and education. With the help of the CDC funding, Arkansas now monitors its fluoridation systems monthly using the Water Fluoridation Reporting System (WFRS) and has improved coordination within state government. Training is being provided to water plant operators, and a state-wide community educational campaign on water fluoridation has been launched. Called "Got teeth? Get fluoride!" the campaign was developed to encourage additional communities to consider implementing water fluoridation. Through these efforts, 62 percent of the Arkansas population on community water systems now receive the benefits of community water fluoridation. Arkansas, through CDC funding, also is strengthening its capacity to monitor oral diseases, develop and implement a state oral health plan, and develop additional collaborative partnerships through an oral health coalition.

Implications and Impact

Water fluoridation is the most cost-effective way to use fluoride to protect populations from dental decay. This program demonstrates the importance of increasing access to fluoridated water as an effective means of decreasing tooth decay and its related pain and suffering, costs for treatment, and lost school and work days.

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Nevada

Reaching Children Through School-based Dental Sealant Programs to Prevent Tooth Decay

Public Health Problem

Tooth decay (cavities) has declined dramatically among school-aged children due to preventive strategies such as community water fluoridation and use of fluoride toothpastes and mouth rinses. Despite these gains, tooth decay remains a significant problem with disparities noted for poor children and those of some racial and ethnic groups. In the United States, 52 percent of children between the ages of 5 and 9 have had a cavity. Only 23 percent of all 8-year-olds in the United States have at least one dental sealant, and only 3 percent of 8-year-olds racial minorities living in poverty have a dental sealant.

Dental sealants, a plastic coating placed in the pits and grooves of molar teeth, have been proven to prevent dental cavities on these chewing surfaces. The U.S. Task Force on Community Preventive Services has reviewed the scientific evidence of effectiveness of school-based and -linked dental sealant programs, which demonstrates a reduction in dental cavities of 60 percent. The Task Force issued a strong recommendation for school-based sealant delivery programs.

Taking Action

Nevada has made significant progress in implementing school-based/-linked dental sealant programs. With a cooperative agreement from CDC, Nevada has funded vital state oral health program infrastructure, including a state sealant program coordinator and state oral health program manager. In one effort, the state has targeted dental sealant programs to schools in low-income areas. It identified 128 of 321 elementary schools statewide as eligible; 29 percent of the eligible schools now have a school-based or school-linked sealant program. During the 2003-2004 school year, 3,677 sealants were provided for 1,211 second grade schoolchildren.

A major milestone was recently reached by the Oral Health Program in developing and signing a Memorandum of Understanding with the Clark County School District to implement a school-based dental sealant program (60 percent of the eligible schools and 70 percent of Nevada's population are located in Clark County).

Implications and Impact

The agreement opens the path for establishing new sealant programs in Clark county soon. Included in the Clark County partnership is the new University of Las Vegas School of Dental Medicine. Capitalizing on this increase in infrastructure, Nevada also is strengthening its capacity to monitor oral disease, plan and evaluate state programs, extend water fluoridation, and strengthen its coalitions and partnerships.

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Prevention Research Centers

For more information about CDC's Prevention Research Centers program,
visit www.cdc.gov/prc

Massachusetts

Curriculum for Schools to Reduce Prevalence of Obesity

Public Health Problem

Between 1980 and 1999, the prevalence of overweight nearly tripled (from 5% to 14%) among adolescents and nearly doubled (from 7% to 13%) in children 6-11 years of age. This finding forecasts an increase in chronic disease as the younger generation ages. Root causes include insufficient physical activity in relation to excess calories consumed.

Taking Action

The Harvard University Prevention Research Center (PRC) developed Planet Health, an interdisciplinary curriculum created to improve the health and well-being of students in public middle schools. The curriculum was designed to fit easily into language, math, science, social studies, and physical education classes. The goals were to increase consumption of fruits and vegetables and physical activity, and decrease consumption of high-fat foods and television viewing.

The Planet Health program was initially implemented in 10 public middle schools over a two year period. Boston Public Schools (BPS) expressed interest in disseminating Planet Health after the program was found to significantly reduce television viewing for both girls and boys, and significantly decrease the prevalence of obesity among girls. A partnership was formed to pilot test how feasible and sustainable the curriculum could be in public school settings where resources are constrained. The BPS selected a sample of six inner-city middle schools to participate, while the PRC provided the Planet Health curriculum, training workshops for more than 100 teachers, small stipends for teacher coordinators within each of the participating schools, and research expertise to assess diffusion of the program.

Implications and Impact

The Planet Health curriculum succeeded in significantly reducing television viewing for both boys and girls, and significantly decreasing the prevalence of obesity for girls. The Planet Health curriculum is now used in hundreds of middle schools in the Boston area, and 2,000 copies of the curriculum have been purchased by interested parties in 48 states and 20 countries. An independent economic analysis found that every dollar spent on the program in middle school translates to a savings of $1.20 in medical costs and lost wages when the children reach middle age.

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http://www.cdc.gov/nccdphp/exemplary

New York

Asthma Intervention for Children in Central Harlem

Public Health Problem

Asthma prevalence and mortality have been increasing in the United States, but the causes are not completely understood. Some asthma risk factors are known or suspected to be more prevalent in poor, urban communities, where low-quality housing, roach infestation, tobacco smoke exposure, and other conditions contribute to a high asthma burden.

Taking Action

In 2001, the Department of Pediatrics at Harlem Hospital Center partnered with The Harlem Children's Zone, Inc. (HCZ) to reduce the burden of asthma on children and their families in central Harlem. Columbia University's Prevention Research Center collaborated with these partners in conducting a comprehensive and rigorous evaluation of the project's impact.

First, a group of children who had the greatest number of recent asthma symptoms was chosen to enroll in the intervention. Participants received medical, legal, social, educational, and environmental services from a multi-disciplinary team over an 18-month period. Results of the study showed substantial and significant improvements among the participants: school absenteeism decreased by more than half, with a decrease from 23% to 8% due to asthma in particular; a 27% reduction in emergency room and unscheduled physician visits, as well as a nearly 9% reduction in hospitalizations were observed; and use of effective asthma management strategies, such as use of daily preventive medicine and development of an asthma management plan, significantly increased. These results strongly suggest that the program is effective in improving asthma management among children enrolled in the project.

Implications and Impact

Plans are underway to expand the program to all children with asthma identified through asthma screening efforts, and the scope of services offered will be expanded by engaging additional agencies such as the New York City Department of Health and Mental Hygiene, the New York City Department of Education, and the New York City Health and Hospitals Corporation.

Contact Information

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Improved Physical Activity and Diet in Elementary School Children

Public Health Problem

Over the past two decades, childhood overweight has steadily increased, and the increase in childhood diabetes has become alarming. These changes have highlighted the importance of developing and disseminating effective programs to increase physical activity and improve diet among children and to coordinate health messages in schools and communities.

Taking Action

Under the auspices of the National Institutes of Health, researchers at the University of Texas Health Science Center, in collaboration with experts from Tulane University, the University of California at San Diego, and the University of Minnesota, developed the Coordinated Approach to Child Health (CATCH), an interdisciplinary program for elementary schools. CATCH is designed to improve environmental influences to support behavior change. The program emphasizes decreasing consumption of high-fat foods and increasing physical activity both inside and outside of school.

With support from CDC, the Prevention Research Center at the University of Texas Health Science Center at Houston sought to disseminate, implement, and institutionalize CATCH in elementary schools. Partnerships to disseminate CATCH included the Texas Department of Health; Texas Education Agency; Paso del Norte Health Foundation; National Heart, Lung, and Blood Institute; American Heart Association; Texas Medical Association; Bexar County Community Health Collaborative; and other organizations.

Initial implementation of CATCH resulted in a 10% increase in the time that participating children spent engaged in moderate to vigorous physical activity within physical education classes, as well as a significant decrease in fat consumption in school meals. A follow-up study indicated a persistent increase in physical activity and reduction in fat intake over the next three years without additional intervention.

Implications and Impact

In Texas alone, more than 1,500 elementary schools (approximately one-third of all schools) have adopted CATCH, thereby potentially reaching more than 750,000 school children. Schools in Illinois, Maine, Florida, Georgia, North Dakota, North Carolina, and New Mexico also have begun to use the program. The U.S. Department of Defense uses it in 320 of its overseas elementary schools.
In seven years, LFP progressed from implementation at one site to 64 community sites (49 in Washington alone), and the program currently has 2,550 seniors enrolled in six states. The National Council on Aging recognizes the program as one of the top 10 physical activity programs for U.S. seniors.

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Washington

Successful Physical Activity Program for Older Adults

Public Health Problem

About 12 million older adults living at home have chronic conditions and report limited ability to perform daily activities. Physical limitations, which are associated with insufficient physical activity and overweight, decrease quality of life, increase the need for costly long-term care, and make challenging demands on family members and other caregivers.

Taking Action

The University of Washington's Health Promotion Research Center focuses on healthy aging. In 1993, the center collaborated with the Group Health Cooperative of Puget Sound and Senior Services of Seattle/King County (SSSKC) to develop the Lifetime Fitness Program (LFP), a physical activity program that consists of exercises developed specifically for older adults. These exercises have been packaged into a program that emphasizes four key areas critical to the health and fitness of seniors: stretching and flexibility; low-impact aerobics; strength training; and balance. One-hour classes that meet three times a week are designed to be supportive and socially stimulating. Many senior participants enter the program for the social stimulation as much as for the physical benefits.

In 1998, Group Health Cooperative, a large Seattle-based Health Maintenance Organization, began offering participation in the program as a benefit to all its Medicare enrollees. SSSKC obtained funding from the local Area Agency on Aging to make the program available to community-dwelling seniors via senior centers.

Implications and Impact

The pilot study showed that LFP participants improved significantly in almost every area tested, from physical and social functioning to levels of pain and depression. The health care costs of participants who attended the program at least once a week were significantly reduced. A recent economic analysis of Medicare enrollees showed that those participating in LFP at least once per week had significantly fewer hospitalizations (by 7.9%) and lower health care costs (by $1,057) than nonparticipants.

In seven years, LFP progressed from implementation at one site to 64 community sites (49 in Washington alone), and the program currently has 2,550 seniors enrolled in six states. The National Council on Aging recognizes the program as one of the top 10 physical activity programs for U.S. seniors.

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West Virginia

Successful Program for Teenagers to Quit Smoking

Public Health Problem

Every year, more than 400,000 people die prematurely from diseases caused by smoking or other forms of tobacco use. Approximately 80% of adult smokers started smoking before age 18, and nearly 70% of adult smokers want to stop smoking but need help to quit permanently.

Taking Action

The American Lung Association's (ALA) quit smoking program for teens, Not on Tobacco (NOT), was proven successful for students in urban schools. It had not been tested in rural areas until West Virginia University's Prevention Research Center completed a 5-year project to test NOT among teens in rural Appalachian schools.

While evaluating the program's effectiveness, the researchers explored the relationship between smoking and mental health among adolescents. The NOT Program engaged teens in group sessions led by trained facilitators during school hours. More than 250 participating students learned techniques to reduce stress, handle peer pressure, control nicotine cravings, eat well, and engage in regular exercise. After three months, the quit rate of smoking was almost four times higher for students in the program than for those who were not.

Implications and Impact

Based on these positive results, many participating schools are maintaining the program. The ALA is also expanding the program to other schools in Appalachian states. NOT is now used in 47 states, and nearly 33,000 teens participated in NOT from 1999 through 2003. Furthermore, the University of North Carolina's Center for Health Promotion and Disease Prevention is collaborating with its West Virginia colleagues on similar projects with American Indian communities in North Carolina, where smoking rates are among the highest in the nation. The program recently received nationwide recognition when the Substance Abuse and Mental Health Services Administration (SAMHSA) designated it a “model program.” SAMHSA will now support the provision of “materials, training, and technical assistance for nationwide implementation” of the program.

Contact Information

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REACH

Racial and Ethnic Approaches to Community Health

For more information about CDC's REACH program,
www.cdc.gov/reach2010

Removal of Barriers to Increase Cervical Cancer Screening Among Vietnamese-American Women

Public Health Problem

Vietnamese-American women have the highest incidence of cervical cancer of any ethnic group in the United States: 43 cases per 100,000, which is five times as high as rates among non-Latina whites. In addition, cervical cancer is the second most common cancer among Vietnamese-American women. More than 25 percent of Vietnamese-American women living in Santa Clara County, California, reported in 2000 that they had never had a Pap test - a much higher percentage than the 5 percent reported for all women in the United States.

Taking Action

The Vietnamese Community Health Promotion Project organized the Vietnamese REACH for Health Initiative Coalition to prevent cervical cancer among Vietnamese-American women in Santa Clara County. The coalition has held community forums, meetings, and retreats to develop an action plan. Community members identified multiple barriers to Pap testing, including lack of information, concerns resulting from traditional beliefs, and absence of culturally and linguistically appropriate screening services that are affordable. To address these barriers, the coalition developed and launched a community action plan to promote Pap screening by creating change among community leaders, the health care system, Vietnamese-American medical providers, and Vietnamese-American families. The coalition's integrated strategy uses six approaches: 1) Media education campaign. 2) Outreach efforts by lay health workers. 3) Help to patients for navigating through the health care system and a low-cost Vietnamese-language clinic for Pap test screening that is staffed by a female Vietnamese-American physician. 4) Continuing medical education. 5) Mailed reminders. 6) Advocacy to reestablish a breast and cervical cancer control program in the county.

Implications and Impact

Preliminary results from the outreach efforts show that 46.8 percent of Vietnamese-American women who had never had a Pap test had the test after meeting with lay health workers. Overall, in this community, the percentage of Vietnamese-American women receiving Pap tests increased by 15 percent. The “patient navigator” received calls from more than 1,214 Vietnamese-American women seeking information and assistance. As a result, 724 women registered to receive a Pap test. In addition, 50 Vietnamese-American physicians have been educated about cervical cancer screening, diagnosis, and treatment, and 29 physicians have registered 4,187 women in a reminder system. A cancer information Web site established for this program has received more than 1,200 visitors and 10,600 hits per month. Moreover, the Breast and Cervical Cancer Control Program has been reestablished in Santa Clara County with two clinics and three health care providers.

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Massachusetts

Achievement of Critical Health Outcomes by Culturally Tailored Prevention and Control Strategies for Diabetes in Latinos

Public Health Problem

The prevalence of diabetes in Latinos in Massachusetts is almost 1.5 times that of whites in the state. The Greater Lawrence Family Health Center reported that for Latino patients, disparities in diabetes prevalence largely occurred among Puerto Ricans and Dominicans. The prevalence of diabetes was 13.7 percent among Puerto Ricans and 9.1 percent among Dominicans as compared with 5 percent among other Latinos (similar to that for the general population in Lawrence).

Taking Action

The REACH 2010 Latino Health Project's Community Action Plan acted to address the high prevalence of diabetes among these two groups. Action included both community-based strategies to educate people about diabetes control and changes to the Greater Lawrence Family Health Center that improved the access of these patients to primary care. Culturally tailored prevention strategies included: intergenerational exercise through the YWCA; media outreach; church involvement; education about children's diabetes through the Lawrence Teen Coalition, Boys and Girls Clubs, and Family Services, Inc.; nutrition education and modeling through the Lawrence Senior Center, Merrimack Valley Nutrition Project, and Home Health Visiting Nurses' Association (VNA); and culturally tailored empowerment groups.

Implications and Impact

Preliminary data from Latino community residents with diabetes who are patients of the Greater Lawrence Family Health Center show dramatic improvements in control of high blood glucose and high blood pressure control between 2001 and 2003. Hemoglobin A1c (blood sugar) measures below 7.0 improved 8.7 percent (from 20.7 percent to 22.5 percent); systolic blood pressure below 130 mm Hg improved by 17.5 percent (from 53.6 percent to 63 percent); and diastolic blood pressure below 80 mm Hg improved 14.4 percent (from 69.6 percent to 79.6 percent).

Several measures of care also improved substantially from 2001 to 2003. Percent of patients referred for eye exams increased from 50.6 percent to 64 percent (a relative increase of 26.5 percent); percent receiving a microalbumin screen increased from 46.1 percent to 69.7 percent (a relative increase of 51.2 percent); percent for which aspirin was prescribed increased from 50.6 percent to 62.9 percent (a relative increase of 24 percent); percent whose smoking status was reviewed increased from 27 percent to 66.3 percent (a relative increase of 145.5 percent); and percent whose activity status was ascertained increased from 42.7 percent to 74.2 percent (a relative increase of 73.8 percent).

Contact Information

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Massachusetts

Increasing Knowledge of HIV Prevention Among Haitians

Public Health Problem

Haitians bear a disproportionate burden of acquired immunodeficiency syndrome (AIDS) in Massachusetts and account for 18 percent of all pediatric AIDS cases. The percentage of reported AIDS cases in Massachusetts among Haitians is 6 times the proportion of Haitians in the state. The proportion of women among Haitians with AIDS is very high compared with the proportion of women in the general population of Massachusetts. Among persons who had AIDS in Massachusetts as of September 1999, 13 percent were born outside the United States and 75 percent were born in Haiti.

Taking Action

To meet the challenges of this public health crisis, the Boston REACH coalition implemented a community action plan to address prevention of human immunodeficiency virus (HIV) among Haitians in Boston. Central actions included: interventions targeted to small groups, with specialized workshops reaching Haitian men, women, youth, couples, those with HIV, and new immigrants; a media campaign with dissemination of culturally and linguistically appropriate messages about HIV through Haitian radio and print; training and technical assistance for coalition partners to provide Haitian health professionals with the tools to effectively serve their constituents and to build the capacity of small Haitian community-based organizations in the metropolitan Boston area; and training on Haitian culture and health beliefs for non-Haitian health care providers serving Haitians.

Haitian faith leaders and media leaders were identified by the community as playing an important role in the lives of Haitians. These potential "agents of change" are, for the first time, becoming engaged in HIV prevention activities in their community.

Implications and Impact

Early outcomes show an increase in knowledge and awareness of modes of HIV/AIDS transmission and of self-protective behaviors to prevent HIV transmission across all targeted groups. The coalition also has made significant progress in creating an environment for dialogue and in assessing shortcomings in the fight against HIV.

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African American Health Coalition

Public Health Problem

Death rates for cardiovascular disease among African Americans living in Oregon are alarmingly high, considering the small size of the population. In Oregon, the average 10-year, age-adjusted rate for stroke mortality is 59.3 percent among African Americans and 29 percent among whites. This finding translates to a 51 percent higher chance of a stroke for African Americans than for whites. Similarly, the compressed 10-year mortality rate for cardiovascular disease among African Americans in Oregon is 121.8 percent compared with 89 percent among whites. The gap between mortality from cardiovascular disease among African Americans and among whites is 26 percent in Oregon compared with 10 percent nationally. Reducing risk factors for cardiovascular disease (smoking, physical inactivity, poor nutrition, diabetes and obesity) can improve health and quality of life, and reduce healthcare costs.

Taking Action

Oregon's African American Health Coalition, Inc. (AAHC) implemented a variety of community-based strategies to address the root causes of the gap in mortality between cardiovascular disease among African Americans and whites. The program "Lookin' Tight, Livin' Right" uses existing relationships between beauty shop and barbershop operators and their clients to promote healthy behaviors. An intervention for youth, HOLLA!, partners with local high schools and trains students to educate their peers about cardiovascular disease and its risk factors. To reach low-income African Americans enrolled in the Oregon Medicaid program, another intervention uses educational mailings designed to raise awareness and increase use of preventive services. The Coalition's Wellness Within REACH (WWR) program consists of free physical activity classes centered on the African American community to open access by increasing the affordability, availability, and comfort level of leading an active lifestyle.

Implications and Impact

Of participants in the Wellness Within REACH program, 58 percent reported exercising more than they had 6 months previously. This program has become a "movement" in the local community, changing the community's norm toward physical activity. In September 2003, AAHC launched its first annual Wellness Within REACH Walk to celebrate the community's health and raise funds to sustain WWR classes. The event drew more than 500 participants and illustrates the community's support for AAHC's community-based, innovative REACH programs.

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South Carolina

Improved Diabetes Care and Control for African Americans

Public Health Problem

African Americans in South Carolina have a greater risk than whites for developing diabetes. African Americans also have a greater risk for diabetes complications, such as heart disease, stroke, blindness, renal failure, and amputation. Diabetes is the sixth leading cause of death in South Carolina, claiming more than 1,600 lives each year. One of every seven patients in a South Carolina hospital has diabetes. The American Diabetes Association reports that the average expenditure for diabetes in 2002 was $13,243 for each person who had diabetes, compared with $2,560 for each person who did not have diabetes.

Taking Action

The goal of the REACH 2010 Charleston and Georgetown Diabetes Coalition is to improve diabetes care and control for more than 12,000 African Americans with diabetes. The Diabetes Initiative of South Carolina and more than 40 partner organizations are supporting the coalition as it develops and carries out a comprehensive community action plan to reach out to African Americans where they live, worship, work, play, and seek health care. The plan aims to decrease the tremendous burden of diabetes and link people with needed services. Strategies include establishing walk-and-talk groups, providing diabetes medicines and supplies, and creating learning environments where health professionals and people with diabetes learn together. In addition, the plan calls for establishing library learning and resources, offering advice on how to buy and prepare healthier foods, and improving the quality of diabetes care.

Implications and Impact

Just 2 years after the program began, African Americans in Charlestown and Georgetown, South Carolina, are more physically active, are being offered healthier foods at group activities, and are getting better diabetes care and control. In addition, some disparities have been greatly reduced for African Americans with diagnosed diabetes. For example, more African Americans are having the recommended annual tests to determine their hemoglobin A1c (blood sugar) level, lipid profile, kidney function, as well as referral for eye examination using dilation, and measurement of blood pressure. A 21 percent disparity in hemoglobin A1c (blood sugar) testing between African Americans and whites has been virtually eliminated. The coalition's goal is to eliminate all disparities in diabetes care and control by 2007.

Contact Information

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Tobacco

For more information about CDC's tobacco program,
visit www.cdc.gov/tobacco

Illinois

An Innovative Approach to Reducing Smoking on College Campuses

Public Health Problem

Tobacco use is a significant problem on college campuses and consequently impacts young adult initiation and use. College is a time in a young person's life that is crucial to whether or not tobacco use becomes an established behavior or is abandoned. College campuses provide an opportune setting for interventions that help young adults make healthful decisions about tobacco use. Among college-age students surveyed at Southern Illinois University at Carbondale (SIU-C), an estimated 35.6 percent of males and 35.3 percent of females were current cigarette smokers.

Taking Action

Over the past few years, the Illinois Department of Public Health has used CDC and state Master Settlement Agreement funding to fund the Live Free! Tobacco Free college campus project developed at SIU-C. The Live Free! project involves engaging college students in comprehensive initiatives to establish smoke-free campuses and to develop and implement tobacco prevention and education strategies. The campus-wide collaboration at SIU-C to develop a comprehensive strategy for combating tobacco use in higher education began in spring 2001. CDC worked closely with the program to ensure that it incorporated a comprehensive approach in the intervention. CDC provided statewide training on the Guide to Community Preventive Services recommendations, and also included a review of the Guidelines for School Health Programs to Prevent Tobacco Use and Addiction. These documents will serve as resources to guide their multi-component initiative. The project was developed as a model that may be adopted by other universities in the state of Illinois and beyond. A full media campaign was initiated in 2002, including print, radio, and Web components. In spring 2003, an advocacy campaign was added to capitalize on the student support of campus policies that support a healthy environment in which students learn and live. A Web site was created to encourage advocacy, provide information, and link the university community to available cessation options.

Implications and Impact

Beginning with the 2004 fall semester, smoking is not permitted within 25 feet of entrances to all university buildings and is not allowed in any of the residence halls at SIU-C. Simultaneously, the student center stopped selling tobacco products. Cessation services are now offered to students through SIU-C student health programs and dental care providers and through the community. To date, seven state universities have expressed interest in Live Free! training, and project staff are collaborating with the Illinois Lung Association of Metropolitan Chicago as well as the Cook County Health Department to offer the training to suburban Chicago junior colleges. Live Free! project staff completed development of a tobacco prevention and control curriculum for university-level health education classes.

Contact Information

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New York

Evaluating the Impact of Clean Indoor Air Laws

Public Health Problem

Secondhand smoke exposure poses serious health risks to nonsmokers. Recent studies suggest that even short-term exposures, such as those experienced by patrons in restaurants or bars that allow smoking, may increase the risk of a heart attack. Studies have found that restaurant and bar workers are less likely than other workers to be protected by smoke-free workplace policies and more likely to be exposed to high levels of secondhand smoke on the job. The Surgeon General has concluded that smoke-free policies are the most effective method for reducing secondhand smoke exposure. A Healthy People 2010 objective calls for the adoption of state clean indoor laws in workplaces and public places.

Taking Action

In 2003, both the state and the city of New York implemented comprehensive clean indoor air laws, making most enclosed workplaces and public places, including restaurants and bars, smoke free. Both the state and the city have conducted thorough, systematic evaluations of the impact of these laws.

The evaluations found that both the state and city laws are highly popular; that most restaurants, bars, and other workplaces are complying with their provisions; that air quality in hospitality venues has improved substantially since the laws took effect; and that worker secondhand smoke exposure has fallen sharply. The findings regarding improved air quality and reduced secondhand smoke exposure would be expected to translate into reduced rates of health conditions associated with this exposure. New York City has reported a sharp reduction in adult smoking prevalence since its law took effect, although other factors, including an increase in the cigarette excise tax, a media/public education campaign, and cessation initiatives, likely also contributed to this outcome. Finally, the evaluations have found that the laws have not harmed restaurant and bar business, as measured by business tax receipts, employment, and the number of liquor licenses issued. A recent study in MMWR reported that the level of particulate matter fell sharply in a number of hospitality venues in western New York after the state law was implemented.

Implications and Impact

The findings of these evaluations add to the evidence that smoke-free policies in workplaces and public places protect nonsmoking employees and patrons from the health risks posed by secondhand smoke without causing a decline in restaurant and bar business. CDC provided technical assistance to the New York state program as it planned its evaluation and worked with the program to disseminate its evaluation methods and findings. The extensive range of approaches being used to assess the impact of these laws provides a menu for other states and communities.

Contact Information

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Utah

A Collaborative Approach to Comprehensive Tobacco Use Prevention and Control Programs

Public Health Problem

The cultural and religious climate of Utah is very supportive of tobacco control. This coupled with a comprehensive tobacco control program has made Utah the first state in the country to meet the national Healthy People 2010 goal of decreasing adult smoking to less than 12 percent of the population. However, Utah residents with low incomes and fewer years of formal education continue to have significantly higher rates of tobacco use compared to the general population, as do Hispanic men, African Americans, American Indians, and Pacific Islanders. A broad-based, long-term commitment to tobacco control is necessary to ensure that these populations fully share in the health benefits that Utah is reaping from a decline in tobacco use, and to sustain that decline over time.

Taking Action

The Utah Tobacco Prevention and Control Program is relatively well-funded by the standard of other states. According to the Campaign for Tobacco-Free Kids, it is allocating $7 million to tobacco control activities in Fiscal Year 2005, just under half the minimum funding level recommended in CDC's Best Practices for Comprehensive Tobacco Control Programs. This ranks Utah 14th among states in this regard, according to the Campaign.

The Program is implementing sophisticated cessation initiatives, including a state quit line and a media campaign that promotes this service; efforts to increase insurance coverage and reimbursement for effective cessation treatment services; and partnerships with a number of public and private sector organizations, including organizations that are in a position to increase the access that underserved population groups such as Medicaid clients have to cessation services. The Program has also developed an innovative media campaign that uses a variety of channels to communicate key messages on several different tobacco topics to a range of audiences.

Implications and Impact

According to BRFSS data for 2002, Utah has the lowest rate of any state for overall adult prevalence (12.7 percent), prevalence among men (14.2 percent), and prevalence among women (11.3 percent), and the highest proportion of everyday smokers who had tried to quit in the past year (66.2 percent). The efforts of the Tobacco Prevention and Control program toward implementing science-based, policy-focused strategies to reach culturally diverse communities have begun to show results. These efforts reached more than 2,000 individuals. Additionally, the Tobacco Prevention and Control Program has partnered with Medicaid and the Association for Utah Community Health to offer enhanced cessation services and medications to more than 2,400 uninsured or Medicaid-insured individuals.

Contact Information

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Washington, D.C.

Developing and Implementing a Strategic Plan for Identifying and Eliminating Tobacco-Related Health Disparities

Public Health Problem

Washington state Behavioral Risk Factor Surveillance Study (BRFSS) data reveal that cigarette smoking rates in various racial/ethnic populations are significantly higher than the state average. Estimates are also higher among low-socioeconomic populations, in rural communities, and for certain other groups. These groups have poor access to health care and other resources.

Taking Action

Using state and CDC funding, the Washington State Department of Health convened an advisory committee called the Cross Cultural Workgroup on Tobacco. This committee comprises community-based organizations from diverse communities who came together to develop a statewide strategic plan to identify and address tobacco-related health disparities. The planning was supported through technical assistance and training from OSH. The plan has resulted in the implementation of several significant activities.

Basic and advanced cultural competency training is now required of all tobacco prevention and control program community contractors in 2005, and "cultural competency" has been added as a guiding principle for the overall tobacco prevention and control program to ensure that programs address the needs of priority communities. Funds totaling $1 million were allocated to five minority communities, including African- American, Asian-American/Pacific Islander, Hispanic/Latino, urban Indian, and lesbian/gay/bisexual/transgender communities. The funds will enable these communities to plan, implement, and evaluate culturally appropriate activities for each community.

Training has been provided to Washington's Medical Support Services and Women Infants and Children staff statewide in support of an intervention to increase cessation among poor pregnant women. Funding has been increased to support 27 of 29 federally recognized tribes across the state to assess tribal capacity and needs and to develop tribe-specific media and policy materials, training, and technical assistance. And, for the first time, state 2003 BRFSS completed oversampling of adult respondents in African-American, Asian-American/Pacific Islander, Hispanic/Latino, and American Indian/Alaska Native communities and added a question related to sexual orientation.

Implications and Impact

Funding and support given to the tribes and the five community-based contractors appears to be greatly increasing the capacity of these communities to plan and address tobacco as a priority issue. Funding and support is also generating new partnerships between these communities and local public health and school-based efforts.

Contact Information

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West Virginia

A Comprehensive Approach to Reducing Youth Tobacco Use Rates

Public Health Problem

West Virginia has long held the unenviable position of consistently ranking among the top five states in the country for youth smoking. As recently as 1999, the cigarette smoking prevalence for youth in this state was 42.2 percent.

Taking Action

West Virginia's Tobacco Prevention Program has implemented a comprehensive approach to reduce youth tobacco use. The youth prevention program includes the implementation of a targeted mass media campaign; involvement of youth in RAZE (their statewide, teen-led, teen-implemented anti-tobacco movement); implementation of CDC's School Health Guidelines; enforcement of tobacco-free school grounds policies; passage of excise tax increase from 38 cents to 55 cents; and offering youth the opportunity to participate in the cessation program, N.O.T. on Tobacco. West Virginia has strengthened its partnerships with the state Department of Education, the Prevention Research Center at the University of West Virginia, and the American Lung Association.

Implications and Impact

Cigarette smoking prevalence among high school students in West Virginia decreased from 42.2 percent in 1999 to 28.5 percent in 2003, which represented a statistically significant relative decline of 32.5 percent. This decline translates into 37,779 fewer youth who smoked than in 1999, and it is estimated that this decline will save an estimated $680 million in lifetime health care costs.

Contact Information

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