KEEPING AMERICA HEALTHY

A Catalog of Successful Programs

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Though the current structure of our health care system is not particularly well-suited for the prevention and management of chronic diseases, participants in the system — providers, health plans, hospitals, and governments — are finding innovative ways to deliver high quality care and manage costs. By understanding and focusing on the patient, innovators are achieving greater coordination and engagement among providers and patients to achieve both quality and cost improvements. These programs illustrate the potential that health systems innovations can bring toward improving health and managing health care costs.
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APN Transitional Care Model

Purpose
To reduce readmission rates after hospitalization by ensuring a smooth transition from hospital to home care for geriatric patients\(^1\)

Target Population
Geriatric patients currently in and recently discharged from a participating hospital\(^2\)

Goals
- Improve post-discharge outcomes
- Lower rates of re-hospitalization
- Reduce health care costs\(^3\)

Years in Operation
1999 – present

Results
- Findings from three clinical trials demonstrate that the APN Transitional Care Model improves quality of care and decreases health care costs:
  - Compared to standard care, there are longer intervals before initial re-hospitalizations, fewer re-hospitalizations overall, shorter hospital stays and better patient satisfaction
  - Following a four-year trial with a group of elderly patients hospitalized with heart failure, the APN Transitional Care Model cut hospitalization costs by more than $500,000, compared with a group receiving standard care — for an average savings of approximately $5,000 per Medicare patient.\(^4\)

Funding
National Institute of Nursing Research; Commonwealth Fund; Jacob and Valeria Langeloth Foundation; John A. Hartford Foundation, Inc.; Gordon & Betty Moore Foundation; California HealthCare Foundation\(^5\)

Key Partners
Advance practice nurses (APNs) and other providers, patients and caregivers. Aetna, Inc. and Kaiser Permanente are testing “real world” applications of this model.\(^6\)

What Works and Why
The model uses a holistic approach of “health care team management,” led by an advance practice nurse. APNs begin to work with the patient and the patient’s family and health care team to design an individualized discharge plan while the patient is in the hospital. By engaging and
working with the caregivers and patients before discharge, there is better, on-going communication about post-discharge care and expectations.

Costs are lowered because the approach reduces the number of re-admissions of elderly patients caused by not understanding or following post-discharge care instructions, a lack of care coordination among providers, and not understanding symptoms that require immediate attention.

**Structure and Operations**

Assures that APNs: establish a relationship with patients and their families soon after hospital admission; design the discharge plan in collaboration with the patient, the patient's physician, and family members; and implement the plan in the patient's home following discharge, substituting for traditional skilled nursing follow-up.

Reduces the incidence of poor communication among providers and health care agencies, inadequate patient and caregiver education, and poor quality of care; enhances access to quality care.

**Barriers to Success**

The APN Transitional Care Model was tested in a clinical trial setting. Real world experience may differ.

**For More Information**

Additional information is available online:
http://www.nursing.upenn.edu/centers/hcgne/TransitionalCare.htm
Community Care of North Carolina
NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

Purpose
To improve the quality of care provided to the Medicaid population through the use of medical homes by contracting with community health networks organized and operated by community physicians, hospitals, health departments, and departments of social services.

Target Population
North Carolina Medicaid population: Ongoing demonstration programs revolve around specific disease states — asthma, diabetes, heart failure and mental health; there is an intensive program with the aged, blind and disabled population.

Goals
- Reduce the increasing rate of Medicaid costs (secondary to quality, though) — saving money for the state
- Place responsibility for performance (and improvement) in the hands of those who actually deliver the care
- Institute independent local networks that can manage all Medicaid patients and services and can address larger community health issues
- Ensure that all funds are kept local and go toward providing care

Years in Operation
2002 – present

Results
A study performed by Mercer Government Human Services Consulting found that, when compared to historical fee-for-service program benchmarks, the state saved $195 to $215 million in 2003 and between $230 and $260 million in 2004.

Funding
North Carolina Division of Medical Assistance

Key Partners
Initially, the program received grants from the Kate B. Reynolds Foundation, the Duke Endowment, and pharmaceutical companies. Two state agencies, the Division of Medical Assistance (Medicaid) and the Office of Research, Demonstrations and Rural Health Development, jointly administer and supervise the local networks.
What Works and Why

The program has always balanced cost and quality, operating under the premise that improving the quality of care will reduce the cost of care delivery in the long run. Allowing local networks to have authority and management for taking care of their respective populations made a tremendous difference. The networks were successful because each network has an established group of community experts to help solve local health problems. Each network employed nurses and/or social workers to coordinate care and identify high-risk patients. These physicians and community leaders have tremendous buy-in, and their support has been critical.

Structure and Operations

Community Care of North Carolina (CCNC) consists of 15 local networks across the state and involves more than 3,000 physicians who practice in collaboration with local social service agencies. All local CCNC networks are nonprofit organizations which, at a minimum, include area primary care providers (PCPs), a hospital, the county Department of Social Services (Medicaid) office, and the county health department. Each provider receives a $2.50 per member per month (PMPM) Medicaid enhanced care management fee. Each network utilizes information gathered both locally and through the state's Medicaid claims system to assess the needs and severity of local Medicaid enrollees. From this information, targeted care and disease management initiatives are developed for those enrollees at greatest risk, who are then followed with comprehensive care management initiatives designed to improve health outcomes.9

Barriers to Success

Practice patterns of physicians are not easily changed. For specialists, the proportion of their patient population represented by Medicaid may not be sufficiently large to warrant participation. Rolling enrollment of Medicaid population makes sustained intervention challenging.

Future savings may be difficult to achieve or to sustain given rapidly increasing medical costs.10

For More Information

Additional information is available online: http://www.communitycarenc.com.
Congestive Heart Failure Program
BLUE CARE NETWORK OF MICHIGAN IN CONJUNCTION WITH ALERE MEDICAL

Purpose
To increase physicians’ use of effective methods for treating congestive heart failure, increase members’ adherence to recommended medications and services, and help avoid unnecessary hospitalizations and emergency room visits.

Target Population
Members age 18 and older who can benefit from a congestive heart failure (CHF) management program.

Goals
- Reduce the high incidence of repeat hospital admissions among heart failure patients.
- Assist patients with diet restrictions, medical regimens, and recognition of worsening symptoms.
- Improve communication between patients and their providers.

Years in Operation
1999 – present

Results
- In 2005, 70 percent of members enrolled in the program used angiotensin-converting enzyme (ACE) inhibitor medications as recommended, and 70 percent reported using beta-blockers as prescribed.
- In 2005, 98 percent of members rated the program as “very good” or “excellent,” and 98.4 percent of these members said they would recommend the program to others.
- Total savings from the program from 2003 to 2004 were more than $1.3 million, attributable to reductions in emergency room visits and inpatient admissions.
- In 2004, the number of inpatient admissions per thousand members at high risk for complications who were enrolled in the CHF program was 1,337, compared with 1,953 per thousand members in the same risk group who were not enrolled in the program.
- The number of emergency room visits per thousand members enrolled in the program in the two highest risk groups was 1,849, compared with 2,179 members with the condition who were not enrolled in the program.

Funding
Blue Care Network of Michigan funds the program.
Key Partners
Blue Care Network of Michigan (BCN); Alere Medical, Inc.

What Works and Why
To reduce the high incidence of repeat hospital admissions among heart failure patients and to help patients with diet restrictions, medical regimens, and recognition of worsening symptoms, BCN partnered with Alere Medical, Inc. to reach this high-risk population. Relying on a variety of monitoring devices used by the patient twice a day, it has been possible for Alere staff to monitor the defined clinical parameters and alert the provider if a weight or symptom change occurs. Preliminary data indicate a favorable trend in member utilization and cost.

Structure and Operations
Blue Care Network uses a variety of sources to identify members with congestive heart failure, including claims, direct referrals from health care practitioners, member self-referrals, and other BCN departments. As members are identified, they are added to the disease management registry. Unless they opt out, members in the registry receive introductory packets and regular mailings on chronic care issues. Each member enrolled in the case management program receives an initial phone call from a nurse case manager, who conducts a health risk assessment and evaluates his or her functional status as well as physical and emotional well-being.\(^\text{11}\)

An electronic scale and DayLink\(^\text{TM}\) monitor are installed in participating members’ homes, and participants are asked to weigh themselves twice a day and answer a few short questions about their symptoms. The information is then transmitted to Alere automatically through a standard telephone line. The entire process takes less than a minute.\(^\text{12}\)

Barriers to Success
Individuals with congestive heart failure often suffer from depression that can impair their ability to follow care plans.

For More Information
Additional information is available online:
http://www.ahipresearch.org/PDFs/Innovations_InCC_07.pdf
Diabetes Prevention Program

NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES

Purpose
To determine whether lifestyle intervention or the drug metformin would prevent or delay the onset of diabetes

Target Population
Eligibility criteria included an age of at least 25 years, a body mass index (BMI) of 24 or higher (22 or higher in Asians), a plasma glucose concentration of 95 to 125 mg per deciliter in the fasting state (<125 mg per deciliter in the American Indian clinics), and 140 to 199 mg per deciliter two hours after a 75 g oral glucose load

Goals
- For all lifestyle participants to reduce their daily intake by 100 calories, and to achieve and maintain at least a 7 percent weight loss
- To engage all lifestyle participants in physical activity of moderate intensity, such as brisk walking, for at least 150 minutes per week

Years in Operation
1996 – 2002

Results
The average follow-up of participants was 2.8 years. The incidence of diabetes was 11.0, 7.8, and 4.8 cases per 100 person-years in the placebo, metformin, and lifestyle groups, respectively. The lifestyle intervention reduced the incidence by 58 percent and metformin by 31 percent, as compared with placebo. To prevent one case of diabetes during a period of three years, 6.9 persons would have to participate in the lifestyle-intervention program, and 13.9 would have to receive metformin.

Funding
The Diabetes Prevention Program (DPP) was funded by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) of the National Institutes of Health.

Key Partners
Twenty-seven community health centers throughout the United States; National Institutes of Health; NIDDK; National Institute of Child Health and Human Development; National Institute on Aging; National Center on Minority Health and Health Disparities; National Center for Research Resources General Clinical Research Center Program; Office of Research on Women’s Health; Indian Health Service; Centers for Disease Control and Prevention (CDC); American Diabetes Association; Bristol-Myers Squibb; Lipha Pharmaceuticals; Parke-Davis;
What Works and Why

Both the lifestyle intervention and metformin were effective in decreasing the incidence of diabetes. Lifestyle intervention decreased the incidence of Type 2 diabetes by 58 percent, compared with 31 percent for the metformin-treated group. The lifestyle intervention included face-to-face counseling for each participant over the course of 20 to 24 weeks, including individual accountability through a private weigh-in and development of individual action plans.

Structure and Operations

The DPP used a goal-based intervention to achieve loss and maintenance of 7 percent of baseline body weight. The recommended pace of weight loss was one to two pounds per week. Lifestyle goals included modest dietary restriction and at least 150 minutes per week of moderate-level physical activity. The primary approach to diet restriction involved a recommendation for low fat (<25 percent fat) intake. If fat restriction did not produce weight loss to goal, calorie restriction was also recommended. Brisk walking was emphasized to achieve the activity goal, but any activity of similar intensity could be applied to the goal. Although most participants completed activities on their own, two supervised exercise classes were offered each week.

Each participant in the lifestyle group was assigned an individual case manager or lifestyle coach, who followed a structured intervention protocol to help the participant achieve and maintain lifestyle goals. The core of the intervention involved a structured, face-to-face, 16-lesson curriculum that was completed over 20 to 24 weeks. Lessons ranged from 30 minutes to one hour and included a private weigh-in, review of self-monitoring records, presentation of a new topic, identification of personal barriers to weight loss and activity, and development of an action plan for the next session.

Barriers to Success

The DPP was successful in proving the efficacy of intensive lifestyle interventions to reduce the risk of developing Type 2 diabetes. Because of the one-on-one counseling with highly qualified personnel and intensive programming involved, the program is expensive and difficult to replicate cost-effectively. Since 2002, there have been a variety of efforts to modify the core DPP curriculum to make the lessons more widely available at a lower cost. Some examples include an adaptation for YMCA centers in Indiana and the CDC’s current Diabetes Primary Prevention Initiative in five states.

For More Information

Additional information is available online:
Evercare Health Plans
(OPERATING IN 35 STATES)

Purpose
To overcome fragmentation and improve health outcomes — including fewer emergency treatments and hospitalizations — by providing coordinated, individualized health care and well-being services to those with complex needs17

Target Population
Evercare members with special needs, including chronic illness or disability, living independently or in long-term care facilities

Goals
• To improve health outcomes by coordinating medical care for people in nursing homes or living independently, who have chronic illnesses or disabilities
• To reduce hospital admissions and emergency department visits
• To focus on individual needs of patients and to provide personalized care management

Years in Operation
1987 – present

Results
Evercare has resulted in greater access to medical and nonmedical services, better health outcomes, and lower costs to Medicare and Medicaid. The Evercare approach has:
• Reduced hospitalizations for nursing home residents by 45 percent, and emergency room trips by 50 percent.
• Achieved high satisfaction rates among enrollees and families. A 2005 survey of enrollees in Evercare’s community Medicaid plans showed 91 percent of enrollees and responsible parties were satisfied; 95 percent intended to continue with Evercare.
• Saved the State of Texas approximately $123 million in Harris County alone between February 2000 and January 2002 through the STAR+PLUS program.18

Funding
Evercare is offered by United Healthcare and funded through Medicaid, Medicare and private-pay premiums.19

Key Partners
Providers; community health services; long-term care facilities; patients; patient families; Medicare; Medicaid
What Works and Why

The integrated care team includes patients' families and community services as well as providers and long-term care facilities. Care is often provided on-site to avoid the difficulties and potential trauma to the patient associated with transporting patients from long-term care facilities to appointments for care. Having a clinical care manager helps communication among providers, facilitates obtaining recommended preventive care and any follow-up required, and assists in identifying potential problems early enough to allow for proactive steps to avoid serious complications. Having ready access to electronic health records for each patient facilitates coordination significantly.

Structure and Operations

Evercare provides a variety of health plans for people with long-term or advanced illnesses. For enrollees, a nurse practitioner or care manager serves at the center of an integrated care team that includes the enrollee's physicians, family members, and nursing home staff or representatives from community service agencies.

Nurse practitioners and care managers work with the enrollee and their integrated care team to develop and manage personalized care plans that increase preventive care and the early detection of potential problems. Evercare developed a proprietary electronic health record system that includes electronic health records for each patient to facilitate coordination, track patient health, and evaluate patient needs.

Nurse practitioners and care managers coordinate multiple services; facilitate better communication among physicians, institutions, patients and their families; and help ensure effective integration of treatments.

Barriers to Success

Care coordination depends upon providers having the resources and willingness to share information and collaborate. Changes in public program reimbursement may make offering new services and sustaining them difficult.

For More Information

Additional information is available online: http://www.evercarehealthplans.com
Fit Kids and TIPPS
CHILDREN’S HEALTHCARE OF ATLANTA

Purpose
To assist overweight children and youth in developing a lifestyle makeover that includes healthy eating and physical activity behaviors, while at the same time improving their self-esteem

Target Population
Fit Kids is a six-week program designed for overweight children, ages 6 to 12, and their families; TIPPs is a 12-week after-school exercise and nutrition program for overweight youth ages 10 to 18 and their families

Goals
Fit Kids
- Create healthy lifestyle changes for everyone in the family
- Use a nondiet approach to eliminate food struggles, increase understanding of nutrition, improve eating habits and patterns, and promote consumption of fruits and vegetables
- Develop increased levels of physical activity
- Decrease amounts of sedentary activities
TIPPs
- Increase daily physical activity
- Decrease sedentary behavior (TV, video and computer games)
- Increase healthy eating behaviors
- Delay for life, if possible, the onset of Type 2 diabetes

Years in Operation
1996 – present

Results
Fit Kids — Nearly 700 families have attended the classes (overall class completion rate of 96 percent). Pre- and post-tests (conducted two years apart) of parents and children to assess changes in knowledge and behaviors demonstrated improvement in the following areas: 97 percent report serving fruits/vegetables; 67 percent report increased physical activity in the family; 58 percent have reduced the total amount of “screen time,” and; 98 percent offer milk or water with meals and snacks.

TIPPs — Pre- and post-tests are conducted to determine program impacts on lab values, height, weight, fitness level and eating habits. Outcomes include stabilization of body mass index, improved lab values, and increased voluntary physical activity: 78 percent decreased/stabilized body mass index, 61 percent decreased total cholesterol, 61 percent low-density
lipoprotein (bad) cholesterol, 54 percent increased high-density lipoprotein (good) cholesterol, and 57 percent normalized or decreased fasting insulin.

**Funding**

Participants are required to pay registration fees of $200 per program.

**Key Partners**

Children's Healthcare of Atlanta

**What Works and Why**

Involvement of parents is critical to the success of these programs. Parents learn about and discuss the importance of family dynamics around eating and nutrition, hunger-fullness regulation, the child's body image, physical activity and the parents as role models, and barriers to change in making family lifestyle improvements.

**Structure and Operations**

**Fit Kids** — There are two instructors for each class, one for parents and one for the kids. At each class, families meet as a group to review nutrition and physical activity goals. The class is then split between parents and kids. Kids follow the same curriculum and receive a 45-minute exercise session. A weekly goal sheet is completed to track behavior changes in five areas: completion of weekly family activity, consumption of fruits and vegetables, amount of “screen time” spent each week, number of family meals served, and number of sweetened beverages served.

**TIPPs** — Participants begin with baseline lab values, height and weight measurements, fitness testing, and eating habits questionnaires, which are used to develop individualized exercise and nutrition sessions. Youth participate in twice-weekly 45-minute exercise sessions after a fitness assessment with an exercise specialist, learning about benefits of an active lifestyle. Participants engage in balance, flexibility and strength training and aerobic conditioning. Four individual nutrition consultants and two food demonstrations of healthy eating provide guidance to facilitate positive eating behaviors and support active lifestyles. After 12 weeks, lab values, height, weight, fitness level and eating habits are reassessed, and healthy lifestyle goals are redefined.

**Barriers to Success**

The small size and scope of the programs limits their ability to reach a large number of children and families. Also, many children who could benefit from the programs may not be able to afford the registration fees.

**For More Information**

Additional information is available online: http://www.choa.org/default.aspx?id=3225
Freedom From Smoking®
AMERICAN LUNG ASSOCIATION

Purpose
To help people who want to quit smoking

Target Population
Adult smokers who are ready to quit smoking

Goals
- To increase the number of adult smokers who are able to stop smoking
- To improve long-term cessation rates among adults quitting smoking

Years in Operation
1975 – present

Results
An unpublished American Lung Association study conducted during initial development of Freedom From Smoking® (FFS) found that 30 percent of 151 participants in the seven clinic sessions had not smoked cigarettes in the past month when interviewed one year after the end of the clinic. Nineteen percent of those reported complete abstinence from smoking over the full 12 months since the clinic. A larger internal evaluation study included 2,126 participants from 135 clinics, held from 1982 through 1985. Participants were interviewed one year after the conclusion of their FFS clinic, and the overall self-reported nonsmoking prevalence rate was 28.6 percent (with “nonsmoking” defined as not having smoked during the 30 days prior to the follow-up interview).

Subsequent evaluations of the program have found similar success rates among clinic participants a year after the program.

Rosenbaum and O’Shea measured the success of the Freedom From Smoking® clinic by studying 494 smokers who had participated in 42 FFS clinics held between October 1985 and June 1987 at locations in and around Buffalo, N.Y. Using a conservative “intent-to-treat” analysis, they found that 29 percent of all clinic participants were nonsmokers one year after their clinic. Quit rates were consistent across age, gender and number of clinic participants.

An evaluation study of Freedom From Smoking® Online was conducted in Wisconsin during 2001 and 2002. When questioned immediately after finishing the online clinic, 55 percent of participants reported they hadn’t smoked in the previous 24 hours. A full year after the program, 16.3 percent of participants reported they hadn’t smoked at all in the previous three months. While these results are encouraging, the study was quite small and additional research is needed.
Funding

The program is funded by the American Lung Association. Participants may have to pay registration fees to cover costs of local Freedom from Smoking® clinics.

Key Partners

American Lung Association; Freedom from Smoking clinics

What Works and Why

The program is research based and thoroughly evaluated. The program is regularly revisited and updated to incorporate the latest research and advances in cessation. Each participant develops an individualized quitting plan tailored to his or her needs. The program relies upon both individual and group participation, which facilitates support and accountability in working through the process and problems of quitting.

Structure and Operations

The Freedom From Smoking® group clinic consists of eight sessions designed to offer individuals a step-by-step plan for quitting smoking. The program focuses almost exclusively on how to quit, not why to quit, using a positive behavior change approach. Each clinic session uses techniques based on pharmacological and psychological principles and methods designed to help smokers gain control over their behavior. The clinic format encourages individuals to work on the process and problems of quitting not only individually but also as a group.

The initial clinic sessions help smokers determine their readiness to quit and figure out what triggers their urges to smoke. Each participant then develops a personalized quitting plan in preparation for his or her quit day. Following that session’s quitting ceremony, the remainder of the clinic covers symptoms of recovery, controlling weight gain, managing stress, relaxation techniques, resisting the urge to smoke and preventing relapse.

Each clinic facilitator is a nonsmoker or ex-smoker and has completed a workshop conducted by an American Lung Association-certified Freedom From Smoking® trainer. The day-and-a-half training includes instruction on understanding triggers for smoking, creating a quit plan, nicotine addiction and withdrawal, the importance of social support, coping with stress, weight management and preventing relapse. The registration fee (if any) charged to clinic participants is determined at the local level and varies depending on factors including available funding and clients’ ability to pay. Freedom From Smoking® Online is available free of charge at http://www.ffsonline.org.

Barriers to Success

Relapse rates are high among smokers, and many require multiple attempts to quit before succeeding.

For More Information

Additional information is available online: http://www.lungusa.org/site/pp.asp?c=dvLUK9Q0E&b=39240
Healthy Outlook Program — Chronic Heart Failure Disease Management Program

AETNA

Purpose
To reduce complications associated with chronic heart failure

Target Population
Members with or at risk for chronic heart failure (CHF)

Goals
- Reduce costs associated with the high incidence of repeat hospital admissions among heart failure patients
- Improve the level and type of communication between patients and their providers
- Help patients follow treatment plans, and promote lifestyle changes such as smoking cessation and weight loss to improve health

Years in Operation
1998 – present

Results
Ninety-six percent of members surveyed in 2004 said they were satisfied with the program, and 92 percent of physicians said they were satisfied with it.

In 2003, Aetna’s Caring for Chronic Heart Failure program won the Best Disease Management Care Award from the Disease Management Association of America.

Aetna’s internal in-depth analysis of members with CHF in plans based in health maintenance organizations found that full participation in the CHF program for at least six months was associated with significantly improved compliance with an appropriate treatment regimen and lower medical costs.

The study also showed that participants in the program had significantly shorter lengths of stay for admissions for heart failure, significantly fewer heart-failure-related emergency department visits, and significantly more days’ supply of angiotensin-converting enzyme (ACE) inhibitors and beta blockers than members who did not participate for six months.21

Funding
The program is funded by Aetna.

Key Partners
Aetna; LifeMasters Supported SelfCare
What Works and Why

- Aetna’s program reflected an organizational commitment to improving disease management capabilities, which bolstered the CHF program.
- The program was founded on evidence-based data demonstrating both the magnitude of CHF as a problem and the capacity for positive change to occur when care is coordinated between patients and providers.
- Program implementation among members was given just as much importance as the initial conceptual design period.

Structure and Operations

AetInfo, Aetna’s performance and outcomes measurement subsidiary, integrates and extracts key information from their data warehouses containing member utilization data sourced by Aetna’s medical, dental, laboratory, pharmacy and group/life claims.

Aetna’s Disease-Specific Risk Stratification Model identifies members with chronic diseases and stratifies them according to severity levels. Risk stratification uses statistical algorithms based primarily on demographics, comorbidities, pharmaceutical use, and members’ previous health care utilization. Assigning members to severity levels helps identify those members with the greatest potential for improvement. Stratification also allows Aetna’s disease management staff to tailor interactions such as education and related assistance for low-risk members and case management services for high-risk members.

Barriers to Success

Although Aetna’s program is designed to create lasting involvement between CHF patients and their network of providers, some members’ participation in the program was short-lived and not long enough to establish regular communication around health improvement.

For More Information

Additional information is available online:
Marshfield Clinic
CENTERS FOR MEDICARE & MEDICAID SERVICES

Purpose
To both increase efficiencies and improve quality by supporting patients and families in partnering with their personal physicians

Target Population
The Marshfield Clinic patient population

Goals
- To improve the quality of life for patients with diabetes, hypertension, heart failure and coronary artery disease
- To save the Medicare program money

Years in Operation

Results
First-year results demonstrated that the Marshfield Clinic improved clinical outcomes and lowered costs for patients with diabetes. Specifically, the number of hospitalizations for any reason among these patients decreased from 350 per 1,000 to 315 per 1,000 during a two-year period of the project. With 17,500 Marshfield Clinic patients with diabetes, an estimated 770 fewer people needed hospitalizations annually.24

Funding
Funds were those provided by a Medicare Demonstration grant, and those received by providing services to patients. Marshfield Clinic funded upgraded technology needs, nurse help lines, and other clinical and administrative supports required.

Key Partners
Centers for Medicare & Medicaid Services (CMS); participating providers

What Works and Why
Marshfield sees its success as an accumulation of incremental gains. Success isn’t a single act but a multifaceted approach. Marshfield credits the use and accessibility of a common medical record for allowing greater coordination among providers, greater transparency, and the benefit of finding complete patient information easily.

Structure and Operations
The Medicare PGP Demonstration Project evaluates physician groups against a cumulative set of quality measures in diabetes (year one), heart failure (added year two), and hypertension
and prevention treatment (added year three). Each medical group in the demo has the freedom to structure and design their own chronic care intervention. CMS evaluates whether the medical groups have saved Medicare money compared with other beneficiaries in the region not treated at the medical groups in the demonstration. Groups generating a savings of more than 2 percent share a part of the savings with Medicare.

Marshfield Clinic is composed of more than 40 clinics covering central, northern and western Wisconsin.

Each site has access to the centralized 24/7 nurse line. The nurses have access to the electronic medical records of the patients, the doctors’ standing orders for the patient, patient education materials, and approved guidelines for treatment. Marshfield also has telephonic health programs for dislipidemia and congestive heart failure. These programs provide disease education as well as information about diet needs, and may include daily check-ins with the patient about how he or she is feeling. Depending on the responses, a nurse may call the patient to follow up and have the patient come into the office to be seen in person.

For the demonstration project, Marshfield accelerated the roll-out of computers to primary care physicians. The programs included chart reminders of recommended care for patients with diseases. Marshfield instituted telephonic programs for heart failure after the demonstration started.

The telephonic programs work as an extension of the physician’s practice, not as a replacement. They are designed for patients not meeting clinical goals for managing their condition. Physicians are advised of the programs, and will refer a patient to them at the physicians’ discretion. For example, if a patient isn’t meeting his lipid goals, he receives education about the importance of meeting his goals, changing his diet, taking his medicine, and making other changes needed. He has his labs checked every eight weeks and is called in for follow-up as needed. Once at goal, he then has regular follow-ups.

The clinic has established metrics for their practice and will alert physicians when there are problems with a patient. The clinic provides tools to help plan the visit in advance. For example, there are alerts when an appointment is needed, and the alerts show what labs are due. That way, labs are scheduled to occur when the patient comes in for the appointment, eliminating the need for a second visit.

**Barriers to Success**

Medicare reimbursement levels, upfront investment in technology required, and rewards coming years after program implementation create barriers to making necessary investments to enhance care services and improve outcomes.

**For More Information**

Additional information is available online:
http://www.marshfieldclinic.org/patients/default.aspx
Mayo Clinic

Purpose
To provide an effective yet efficient care model through an integrated network of specialties, which are facilitated by electronic health records

Target Population
Mayo Clinic provider and patient population

Goals
- Practice medicine as an integrated team of multi-disciplinary physicians, scientists, and allied health professionals who are focused on the needs of patients
- Educate physicians, scientists, and allied health professionals and be a dependable source of health information for patients and the public
- Conduct basic and clinical research programs to improve patient care and benefit society
- Continuously improve all processes that support patient care, education and research
- Reduce the cost of provided care without negatively impacting its quality

Years in Operation
The clinic first opened its doors in 1889, and since that time has continually fostered care provided by an “integrated team.”

Results
Dartmouth Atlas research (Wennberg & Fisher), which showed significant regional disparities in the cost of care and the outcomes received by Medicare, consistently showed that Mayo offers better quality at a lower cost.

Funding
Funding is provided by patient care revenue (through public and private payers), contributions, private grants, and endowments from nearly 87,000 donors.

Key Partners
Mayo Medical School, Mayo Graduate Schools in Health Sciences and Continuing Medical Education

What Works and Why
Mayo attributes much of the success in delivering lower-cost, higher-quality care to three critical factors:
- The integration of specialties. The patient is the center of care — both physically and conceptually. All the physicians work for the same organization, which is centered on providing care to the patient at hand.
• A culture that attracts physicians with an interest in collaboration, patient-centric care, and research.
• Constant peer review for each patient, which is facilitated by a single medical record for the patient throughout the treatment at Mayo (hospital and any physician).

Structure and Operations
• The Mayo Clinic is a not-for-profit physician group practice that owns two hospitals. There are other “subsidiary” groups with Mayo, including a for-profit group that provides disease-management services to large employers around the country. Mayo’s clinical practice is regularly held up as an example of providing high-quality, lower-cost services to Medicare, particularly as it relates to hospital care.
• Mayo also has affiliated with several practices and hospitals in Iowa, Wisconsin and Minnesota (within about a 100-mile radius of Rochester, Minn.). These groups are integrated both administratively and clinically (providing referrals, continuing medical education, and expertise). They are not yet using a single medical record, but information can be transferred electronically among the groups.
• Care provided to patients receiving primary care outside Mayo is coordinated by ensuring that the primary care practice receives full record of treatment at Mayo from Mayo.

Barriers to Success
Trends of declining reimbursement from public and private payers

For More Information
Additional information is available online: http://www.mayoclinic.org/about
Purpose
To provide a coordinated care intervention model that focuses entirely on older people who are frail enough to meet their state’s standards for nursing home care

Target Population
A high percentage of the PACE population has a significant degree of cognitive impairment; according to the National PACE Association (2002), 62 percent of PACE and pre-PACE enrollees suffer from cognitive deficits.28

Goals
- To manage all of the medical, social and rehabilitative services these enrollees need to preserve or restore their independence, to remain in their homes and communities, and to maintain their quality of life.29
- To promote continued community residence, with an emphasis on frequent attendance at an adult day health center

Years in Operation
The model was tested via demonstration projects that began in the mid-1980s through the Centers for Medicare & Medicaid Services (CMS), which was then the Health Care Financing Administration.30

Results
Research shows that PACE can achieve better health outcomes. For example, in Texas, PACE enrollees have had fewer hospital admissions than the overall Medicare population (2,399 per 1,000 per year versus 2,448) even though PACE enrollees are far frailer than the average Medicare patient. Nursing home admissions in PACE are lower, too; only 7.6 percent of PACE enrollees live in nursing homes, although all are certified as eligible for institutional care.31

Funding
Funding for PACE programs is provided by Medicare and Medicaid.

Key Partners
Centers for Medicare & Medicaid Services; respective states; National PACE Association; John A. Hartford Foundation

What Works and Why
Though clients are frail enough to be eligible for nursing home care, PACE’s comprehensive and preventive services enable most to remain in lower-cost community settings, and provides benefits to consumers, health care providers and payers.32
For consumers, PACE provides:
- Caregivers who listen to and can respond to their individualized care needs
- The option to continue living in the community as long as possible
- One-stop shopping for all health care services

For health care providers, PACE provides:
- A capitated funding arrangement that rewards providers who are flexible and creative in providing the best care possible
- The ability to coordinate care for individuals across settings and medical disciplines
- The ability to meet increasing consumer demands for individualized care and supportive service arrangements

For those who pay for care, PACE provides:
- Cost savings and predictable expenditures
- A comprehensive service package emphasizing preventive care that is usually less expensive and more effective than acute care
- A model of choice for older individuals, focused on keeping them at home and out of institutional settings

Structure and Operations
Participants in PACE programs are served by a multidisciplinary team, with much care centered in an adult day health center model. These services are supplemented by in-home and referral services in accordance with participants’ needs.

After more than a decade operating as a federally supported demonstration project, the Program of All-Inclusive Care for the Elderly is now recognized as a permanent provider under Medicare and a state option under Medicaid. More than two dozen sites serving Medicaid and Medicare patients currently operate nationwide. Approximately 17,000 persons are being served through the various sites. The Balanced Budget Act of 1997 (BBA [P.L. 105-33]), in establishing PACE as a permanent provider, also mandated monitoring of the quality of care received by PACE enrollees.

Barriers to Success
A PACE organization needs significant capital to finance site acquisition and renovation, the purchase of vans, and other startup costs. The sponsor needs to do financial projections for its PACE program, often with the help of a business consultant, an actuary, or financial experts within its own organization.33

For More Information
Additional information is available online:
http://www.medicare.gov/Nursing/Alternatives/Pace.asp
Camino de Salud (Healthy Road) Network
COPE Health Solutions

Purpose
To create an innovative community care management system that links primary and specialty care to patients in their neighborhoods and monitors them through a Web-based system.

Target Population
LAC+USC (Los Angeles County and the University of Southern California) Healthcare Network Service Area patients.

Goals
- To improve the overall health and well-being of LAC+USC Healthcare patients and maximize the availability of medical center resources.
- To decrease unnecessary/inappropriate utilization of high-cost and intensive emergency department and inpatient services at LAC+USC Medical Center.
- To improve communication and coordination of services between LAC+USC Medical Center and local nonprofit primary care clinics.

Years in Operation
2004 – present

Structure and Operations
- Clinic to Hospital Communication with Centralized Care Management System: LAC+USC Healthcare Network enables the community clinics to access the Affinity electronic medical records system that makes case notes, records, lab results, and more available to partnering clinics.
- Primary Care Home in the Patient’s Neighborhood: Clinics and partners provide accessible, multidisciplinary primary care in a community setting. Care includes both basic medical care and social support services, and is culturally and linguistically appropriate. Clinics serve as “medical homes.”
- Care Coordination Between the Hospitals and Clinics: Coordinating patient care between the hospital and the clinics allows for a sharing of high-cost intensive resources. As part of the overall LAC+USC Healthcare Network strategy, re-orientation and re-positioning of specialty care and diagnostic resources based on geographic locations will improve patient access. The Camino de Salud Network Integrated Community Health Specialist and/or Comprehensive Prenatal Services Program provides patients with help navigating the health care system and accessing appropriate social resources. Positive health and lifestyle behaviors are reinforced.

Funding
COPE Health Solutions

For More Information
Additional information is available online: http://copehealthsolutions.org/services/hsi/index.html
Cancer Preventorium
WASHINGTON HOSPITAL CENTER

Purpose
To promote the seeking of preventive care within the Latino community, and to create a health facility that provides preventive care for people without symptoms

Target Population
Latino community in Washington, D.C.

Goals
- To overcome barriers to Latinos seeking preventive care
- To promote prevention and preventive care in the Latino community through commonly followed media
- To provide low-cost preventive care

Structure and Operations
The “preventorium” clinic operates within the Washington Cancer Institute at the Washington Hospital Center. To come to the clinic, people must be healthy (symptom-free) and pay a low-cost fee pegged to the Medicare rate. More than 20,000 people have been seen, and most have no insurance and come though they are symptom free. The preventorium books appointments two months in advance. To overcome linguistic barriers and a lack of understanding of the medical system, a navigation program helps people with setting up appointments, sends reminders, and provides explanations. The navigation program has improved compliance rates for mammograms and follow-up visits.

Local radio and television health education shows created by the preventorium’s founder are followed by 75 percent of the Latino community in Washington, D.C.

Years in Operation
1994 – present

Funding
Revenues from people attending facilities at Washington Hospital Center

For More Information
Additional information is available online: http://www.cancermeetings.org/chdsummit07/PDF/Huerta.pdf and http://www.prevencion.org/?c_ID=12
Colorado Influenza and Pneumococcal Alert Coalition

Purpose
To decrease vaccine-preventable respiratory disease in Colorado through collaborative efforts in education and immunization

Target Population
Anyone with an interest in influenza and pneumococcal vaccination in adults

Goals
- To improve immunization rates for influenza and pneumonia among Colorado residents
- To raise awareness about the benefits of immunization
- To improve provider awareness and participation in immunization efforts

Structure and Operations
The Colorado Influenza and Pneumococcal Alert Coalition (CIPAC) has 50 members representing local and state public health agencies, community nursing organizations, influenza vaccination providers, private physicians, pharmacists, influenza vaccine manufacturers, Medicare quality improvement organizations, other health coalitions, and Medicare and Medicaid organizations.

Pharmacists give the coalition updates on state legislation related to immunization, collaborate with other health care providers to develop standing orders for immunizations to be distributed in state-run long-term care facilities, and provide lists of flu shot clinics for the pharmacies in the state. They have been working to raise immunization rates in hospital settings among health care workers, as well asflagging high-risk patients in out-patient settings for immunization. In 2002, CIPAC won the Excellence in Immunization Award, given by the National Partners for Immunization, for its community outreach efforts.

Years in Operation
Approximately 20 years

Funding
CIPAC is funded by a grant from the Centers for Disease Control and Prevention and through the support of the Immunization Program at the Colorado Department of Public Health and Environment.

For More Information
Additional information is available online: http://www.immunizecolorado.com
Excellus BCBS Step Up Health Initiative
Excellus Blue Cross Blue Shield

Purpose
To improve the health of members through a Web-based program that promotes physical activity and healthy eating

Target Population
Excellus Blue Cross Blue Shield (BCBS) members

Goals
- To promote overall health improvement
- To influence and motivate adults to become more physically active and/or eat better

Structure and Operations
- The Step Up Web site offers program participants extensive health information, recipes, lifestyle tips, scientific calculators, activity conversion charts, and personal progress trackers.
- Step Up also offers “kits” for use at work to encourage increased activity. These kits include motivation “point of decision” posters (e.g., use the stairs posters placed at elevator entrances) as well as information pamphlets, pedometers and tracking booklets.34

Years in Operation
2004 – present

Funding
The Excellus BCBS Step Up Health Initiative is funded by Excellus Blue Cross Blue Shield.

For More Information
Additional information is available online: http://www.stepup.excellusbcbs.com/about.jsp
In SHAPE
Monadnock Family Services

Purpose
To empower people with severe mental illness to improve their health and avoid preventable illness by adopting healthy lifestyles

Target Population
People with severe mental illness in New Hampshire

Goals
- To improve physical health and quality of life
- To reduce the risk of preventable illness
- To enhance life expectancy

Structure and Operations
A trained health mentor works with each In SHAPE participant to develop a Self Health Action Plan for Empowerment (SHAPE) that includes physical activity, healthy eating goals, smoking cessation, and attention to other medical needs. The mentor helps the participant implement his or her SHAPE plan by encouraging participation in a variety of activities that already exist in the community and attending the activities with the participant until he or she feels comfortable going alone. Every 12 weeks, participants attend a celebration where they receive incentive items and verbal recognition for their efforts.

Years in Operation
2004 – present

Funding
The Endowment for Health; The Hoffman Family Foundation; New Hampshire Charitable Foundation; The Monadnock Community Foundation; Cogswell Benevolent Trust; The Harvard Pilgrim Health Care Foundation; Monadnock United Way

For More Information
Additional information is available online: http://www.mfs.org and http://www.lifp.org/html/project/2007GraduateReports/InShape.pdf
Medicare Diabetes Screening Project
American Diabetes Association & Novo Nordisk

Purpose
To help reduce the burden of diabetes on seniors through early detection and treatment and through primary prevention or delay of onset

Target Population
People with Medicare at risk for diabetes

Goals
- To increase the long-term use of the diabetes screening benefits authorized by Congress in 2005, as measured by Centers for Medicare & Medicaid Services (CMS) data
- To go upstream in disease management and reach seniors with pre-diabetes and undiagnosed diabetes, and their providers, with messages about diabetes detection, prevention and treatment
- To gain an understanding of provider-patient interactions regarding diabetes detection and any counseling based on results of testing

Structure and Operations
- Providers order diabetes testing for those at risk, not just those with symptoms.
- Groups inform seniors about diabetes risk factors and urge them to ask their doctors about screening.
- CMS, the Centers for Disease Control and Prevention, and other federal, state and local agencies aggressively promote Medicare diabetes screenings and preventive services.
- Seniors become more active about their health, learn about their risk for diabetes, and use screening benefits.
- Those with pre-diabetes get access to necessary prevention services.

Years in Operation
2006 – present

Funding
The co-chairs are the American Diabetes Association and Novo Nordisk.

For More Information
Additional information is available online: http://www2.niddk.nih.gov/NR/rdonlyres/20F6C3C6-9F04-4489-B637-D74B89269F23/0/FranzDMICC92007.pdf
Patient-Centered Care Delivery

Hudson River HealthCare

Purpose
To provide an enhanced model of care that features open scheduling, expanded hours, and improved communication to improve the health status of the underserved communities

Target Population
The rural and urban poor and uninsured, pregnant women, migrants and immigrants, agricultural workers, the homeless, children and adolescents, the elderly, and those with HIV or substance abuse problems

Goals
- To provide 100 percent of patients with electronic health records (EHRs)
- To measure EHR reports of encounters by provider
- To offer same-day appointments with the patient’s provider, and to have an average office visit cycle time of 45 minutes or less
- To improve health outcomes through a preventive and planned care model
- To eliminate differences in care and health status among racial, ethnic and economic groups
- To ensure that 100 percent of patients recommend the health center to friends and family
- To evaluate the health service penetration rate for the target populations
- Vital Aim: To achieve high productivity and staff satisfaction

Years in Operation
Began operations in 1975; today’s patient-centered improvements began in 1996

Structure and Operations
Hudson River HealthCare provides care to nearly 50,000 patients at 14 sites across New York State. Its first site, in Peekskill, was opened by local residents and religious leaders in 1975 to meet the needs of the community’s underserved population. A consumer-majority board, whose composition mirrors the health center’s diverse patient population, governs the organization. The health center offers a range of medical specialties, as well as key support services like health education and transportation.

Hudson River HealthCare is accredited by the Joint Commission and is recognized by the National Committee for Quality Assurance (NCQA) Physician Practice Connections program.

Funding
Hudson River HealthCare operates as a “Federally Qualified Health Center.”

For More Information
Additional information is available online:
http://www.commonwealthfund.org/innovations/innovations_show.htm?doc_id=670400
Vermont Blueprint for Health
VERMONT DEPARTMENT OF HEALTH, AGENCY OF HUMAN SERVICES

Purpose
To improve health and the health care system for all Vermonters

Target Population
All Vermonters

Goals
- To reduce the prevalence of chronic disease throughout Vermont
- To expand the Blueprint for Health into additional communities and health service areas throughout the state
- To add chronic disease specialists to local health department district offices to support community-level work with partners and integration with other activities
- To expand physical activity initiatives statewide in coordination with Fit & Healthy Vermon ters
- To fund community-level health and wellness activities integrated with Coordinated Healthy Activity, Motivation, and Prevention Programs
- To develop new payment recommendations to reward providers for high quality care and patient wellness

Years in Operation
2003 – present

Structure and Operations
The Blueprint for Health is designed to use prevention and planning to help people who have or are at risk for developing chronic conditions.

The Blueprint for Health encourages communities to become healthier places. In preparation for expanding the Blueprint, communities throughout the state have been funded to assess community infrastructure, develop coalitions and walking programs, and engage residents.

Nearly 75 percent of all primary care providers in funded communities have signed on to the Blueprint.37

Funding
The state general fund is estimated to represent half of all estimated current costs. Participating providers and community hospitals contribute significant in-kind and out-of-pocket support.38

For More Information
Additional information is available online: http://healthvermont.gov/blueprint.aspx
**Blueprint for Health Asthma Program**

**Blue Cross & Blue Shield of Florida**

**Purpose**
To increase the proportion of members with asthma who use effective treatments, and to reduce unnecessary emergency room use and hospital admissions

**Target Population**
Members are eligible for the program if they are age 5 to 56, are members of the health plan’s health maintenance organization (HMO) or Medicare Advantage plan, and have a primary diagnosis of asthma. The program automatically enrolls all eligible members and gives them the opportunity to opt out at any time.

**For More Information**
Additional information is available online: http://www.fepblue.org/bcbsflorida/index.html

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**Blueprint for Health Congestive Heart Failure Program**

**Blue Cross & Blue Shield of Florida**

**Purpose**
To promote effective care and avoid unnecessary hospitalization for individuals with heart failure

**Target Population**
Members are eligible for the program if they are 18 years or older, are members of the health plan’s health maintenance organization (HMO) or Medicare Advantage plan, and have a diagnosis of congestive heart failure.

**For More Information**
Additional information is available online: http://www.fepblue.org/bcbsflorida/index.html
Blueprint for Health Diabetes Program
BLUE CROSS & BLUE SHIELD OF FLORIDA

Purpose
To promote delivery of diabetes care according to the medical evidence

Target Population
Members are eligible if they are 18 years or older and are members of Blue Cross & Blue Shield of Florida’s health maintenance organization (HMO) or Medicare Advantage plan, have had at least one primary care physician visit with a diagnosis of diabetes, or have had at least one hospital, outpatient or emergency room claim with a diagnosis of diabetes.

For More Information
Additional information is available online: http://www.fepblue.org/bcbsflorida/index.html

Center for Weight Management and Nutrition
BOSTON MEDICAL CENTER

Purpose
To provide weight management services and medical nutrition therapy for patients with diabetes, eating disorders, hyperlipidemia, or pregnancy-related nutrition issues

Target Population
Patients in need of weight management

For More Information
Additional information is available online: http://www.bmc.org/medicine/medicine/nutrition
**Cherokee Health Systems**

**Purpose**
To provide “biopsychosocial” holistic care by integrating behavioral health services into primary care

**Target Population**
People living in Eastern Tennessee needing primary care services

**For More Information**
Additional information is available online: http://www.cherokeehhealth.com

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**Dare to C.A.R.E. About Vascular Disease**

**LOCTIONS NATIONWIDE**

**Purpose**
To help prevent complications of cardiovascular disease through free vascular screenings to those at risk and through educational public lectures

**Target Population**
People at risk for cardiovascular disease

**For More Information**
Additional information is available online: http://www.daretocare.us
Dedham Health & Athletic Complex and Joslin Clinic

**Purpose**
To provide specially designed exercise programs to benefit people with diabetes provided by fitness staff trained by Joslin Clinic in diabetes and how to develop safe exercise prescriptions.

**Target Population**
People at risk for or diagnosed with diabetes in the Dedham, Mass., area.

**For More Information**
Additional information is available online:
http://www.dedhamhealth.com/club/scripts/section/section.asp?NS=MS1

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Diabetes Care Pilot Program

**Purpose**
To improve the health and health care of individuals with diabetes.

**Target Population**
Patients with diabetes and doctors who treat them.

**For More Information**
Additional information is available online:
Diabetes Self-Management Education and Medical Nutrition Services

**Kerr Drug, Inc.**

**Purpose**
To help people with diabetes and their families by providing them with access to a collaborative education team and the skills and knowledge to manage diabetes appropriately with the goal of improving their overall quality of life.

**Target Population**
People with diabetes and their families

**For More Information**
Additional information is available online:

Eleventh Street Family Health Services

**Drexel University**

**Purpose**
- To provide a full range of health care and dental services to patients, regardless of ability to pay
- To offer a single source for health and life concerns, including providing a fitness center, a teaching kitchen, and a distribution point for fresh fruits and vegetables

**Target Population**
Medicaid and uninsured patients in Philadelphia

**For More Information**
Additional information is available online: http://www.drexel.edu/cnhp/11thstreet/home.asp and http://www.aannet.org/i4a/index.cfm?pageid=3303
**Exercise Is Medicine**

**American College of Sports Medicine & American Medical Association**

**Purpose**

To encourage physicians to assess and review every patient’s physical activity and exercise at every encounter and counsel patients on a regular basis, referring them if needed, according to their physical activity and health needs.

**Target Population**

Physicians

**For More Information**

Additional information is available online: [http://www.exerciseismedicine.org](http://www.exerciseismedicine.org)

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**Fitblue**

**BCBS Massachusetts**

**Purpose**

To identify members through claims, pharmacy, and personal health assessment indicating potential issues with obesity.

**Target Population**

BCBS Massachusetts members with potential obesity problems

**For More Information**

Geriatric Case Management Program
AETNA

Purpose
To improve health status and remove barriers to care for Medicare beneficiaries with chronic conditions

Target Population
Medicare Advantage members

For More Information
Additional information is available at the following Web site: www.nursing.yale.edu

Healthier Florida

Purpose
To improve the health of Florida’s Medicaid population and reduce health care spending in the state

Target Population
Chronically ill fee-for-service Medicaid beneficiaries

For More Information
Additional information is available online:
http://www.pfizerhealthsolutions.com/ourprojects/projectsmedicaid_florida.asp
**HealthMapRx™: Patient Self-Management**

**Purpose**
To provide patients who have chronic conditions with incentives to utilize benefit design and collaborative practices to improve their health.

**Target Population**
Patients with chronic disease conditions covered by the program, including diabetes and cardiovascular health (asthma and depression under development).

**For More Information**
Additional information is available online:
http://www.aphafoundation.org/employers_payers/HealthMapRx

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**Kerr Drug Inc. Clinical Services**

**Purpose**
To create an innovative and sustainable business model within the community pharmacy in order to identify and prevent onset of disease, assist physicians in optimizing therapy, and educate patients on disease management.

**Target Population**
Kerr Drug pharmacies

**For More Information**
Additional information is available online:
Patient Navigator Research Program  
NATIONAL CANCER INSTITUTE

Purpose
To develop interventions to reduce the time of delivery of standard cancer services, cancer diagnosis, and treatment after identifying an abnormal finding.

Target Population
People with cancer and their families.

For More Information
Additional information is available online:  
http://www.cancer.gov/cancertopics/factsheet/PatientNavigator

Patient Self-Management Program for Diabetes  
AMERICAN PHARMACIST ASSOCIATION FOUNDATION

Purpose
To establish a new health care delivery program at five pilot sites with approximately 50–100 patients enrolled at each site for a minimum of one year.

Target Population
Patients with diabetes, employers, providers.

For More Information
Practice Excellence Program
INDEPENDENT HEALTH ASSOCIATION

Purpose
To help prevent potential life-threatening and costly complications from the most prevalent chronic conditions among its members

Target Population
Independent Health, which serves more than 130,000 people across 35 states, identifies a random sample of patients from each physician's practice (15 patients with asthma, 15 with diabetes, and 15 with cardiovascular disease as the primary diagnosis) who have had at least two visits with the physician in the past 12 months.

For More Information
Additional information is available online: https://www.independenthealth.com

Project ImPACT: Hyperlipidemia
AMERICAN PHARMACIST ASSOCIATION FOUNDATION

Purpose
To demonstrate that pharmacists, working collaboratively with patients and physicians and having immediate access to objective point-of-care data, promote patient persistence and compliance with prescribed dyslipidemic therapy that enables patients to achieve their National Cholesterol Education Program goals

Target Population
Hyperlipidemia patients, providers and physicians who work with hyperlipidemia patients

For More Information
Additional information is available online: http://www.aphafoundation.org/programs/Project_ImPACT
**Project ImPACT: Osteoporosis**

**Purpose**
To identify patients at risk for osteoporosis in the community, to refer at-risk patients to primary care and/or specialty practice physicians, and to follow up with at-risk patients.

**Target Population**
Patients at risk for osteoporosis

**For More Information**
Additional information is available online: http://www.medscape.com/viewarticle/474164

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**Smoking Cessation Program**

**Purpose**
To help employees and members of the community stop smoking through counseling services and medication use.

**Target Population**
People wanting to quit smoking in the Mercy Memorial community in Monroe, Michigan.

**For More Information**
Additional information is available online: http://www.mercymemorial.org/Layout-1.pdf
**Purpose**
To lead and empower family physician medical practices to implement the new model of patient-centered care (i.e., medical home)

**Target Population**
Primary care medical practices

**For More Information**
Additional information is available online: http://www.transforMED.com

2. Ibid.

3. Ibid.

4. Ibid.

5. Ibid.

6. Ibid.


10. Ibid.


12. Ibid.


14. Ibid.


16. Ibid.


18. Ibid.

19. Ibid.

20. Ibid.


23. Ibid.


30 Ibid.


36 Ibid.


People around the country are working with neighbors to build healthier communities. Creating healthy communities can mean working to change policies and infrastructure for an entire city, or creating opportunities for healthier living within a single neighborhood. Successful efforts take advantage of the collective influence of a variety of community leaders, and can build upon the existing sense of community to start and sustain programs. The examples contained in this section represent a range of community-based initiatives that are working to improve health for multiple diverse populations.
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Chronic Disease Self-Management Program

Stanford School of Medicine

Purpose
To develop and evaluate, through a randomized controlled trial, a community-based self-management program that assists people with chronic illness.

Target Population
Adults with chronic diseases

Goals
- To enable participants to build self-confidence to assume a major role in maintaining their health and managing their chronic health condition.
- To improve health behaviors (e.g., exercise, cognitive symptom management, and communication with physicians), self-efficacy, and health status of all program participants.
- To reduce participants’ health care utilization, including a reduction in emergency department visits.

Years in Operation
1992 – 1996

Results
The program assessed health status, health services utilization, and perceived self-efficacy to manage different aspects of health and functioning through questionnaires that were mailed to each participant. After the first year of participating in the program, participants had significant improvements in energy, health status, social and role activities, and self-efficacy; less fatigue or health distress; and fewer visits to the emergency room (ER). After two years, participants had no further increase in disability, reduced health distress, fewer visits to physicians and the ER, and increased self-efficacy. Researchers also found that the program saved between $390 and $520 per participant over a two-year study period because participants used fewer health care services. A study funded by Kaiser Permanente found that Kaiser paid approximately $200 per participant for training, materials and administration, costing $97,800. However, the cost for each participant decreased by about $990 because participants used fewer health care services, thereby creating a net savings for Kaiser Permanente of $400,000.1,2,3

Funding
A five-year research grant was awarded by the Agency for Healthcare Research and Quality and the State of California Tobacco-Related Disease Office.

Key Partners
Stanford School of Medicine; Kaiser Permanente Medical Care Program.
What Works and Why

The Chronic Disease Self-Management Program (CDSMP) provides flexibility to address all risk factors, including behavioral, and does not conflict with existing programs or treatment. Barriers to participation, including access and cultural differences, are addressed through the use of lay leaders and the location in a community setting, one of the major contributors to the success of the program.

Structure and Operations

The CDSMP was taught at community sites, with 10 to 15 members participating in each session. Sessions ran for seven weeks and were held for two-and-a-half hours each week. Each session was taught by a peer leader, the majority of whom had one or more chronic diseases. Topics discussed at the sessions included adoption of exercise programs; fatigue and sleep management; nutrition; techniques to deal with problems such as frustration, fatigue, pain and isolation; appropriate use of medications; health-related problem solving and decision making; and others. All program content was published in Living for a Healthy Life with Chronic Conditions, which was provided to each participant as a guide. The program also addressed modeling and social strategies that have enhanced personal efficacy such as reinterpretation of symptoms and social persuasion through group support.

Barriers to Success

A major barrier to success in CDSMP was the problem of participants dropping out of the program. By the end of year one, almost 20 percent of study participants dropped out of the program. It was found that most of these participants were young, nonwhite and unmarried. Additionally, the fact that the program was optional posed problems. Participants had the choice of whether or not to show up for classes, and they did not have to attend class every week.

For More Information

Additional information is available online: http://patienteducation.stanford.edu/programs/cdsmp.html
EnhanceFitness
Senior Services of Seattle, WA

Purpose
To provide a low-cost, evidence-based group wellness and exercise program for older adults for them to stay fit and capable of living in the community setting

Target Population
Older adults

Goals
To improve the overall functional fitness and well-being of older adults

Years in Operation
1997 – present

Results
EnhanceFitness conducts outcomes testing on all participants throughout the first week of classes and repeats the testing every four months. Tests include:

- Bicep Curl to test upper body strength
- Eight Foot Up and Go to test balance and mobility
- Chair Stand to test lower-body strength

Outcomes testing is compiled and analyzed by Senior Services Project Enhance. Each EnhanceFitness site receives an annual outcomes report that includes baseline data as well.

Group Health Cooperative performed a cost analysis of the program in 2000. The analysis found that the average increase in total health costs of participants was $642, compared to that of $1,175 for non-participants. If participants attended one class per week, there was a 6 percent cost savings for participants compared to nonparticipants; if they attended more than one class per week, there was a 21 percent cost savings.

In 2005, 403 EnhanceFitness participants improved in the “Arm Curl,” “Up and Go,” and “Chair Stand” measurements after four months compared to baseline measurements.6

Funding
Funding for EnhanceFitness is provided in part by the U.S. Department of Health and Human Services’ Administration on Aging; Aging and Disability Services of Seattle/King County; Public Health, Seattle/King County, and; the Washington State Aging and Disability Services Administration.7
Key Partners

Group Health Cooperative; University of Washington Health Promotion Research Center; Centers for Disease Control and Prevention's Health Alert Network; community centers; active adult retirement centers; senior housing; health systems; local parks and recreation departments

What Works and Why

EnhanceFitness works because of the way the program is designed. The program can accommodate all levels of fitness — Level 1 participants are in seated positions while Level 2 participants are in the standing position. The program includes an instructor and on-site support, and is supported by ongoing research. EnhanceFitness can also be tailored for specific diseases (e.g., arthritis), and it includes many different forms of exercise. EnhanceFitness has many successful partnerships, which helps with implementation and integration of the program throughout the entire community.8

Structure and Operations

EnhanceFitness provides an hour of cardiovascular exercise, strength training and stretching. EnhanceFitness classes are proven to increase strength, boost activity levels and elevate mood. Classes are taught by a certified instructor who has special training to work with older adults. Classes usually have 10 to 25 people in attendance on any given day. In a typical class, a participant will experience:

- 5-minute warm-up
- 20-minute aerobic workout
- 5-minute cool-down
- 20-minute strength training workout with soft ankle and wrist weights (0 up to 20 pounds)
- 10-minute stretch
- balance exercises9

Costs to implement EnhanceFitness at a new location are about $3,000. Each location must be Americans with Disabilities Act (ADA) accessible and have enough space for each participant to move around safely. Locations must be able to provide ankle and wrist weight cuffs, music, and performance measure equipment.10

Barriers to Success

One barrier to the success of EnhanceFitness is not having a program champion to develop and implement the program throughout the community. Another barrier is not providing continuous instruction to trainers on how to work with older adults most effectively. The program also must be adapted to the local community to work best.11

For More Information

Additional information is available online: http://www.projectenhance.org/index.html
Healthy Hawaii Initiative
HAWAII DEPARTMENT OF HEALTH

Purpose
To implement a social ecological approach to reduce obesity, increase physical activity, and improve nutrition

Target Population
All Hawaiians

Goals
- To increase the years of healthy life for all people of Hawaii and reduce existing health disparities among ethnic groups in Hawaii
- To educate on leading causes of preventative death
- To encourage the public to incorporate healthy choices into their lifestyles
- To reduce the burden of chronic disease

Years in Operation
2000 – present

Results
Evaluation of the program is divided into long-term (10–20 years), intermediate (five–10 years), and short-term (two–five years) indicators. Long-term outcomes focus on health conditions significantly related to physical inactivity and poor nutrition such as stroke and cardiovascular disease mortality and diabetes prevalence. Behavioral data results show positive trends. The amount of “no leisure time” physical activity in adults decreased by 7.2 percent from 25.5 percent in 1999 to 18.3 percent in 2003. Over the same time period, the percentage of adults eating five or more servings of fruit/vegetables per day also increased by 5.2 percent from 22.4 percent to 27.6 percent. The percentage of overweight and obese adults decreased by 0.2 percent in Hawaii. For the rest of the United States, the median percentage of overweight and obese adults increased by 3.0 percent.12

Funding
Funds from the Tobacco Master Settlement Agreement fund are being used to fund the Healthy Hawaii Initiative. In 1999, the Hawaii legislature appropriated $3,665,665 of these funds for health promotion and disease prevention programs.13

Key Partners
University of Hawaii; Hawaii Department of Education; Hawaii County Planning Department; Honolulu Theatre for Youth; Olelo Community Television; local schools; parks and recreation departments; community fundraisers; local businesses; faith-based organizations
What Works and Why

The Healthy Hawaii Initiative has worked because of its overall focus on improving health for all Hawaiians. Any school, organization or business can take part in Healthy Hawaii activities and programs, and any individual is able to use the Initiative’s Web site to find ways to improve their overall health. The Initiative is also the only long-term, statewide program to implement a social ecological approach to reduce obesity, increase physical activity, and improve nutrition. The partnership between the state Department of Health and the state Department of Education, in addition to the University of Hawaii, provides a true multi-disciplinary setting in which to move forward with interventions.14

Structure and Operations

The Healthy Hawaii Initiative is made up of five components — schools, community programs, public and professional education, research and evaluation, and the nutrition education network — focused on the social-ecological model to effect behavior change at multiple levels of society. Programs are focused on three main areas:

• Start Walking — The program provides ideas on how to implement walking into a person’s everyday routine, and how to make walking fun. Fitness maps of 12 walking-friendly areas in Hawaii are provided, as well as direction on how to set up community walking teams. The program also provides tips on how to exercise at work and how to implement walking clubs in faith-based organizations.

• Tobacco Free — The Initiative offers tips on how to quit smoking and why becoming tobacco-free improves your health. Ideas are provided on how to implement smoke-free homes, schools, communities and businesses. A Smoker’s Quit-line is also offered to Hawaii residents.

• Healthy Eating — The program describes benefits of healthy eating as well as ways to eat healthy at home and on the go. Tips on how to shop smarter at the grocery store are provided, along with tips on eating healthy at restaurants.

The program also sponsors four different educational campaigns throughout the state: Fruits and Veggies. Good Choice!; Step It Up Hawaii; You Gotta Start Somewhere; and 1% or Less Is Best.

Barriers to Success

One of the major barriers to the success of the Healthy Hawaii Initiative is the participation rate among Hawaii residents, especially because Hawaii’s population is very ethnically and culturally diverse. Another major barrier is funding for the project. Although the funding currently comes from the Master Settlement Agreement, funding in the long term may be difficult to secure.

For More Information

Additional information is available online: http://www.healthyhawaii.com
Healthy Homes
DEPARTMENT OF PUBLIC HEALTH, SEATTLE & KING COUNTY

Purpose
To help children with asthma reduce the frequency and severity of their asthma attacks through providing their families with education and resources to make their homes asthma-friendly and to keep asthma under control.

Target Population
Children with asthma in the Seattle and King County region; households were eligible for enrollment in the study if they included at least one child between the ages of 4 and 12 with diagnosed asthma, their income was below 200 percent of the 1996 federal poverty level or the children were on Medicaid, and the primary caregiver spoke English, Spanish or Vietnamese.

Goals
- To reduce exposure to asthma triggers and other indoor environmental risks
- To focus on education and participant action to empower individuals

Years in Operation
1997 – 2001

Results
Of the 1,116 children identified with asthma and their 714 caregivers, the study reached 274 eligible and interested families. A total of 214 families completed the study (110 in the high-intensity group and 104 in the low-intensity group). Households with children with asthma who received multiple visits from community health workers (CHWs) and asthma-reducing resources used significantly less urgent health services and had improved caregiver quality-of-life scores relative to households that did not receive these resources. Days of asthma symptoms also decreased more in the high-intensity group, although the difference between the high-intensity and low-intensity groups did not differ greatly. Additionally, missed school or child care and the need for asthma medications decreased only in the high-intensity group. The high-intensity group showed more behavior changes than the low-intensity group, such as reducing dust exposure and adopting the use of bedding encasements. Additionally, urgent care costs were less in the high-intensity group than the low-intensity group during the two months before the exit interview.\(^{15}\)

Funding
The first two approaches of the Healthy Homes project were funded through the National Institute of Environmental Health Sciences. The third approach was funded by the U.S. Department of Housing and Urban Development.
Key Partners
Partners for Healthy Communities; American Lung Association of Washington; the Apartment House Association of Washington; the Center for Multicultural Health; Engineering Plus; Group Health Cooperative of Puget Sound; the League of Women Voters of Seattle; Public Health – Seattle and King County; Washington Toxics Coalition; University of Washington

What Works and Why
The Healthy Homes project worked because the study chose a low-income population that needed help in overcoming barriers to effective asthma treatment for children and in identifying multiple triggers of asthma inside the home. Additionally, the CHWs were able to share culture and life experiences with the families involved, and educate them about common asthma triggers.16

Structure and Operations
Healthy Homes uses three different approaches to improve asthma control.
• Utilize a “community asthma nurse” who provides patient education, training in self-management, case management and review, and the development of an asthma action plan.
• Provide in-home outreach, education and resources (bedding covers, vacuums, cleaning supplies, etc.) to address environmental triggers in addition to all aspects of the community asthma nurse intervention. Reinforce self-management techniques, medication use and provider-patient communication. CHWs provided in-home outreach also.
• Add structural remediation of housing for conditions that increase exposure to asthma triggers. On average, each unit cost about $3,000, which was supplemented by funds from weatherization and other local housing programs.17

Participants in the study were randomly assigned to a high-intensity (multiple interventions) or low-intensity (minimal interventions) group. With the high-intensity group, CHWs created an environmental home assessment on the first visit. Each finding from the assessment generated prioritized actions for participants. Then, the CHW made an additional four to eight visits to the home throughout the year. The low-intensity group received only one CHW visit over the year, and it included the home assessment. After the one-year assessment, the low-intensity group received the same full package of resources as the high-intensity group.18

Barriers to Success
Barriers to the success of the Healthy Homes project include the stresses of setting boundaries with participants, and dealing with their difficult life situations. Another barrier to this program was that the CHWs spent a lot of time traveling to and from homes and carrying heavy equipment. Another barrier was the recruitment and retention of participants. However, at the completion of the one-year program, 226 (82 percent) of the original 274 eligible and interested families remained in the program.19

For More Information
Additional information is available online:
http://www.metrokc.gov/health/asthma/healthyhomes/overview.htm
HealthyTown
AMERICA’S PHARMACEUTICAL RESEARCH COMPANIES

Purpose
To educate citizens of Jackson, Miss., and Fresno, Calif., on health and wellness and to reduce the burden of chronic disease on communities

Target Population
All residents of Jackson and Fresno

Goals
- To improve positive lifestyle behaviors in order to reduce preventable chronic conditions
- To raise awareness of the prevalence and cost of chronic disease

Years in Operation
2006 – present

Results
- HealthyJackson — Since HealthyJackson began, it has been supported by many community partners and sponsors, including all of the medical centers in Jackson, the City of Jackson, and restaurants and health food stores around the city. The program has screened almost 5,000 people throughout the metro area. Additionally, HealthyJackson provided 35 days of health curriculum to more than 900 children at a local summer camp, and more than 7,500 employees participated in HealthyJackson’s Well Workplace seminar.
  - Health Literacy and Compliance Luncheon — The luncheon brought pharmacists throughout the community together with program partners to work on understanding the obstacles that community members faced due to health literacy.
- HealthyFresno — Since HealthyFresno’s inception, the program has been able to bring together health care organizations, community and civic leaders, and business community and nonprofit groups to encourage Fresno residents to lead healthier lives. HealthyFresno has been able to host multiple events, including: worksite wellness initiatives; health literacy outreach efforts for the Latino, Hmong and African-American populations; chronic disease screenings; and children’s sport and activity programs.
  - Body Mass Index Challenge — The program worked with 10 small businesses on this challenge over eight weeks. About 180 employees competed to lower their body mass indexes (BMIs), and competitors lost 351 pounds and 51.5 BMI points collectively. As a result of the challenge, 26 people joined a gym.

Funding
HealthyTown is funded by America’s pharmaceutical research companies.
Key Partners
American Lung Association of Mississippi; Central Mississippi Medical Center; Community Eldercare Services; Fresno Business Council; Coalition of Urban Renewal and Excellence; The Discovery Center; Mental Health Association of Greater Fresno; Arthritis Foundation Fresno; American Stroke Association of Mississippi; Mothers Against Drunk Driving; Quinn Healthcare; The University of Mississippi Medical Center

What Works and Why
HealthyJackson and HealthyFresno have worked because they have both demonstrated teamwork at the community level by coming together to prevent chronic disease. Leaders in both communities were also involved, and in both created health communications networks to steer the community effort. Business communities in both Jackson and Fresno supported the program as well. Businesses offered discounts on healthy goods and services, and they sponsored events throughout the community. Businesses played an integral part in the program by encouraging employees to lead healthier lives.

Structure and Operations
Both HealthyJackson and HealthyFresno offer numerous programs and interventions for their respective constituents. Healthy Living programs are offered on topics such as healthy eating, fitness and worksite wellness. Program participants are advised to take the whole-family approach when making healthy lifestyle changes. Participants are also educated on how to take control of their health, through visiting a local physician and learning how to prepare for that visit. Other programs offered include chronic disease and prevention programs for asthma, cancer, diabetes, heart disease and mental health.

Other programs that the communities focused on were prenatal and neonatal health, children’s health, young adult health and senior health. HealthyJackson and HealthyFresno have also partnered with the Centers for Medicare & Medicaid Services to promote Medicare preventive benefits. Both participating communities have incorporated “best-in-class” educational resources on health literacy and communication.

Barriers to Success
The major barrier to success of HealthyJackson and HealthyFresno was finding a unified vision within the community itself. It was difficult at times for different organizations to come together and work toward a common goal to encourage healthy behaviors for the benefit of the community. Another barrier to the success of the programs was overcoming cultural issues. For example, in Jackson, many types of unhealthy food (e.g., fried foods) are consumed on a daily basis. In Fresno, many community members were skeptical of the program at the outset, and interactions had to be tailored to include more face-to-face interactions at every level of the program, from the individual community member to the CEO or elected official.

For More Information
Additional information is available online: http://healthyjackson.org and http://healthyfresno.org
Hearts N’ Parks
NATIONAL HEART, LUNG, AND BLOOD INSTITUTE & NATIONAL RECREATION AND PARK ASSOCIATION

Purpose
To reduce the growing trend of obesity and the risk of coronary heart disease in the United States

Target Population
Americans of all ages

Goals
- To encourage participants to aim for a healthy weight, follow a heart-healthy eating plan, and engage in regular physical activity
- To increase the percentage of children, adolescents and adults who engage in heart-healthy behaviors to prevent the development of cardiovascular disease (CVD)
- To increase the knowledge of nutrition and healthy eating habits among children, adolescents and adults
- To improve attitudes of children, adolescents and adults toward healthy eating and physical activity

Years in Operation
1999 – 2004 (the program has since evolved into the Step Up to Health program)

Results
The pilot sites of North Carolina and Arlington County, Va., were administered pre- and post-questionnaires about the effectiveness of the program. The evaluation found that participants retained information about heart-healthy behaviors and wanted to eat healthier. Children reported wanting to learn new physical activities, and senior citizens reported feeling healthier.

Further data analysis from the “Magnet Centers” found:
- Children — Positive attitudes toward physical activity increased significantly, and children reported learning new ways to be physically active. There was also significant improvement in heart-healthy eating.
- Adolescents — There was significant improvement in heart-healthy eating and heart-healthy eating attitudes for both boys and girls, while boys scored higher than girls in overweight/obesity attitudes and heart-healthy eating intentions.
- Adults — Participants finished programs with improved scores in heart-healthy nutrition, and reduced obesity, and risks of high cholesterol and high blood pressure, while engaging in proper physical activity. It should also be noted that adults without a college education showed greater improvement than those with some college education.
Funding
Hearts N’ Parks is funded by the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health and by the National Recreation and Park Association (NRPA).22

Key Partners
American Dietetic Association; U.S. Department of Health and Human Services

What Works and Why
Hearts N’ Parks programs work because they have increased credibility and visibility through the NHLBI and the NRPA. It is a self-sustaining program because it is developed by a community agency and must operate within the community. Program components can also be incorporated into already-existing health and wellness programs. Most importantly, the program is meant for everyone, so entire families and the entire community can participate.23

Structure and Operations
Hearts N’ Parks was started as a pilot program in North Carolina in 1999 and in Arlington County, Va., in 2000. Both pilot sites educated participants in local youth and adult community park and recreation programs about physical activity and heart-healthy eating. After the completion of the pilot program, Hearts N’ Parks expanded to 56 new sites in 2002. The new sites, known as “magnet centers,” were selected based on the elevated risk of CVD in their area. All participating magnet centers were required to make a three-year commitment to the program. Hearts N’ Parks taught participants skills for incorporating healthy behaviors into everyday life, including how accessing public parks can positively impact health. The foundations of the program include:

- Activities that can be incorporated into many different programs. Activities focus on nutrition, fitness and stress reduction, and can be tailored for youth, adolescents and adults.
- Training for recreation and park departments and other community organizations to integrate heart-healthy activities into existing activities or to develop new activities.
- Consumer-oriented materials to communicate heart-healthy messages related to weight management, physical activity, high blood pressure, cholesterol, and heart disease. Materials are also tailored to specific populations such as African-Americans and Hispanics.
- Evaluation materials to measure the program’s impact.24

Barriers to Success
Barriers to the success of Hearts N’ Parks were money, time and staff resistance. Many resources were provided to each community, but in some cases there were direct outlays of money. For instance, more staff members were needed to handle the increased workload created by the program. Additionally, many sites had staff resistance that came from the top down. Staff resisted because they did not think something needed to be fixed if it was not already broken.25

For More Information
Additional information is available online:
Project Dulce
WHITTIER INSTITUTE FOR DIABETES, SAN DIEGO COUNTY, CA

Purpose
To provide outreach, education, screening, diagnosis and clinical care to Type 1 and Type 2 diabetics

Target Population
Low-income, uninsured or underinsured minority adults

Goals
- To improve the quality of care and quality of life for low-income, underserved minority individuals with diabetes
- Provide diabetes management by removing cultural and language barriers
- Meet the American Diabetes Association (ADA) standards of care
- Achieve improvements in HbA1C, blood pressure, lipid parameters and health behaviors

Years in Operation
1997 – present

Results
An evaluation of the pilot project was conducted from June 1998 to June 2000 at six community clinic sites in San Diego County, Calif. Participants in the program had an average of eight nurse case manager (NCM) visits per year, and 56 percent of all participants attended peer education classes. Improvements were also made in systolic blood pressure and high-density lipoprotein (HDL) cholesterol. A total of 100 percent of all Project Dulce participants adhered to the ADA standards of care for HbA1C, lipid panel, foot examination, monofilament examination, and urinary crealbumin-to-creatinine ratio.

Funding
Project Dulce receives funding from the California Endowment in addition to other small grants and contracts.

Key Partners
Community Health Improvement Partners; The Whittier Institute for Diabetes; The California Endowment; Physician’s Council of Community Clinics; University of California, San Diego School of Medicine Department of Endocrinology; Latino Health Access; San Diego State University Graduate School of Public Health; Johnson & Johnson; Merck; Scripps Health; LifeScan; Kaiser Permanente; Las Patronas; Bristol-Myers Squibb
What Works and Why

Project Dulce was shown to work because the program model targeted specific barriers to care that are experienced by uninsured, underinsured and low-income populations such as cultural differences in health care. Program participants were taught how to use medications properly, all services were scheduled for the same clinic visit, and the nurse team developed partnerships with the physicians at the community clinics. The involvement of a medical assistant who is multilingual was especially helpful for translating between the patient and the physician. Most importantly, Project Dulce used community health workers or promotoras to effectively raise awareness about the issues and overcome ethnic and cultural barriers.  

Structure and Operations

Project Dulce began in 1997 as a pilot program in North San Diego County, and has since spread to 17 other clinics throughout the United States. The program was designed to see how effective a culturally sensitive nurse case management/peer education class approach would be in improving diabetes care for underserved populations. Program participants are referred to the program by their primary care physician if they are found to have diabetes. The participant is then contacted by an NCM who then follows American Diabetes Association guidelines for appropriate physical and laboratory exams. The NCM stays in constant contact with the participant's primary care provider throughout the participant's entire enrollment period.

- Clinical: High-risk diabetics receive intensive care from a nurse team (RN/certified diabetes educator, and dietician). Program participants take part in diabetes self-management classes, and also have access to pharmaceutical and glucose monitoring supplies, podiatry and eye care services.
- Health Promotion: Diabetics receive comprehensive diabetes education. Participants take part in a bilingual 12-week course taught by promotoras. The promotoras are members of the community who are trained to be peer teachers. Weekly classes focus on diet, exercise and medication, in addition to the basic concepts of diabetes.

Barriers to Success

One of the barriers to Project Dulce's success was the fact that not all participants filled out the knowledge questionnaire about the program. Therefore all programs components were based on different response volumes. Another barrier was that funding allowed the enrollment of only about 300 patients in the San Diego County area, whereas more participants would have enrolled if allowed.

For More Information

Additional information is available online: http://www.whittier.org/pages/pp_dulce.html
Purpose
To eliminate racial and ethnic health disparities for more than 13,000 African-Americans with diabetes in Charleston and Georgetown counties in South Carolina

Target Population
African-Americans with diabetes in Charleston and Georgetown counties

Goals
- To improve health outcomes
- To increase access to care
- To generate funding for the continuation of coalition activities
- To empower the coalition
- To increase community awareness

Years in Operation
2000 – 2008

Results
The coalition found the following outcomes using the logic model:33
- Increased attendance at annual testing for at least 13,000 African-Americans: an increase in kidney testing from 13 percent to 53 percent and foot exams from 64 percent to 97 percent
- Improved diabetes control (HbA1C <7 percent) from 11 percent to 48 percent for 13,000 African-Americans
- Improved adherence to American Diabetes Association guidelines for diabetes education, with teaching provided at 94 percent of visits, up from 41 percent
- Decreased emergency room visits (about 50 percent less) for unfunded persons with diabetes
- Decreased lower-extremity amputations in African-American men (from 80 per 1,000 hospitalizations to 31 per 1,000 hospitalizations)
- Community support for funding diabetes supplies and medication for uninsured people
- Improved community education for persons with diabetes

Funding
Funding is generated by community fundraising, coalition activities, and an agreement from the Centers for Disease Control and Prevention.34
Key Partners
Alpha Kappa Alpha (Omicron Rho Omega Chapter); Carolinas Center for Medical Excellence; Charleston Diabetes Coalition; Commun-I-Care; Diabetes Initiative of South Carolina; East Cooper Community Outreach; Franklin C. Fetter Family Health Center; Georgetown County Diabetes Group; S.C. State Budget and Control Board; the Diabetes Prevention and Control Program of the S.C. Department of Health and Environmental Controls (DHEC); S.C. Budget and Control Board; S.C. DHEC Regions 7 (Charleston) and 5 (Georgetown); South Santee St. James Community Center; Tri-County Black Nurses Association; various churches, community centers, worksites, libraries.35

What Works and Why
The coalition works to decrease disparities through community-based participatory research and service learning. However, much of its success is attributed in part to a clear articulation of the principles of community-campus partnerships and of community-based participatory research, as well as working with honest communication and issue identification. Another factor that has supported the coalition’s success is clearly identified and prioritized goals and objectives and community support for reaching the identified milestones.

Structure and Operations
The Charleston and Georgetown Diabetes Coalition is a partnership between the Charleston and Georgetown communities and the Medical University of South Carolina College of Nursing.36 It is an urban-rural, community-university diabetes coalition, working in partnership to eliminate ethnic health disparities for more than 13,000 African-Americans with diabetes in Charleston and Georgetown counties in South Carolina. Local community groups, health care professionals, and people with diabetes identify assets and implement and evaluate community actions.37

Decisions are made through a democratic process, with each group getting one vote. Local coalitions in each county are governed by a board and bylaws. At each meeting (quarterly or monthly), they assess some aspect of their progress, and they use continuous quality improvement processes to move toward their mission and goals.

Barriers to Success
One of the major barriers to the success of REACH 2010 in Charleston and Georgetown counties is the participation of the target population in the program. Working with such a large target audience is difficult when trying to attain the predetermined goals.

For More Information
Additional information is available online: http://reach.musc.edu/index.html
Reducing Environmental Triggers of Asthma Home Intervention Project

MINNESOTA DEPARTMENT OF HEALTH

Purpose
To minimize or eliminate exposures to environmental allergens and triggers of asthma

Target Population
Minnesota children with asthma

Goals
- To reduce environmental triggers through patient-specific asthma education from a certified asthma educator (AE-C) and inexpensive, uncomplicated treatments, such as high-efficiency particulate air (HEPA) cleaners, pillow and mattress dust encasements, and HEPA vacuum cleaners

Years in Operation
2006 – 2008

Results
The project — known as RETA — has shown dramatically improved health outcomes and reduced health care costs. According to urgent care claims data from the Minnesota Council of Health Plans, an average unscheduled asthma office visit (urgent care) costs $84. Hospital discharge data from the Minnesota Hospital Association estimates that the average hospitalization for pediatric asthma in the Twin Cities metropolitan area costs $2,260. With the RETA project, unscheduled office visits declined by approximately two office visits, and hospital visits declined by approximately one visit, over the 12-month study period. These visits would have cost $2,428. Since the average cost of treatment was $468, the approximate cost savings were $1,960.

Product interventions also reduced the number of school days missed from seven days to less than one day on average 12 months later. There were improvements in daytime symptoms and functional limitation scores. The post intervention scores were dramatically closer to values generally viewed as moderate-to-no symptom impact on quality of life.38

Funding
Funded by the U.S. Environmental Protection Agency

Key Partners
Pediatric Home Service; Hennepin County Medical Center; Partners In Pediatrics; Children’s Respiratory Care and Critical Care; Minneapolis Public School District
What Works and Why

Commissioner Dr. Sanne Magnan attributes the project’s success to the following: the project’s AE-C who provided education about medications and asthma management, the asthma action plan, and environmental assessments that identified asthma triggers.39

Structure and Operations

Sixty-four families received both family-specific education and appropriate materials to minimize or eliminate exposures to environmental allergens and irritant triggers of asthma. During the initial home visit, information was collected regarding the number of emergency department visits, hospitalizations, missed school days, and unscheduled clinic visits that occurred in the previous three months. Products were delivered in a follow-up visit by the AE-C, with the total average cost of these visits being $468. Quality of life improvement was measured by responses to questions completed by the child’s parent or guardian regarding how the child’s life was affected by asthma during the past four weeks.40

The Minnesota Department of Health Asthma Program partnered with Pediatric Home Service to conduct RETA, a demonstration project.

Barriers to Success

Barriers to the success of RETA include families failing to be ready and willing to take part in the program in addition to families and children not making lifestyle changes. Without removing environmental allergens and irritant triggers of asthma in the home, asthma conditions will not change and may even worsen.

For More Information

Additional information is available online:
http://health.state.mn.us/asthma/documents/retafullreport0907.pdf
Steps to a HealthierUS
U.S. Centers for Disease Control and Prevention

Purpose
To fund community implementation of chronic disease prevention and health promotion programs that target three major chronic diseases and their underlying risk factors.

Target Population
Hispanics, Native Americans, African-Americans, Asian-American/Pacific Islanders, immigrants, low-income populations, people with disabilities, school-age youth, senior citizens, the uninsured or underinsured, and people at high risk for chronic disease.

Goals
To help Americans live longer and healthier lives.

Years in Operation
2003 – present

Results
Results from “Steps” communities include:
- Austin, Texas — The Steps program partners with Capital Metro to implement a worksite wellness program. Since its inception, employee absences have dropped more than 44 percent, health care costs increased by only 9 percent during 2004 – 2005 (compared to 27 percent during the previous year), and the Healthy Cafeteria program reported a 172 percent increase in the purchase of healthy foods.
- Pinellas County, Fla. — As a result of a Steps program, more than 3,700 students and staff increased their consumption of fruits and vegetables by the program’s third year, and 90 percent of students and staff participate in the schools’ farmers markets.
- Broome County, N.Y. — In 2004, a significant percentage of adults were overweight or obese in Broome County. After Steps’ “Mission Meltaway” program — an eight-week healthy lifestyle program — more than half of participants enjoyed weight loss and reduced body mass index (BMI).

Funding
The Steps program is funded by the U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention. Communities receive between $500,000 and $1.5 million to implement programs.

Key Partners
YMCA-USA/Steps; Agency for Healthcare Research and Quality; Health Resources and Services Administration; Administration on Aging; Ad Council; Active Living by Design; HealthierUS Veterans; United States Department of Agriculture.
What Works and Why

The Steps program works because it focuses its strategies on six fundamental principles:44

- Responding to community needs — In each Steps community, leaders from the public sector, nonprofit organizations and private organizations are brought together to promote disease prevention and health promotion strategies.

- Reaching diverse population groups — Steps communities partner with members of different racial and ethnic groups.

- Creating nontraditional partnerships — Steps communities partner with nonhealth entities such as Chambers of Commerce, transportation agencies, and media.

- Working in a wide range of settings — Communities promote disease prevention and health promotion activities at schools, workplaces, faith-based organizations, and health systems.

- Implementing large-scale interventions — Steps communities focus on the entire community population, not just one specific age group.

- Making programs sustainable — Steps programs are designed to be sustainable and to be integrated within the whole community.

Structure and Operations

Since the Steps program began in 2003, it has awarded more than $100 million to 40 communities to implement evidence-based activities. Currently, Steps funds 12 large city/urban communities, 25 counties in seven states, and three tribes/tribal entities.45

Steps communities create action plans and evaluation strategies to address and implement activities for its priority health challenges: obesity, diabetes, asthma, physical inactivity, poor nutrition, and tobacco use. Steps communities form partnerships to extend the reach of their programs and further their progress. In addition, all activities are integrated throughout the community — in schools, workplaces, businesses, and health systems. Steps uses the Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System to measure program outcomes and goals.46

Steps also funds the YMCA of the USA to expand the reach of community-based programs. Local YMCAs receive mini-grants to partner with local Steps communities and implement Steps programs. Examples of activities include after-hours physical activity programs, promoting healthy eating, and supporting healthy vending machines for children.47

Barriers to Success

One of the major barriers that Steps communities have had to overcome is payment for community activities. Many of the populations being served by Steps communities are low-income and cannot afford activities that cost money.48 Another barrier is the involvement of leaders within the community; if school principals, mayors or business executives are not on board with the program, then the program will not survive.

For More Information

Additional information is available online: http://www.cdc.gov/steps/about_us/index.htm
VERB: It’s What You Do
U.S. Centers for Disease Control and Prevention

Purpose
To create a social marketing campaign for children that promotes increasing and maintaining physical activity, and that influences teens’ lifestyle decisions.

Target Population
Children ages 9 to 13 (teens); parents and teachers of children ages 9 to 13; the campaign was used with all ethnicities throughout the country.

Goals
- To increase knowledge and improve attitudes and beliefs about teens’ regular participation in physical activity.
- To reach 50 percent of all 9- to 13-year-old children in the United States in the first year.
- To increase parental and influencer support and encouragement of teens’ participation in physical activity.
- To heighten awareness of options and opportunities for teen participation in physical activity.
- To facilitate opportunities for teens to participate in regular physical activity.
- To increase and maintain the number of teens who regularly participate in physical activity.

Years in Operation
2002 – 2006

Results
During the campaign’s first year, approximately 74 percent of all 9- to 13-year-olds in the United States had some sort of awareness of the campaign. As VERB awareness increased, so did physical activity. It should also be noted that during the first year of the campaign, 9- to 10-year-old children had 34 percent more free-time physical activity sessions than children who were not aware of the campaign. Among the female population ages 9 to 13, the campaign increased free-time physical activity by almost 27 percent.

Funding
Over the five-year campaign, the Centers for Disease Control and Prevention (CDC) was allocated $335 million ($125 million in FY 2001 and decreasing in each subsequent year) by Congress to implement VERB. The program also received additional funding from its key media partners for programming and other events. Congress did not renew funding for VERB in 2006, and the program ended.
Key Partners
Viacom; Disney; AOL; Primedia; Nickelodeon; Girls Inc.; National Recreation and Park Association; United Neighborhood Centers of America; Lexington-Fayette County (Ky.) Health Department; Office of Women’s Health – Nebraska Department of Health and Human Services; National Football League; Major League Soccer; Women’s Tennis Association

What Works and Why
One of the main reasons why the VERB campaign was successful was the strategic use of modern media marketing techniques to engage teens. The campaign also reached out to children who were not yet in high school, which is when physical activity levels are shown to decline. Communities around the United States also offered various VERB activities. Clark County Health Department in Winchester, Ky., offered a “summer scorecard” program and had 350 children sign up. Children kept track of their physical activity on scorecards, while community organizations offered free activities to those participants who were engaged in physical activity.\(^52\)

Structure and Operations
The VERB campaign was designed by the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health. The campaign purchased media time on television channels (e.g., Disney, Nickelodeon) in 15- to 30-second spots, in addition to print, online and radio ads. The campaign also placed information in school materials.\(^53\) The CDC contracted with four advertising agencies that specialize in reaching out to certain populations (e.g., Hispanic/Latino, Asian, Native American and African-American).\(^54\)

The CDC furthered the VERB campaign by using a social marketing framework to advertise nationally and in the nine VERB-focus communities. The campaign used commercial marketing methods to advertise to teens that physical activity was cool and fun. VERB also promoted different activities such as the “Longest Day of Play” on the summer solstice, and reached out to teens in schools through Weekly Reader and TIME for Kids.\(^55\)

Barriers to Success
The VERB campaign was able to produce very positive results in a short amount of time. The barrier to VERB’s success was the discontinuation of funding.

For More Information
Additional information is available online: http://www.cdc.gov/youthcampaign/index.htm
BCBSMA Jump-Up and Go!
BLUE CROSS BLUE SHIELD MASSACHUSETTS

Purpose
To help children, their families, and their communities become more physically active and develop lifelong healthy behaviors

Target Population
Children and families in the Blue Cross Blue Shield Massachusetts (BCBSMA) network

Goals
- To enable families, school leaders, physicians, peer leaders and community resources to work together to reinforce and support healthy behaviors in childhood
- To offer kids a fun, easy way to learn what it means to be healthy and grow strong
- To promote the 5-2-1 message:
  - Eat 5 servings of fruits and vegetables each day
  - Keep television, computer and video game time down to less than 2 hours per day
  - Get at least 1 hour of physical activity each day

Years in Operation
1998 – present

Structure and Operations
- Resources are designed to assist and support families and youth-serving organizations — schools, community-based organizations, and health centers and clinicians — in creating communitywide childhood obesity prevention and intervention efforts, including:
  - Educational resources
  - Challenges and rewards
  - Promotional materials
- Special events and quality initiatives give visibility to outstanding individuals and organizations that work to promote healthy eating and active living for youths and their families.

Funding
Blue Cross Blue Shield Massachusetts

For More Information
Additional information is available online:
Purpose
To promote increased opportunities for healthy eating and physical activity, the program wants communities, schools and businesses to make it easy for people to eat healthy food and be physically active. It also encourages individuals to think differently about what they eat and how much they move, and to make choices that will help them feel good and live better.

Target Population
All North Carolinians

Goals
- To increase healthy eating and physical activity opportunities for all North Carolinians by fostering supportive policies and environments
- To increase the percentage of North Carolinians who are at a healthy weight and consume a healthy diet
- To increase the percentage of North Carolina adults and children ages two and up who participate in recommended amounts of physical activity

Years in Operation
2000 – present

Structure and Operations
The work of Eat Smart, Move More … North Carolina (ESMM) addresses not only individuals but also their social and physical environments, including the social networks, communities and organizations that affect them.

To address behavior change at these various levels of influence, the programs and tools of ESMM are focused on nine settings. Successful changes within each of the settings will work to achieve the goals set forth in ESMM’s plan and help North Carolinians eat smart, move more, and achieve a healthy weight. The settings include: community, preschool, school, families, faith, worksites, health care, policy and media.

Funding
The ESMM Community Grants program provides funding to local communities to implement strategies of ESMM. In 2007–2008, it is granting 21 different programs $10,000 to $20,000 each.

For More Information
Additional information is available online: http://www.eatsmartmovemorenc.com
Mission Meltaway
Steps to a HealthierNY – Broome County, NY

Purpose
To increase the availability of weight loss programs

Target Population
All Broome County residents

Goals
- To increase the number of residents who are at a healthy weight
- To decrease the number of residents who are at risk for diabetes and obesity
- To increase the percentage of residents who consume a healthy diet and participate in regular physical activity

Years in Operation
2004 – present

Structure and Operations
Mission Meltaway is a free eight-week healthy-lifestyle program that uses a group approach to weight loss and maintenance, and builds on the concepts of the National Diabetes Education Program, “Small Steps, Big Rewards.” Volunteer facilitators receive manuals and are trained to provide weekly session to various groups. These trained facilitators adjust Mission Meltaway to meet the needs of specific community groups in a variety of settings. Changes are tracked through pre- and post-program weight measurements, body mass index, waist measurements, nutrition and physical activity surveys, and diabetes risk scores. Participants receive educational materials, food diaries, menu plans, and a free eight-week membership to the YMCA.

Specific examples of impact to date include:
- More than 2,000 participants lost an average of more than five pounds; average waist measurement was reduced also, indicating improved weight status
- BMI, an indicator of body fat, was lowered, and some participants reduced their disease risk related to weight
- Participants report eating a healthier diet, including more servings of fruits and vegetables and less fast food, baked goods, fried foods, processed/prepared foods, candy and chips
- Participants report being more physically active

Funding
Mission Meltaway is funded through a grant from the Centers for Disease Control and Prevention.

For More Information
Additional information is available online: http://www.broomesteps.org/hd/steps
National Memory Screening Day
ALZHEIMER’S FOUNDATION OF AMERICA

Purpose
To promote early detection of memory problems, Alzheimer’s disease and related illnesses, and to encourage appropriate intervention

Target Population
Individuals concerned about memory loss

Goals
- To offer free and confidential memory screenings to people concerned about memory loss
- To increase the early detection of memory loss and establish a baseline for people with normal scores
- To encourage appropriate intervention, including medical treatments, social services, and other resources for those with detected memory problems
- To raise public awareness about memory impairment, Alzheimer’s disease and related illnesses, successful aging and brain health62

Years in Operation
2003 – present

Structure and Operations
National Memory Screening Day is an annual event spearheaded by the Alzheimer’s Foundation of America in collaboration with community organizations. In November 2007, qualified health care professionals at more than 2,000 sites in 46 states offered resources and free, confidential screenings, consisting of questions and tasks designed to test memory, language skills, thinking ability and other intellectual functions.

The person who administered the screening then suggested whether follow-up for more extensive testing was necessary. The person screened received the results to take to his or her health care professional. Screening sites also provided information about successful aging.63

Funding
National Memory Screening Day is funded by the Alzheimer’s Foundation of America and corporate sponsors.

For More Information
Additional information is available online: http://www.nationalmemoryscreening.org
New York State Colorectal Cancer Screening Program
New York State Department of Health

Purpose
To increase the availability of colorectal and prostate cancer education and routine colorectal screening

Target Population
Underserved and uninsured populations age 50 and older

Goals
- To increase the prevention and early detection of colorectal cancer
- To help reduce mortality due to colorectal cancer
- To raise public awareness about colorectal cancer prevention

Years in Operation
1997 – present

Structure and Operations
The program is currently the largest of its kind in United States. Screening kits are distributed to eligible individuals through local partnerships involving county health departments, American Cancer Society chapters, hospitals, physicians, health care clinics, and individual health care workers. To date, there are 30 community-based partnerships involving 43 counties that provide colorectal cancer screening and education related to screening and treatment, each partnering with its local Cancer Services Program. The multitude of partnerships allows the program to reach the target population.

Individuals who receive a positive test through the screening kit receive a complete colon exam, including a colonoscopy. Since program implementation, more than 44,000 tests have been completed, and more than 1,800 individuals have had positive results requiring follow-up. In 2003, the program was expanded to allow screening colonoscopies for program participants at elevated risk for colorectal cancer based on the American Cancer Society guidelines.

Funding
The Colorectal Cancer Screening Program is funded by the State of New York.

For More Information
Additional information is available online:
http://www.health.state.ny.us/nysdoh/cancer-center/cancer_services.htm
Oklahoma Arthritis Network
OKLAHOMA ARTHRITIS PREVENTION AND EDUCATION PROGRAM, OKLAHOMA STATE DEPARTMENT OF HEALTH

Purpose
To reduce the burden of arthritis throughout the State of Oklahoma by increasing physical activity for residents who suffer from arthritis.

Target Population
All Oklahomans

Goals
- To promote awareness of arthritis
- To teach those who suffer from arthritis how to reduce symptoms

Years in Operation
1999 – present

Structure and Operations
The Oklahoma Arthritis Network is a statewide coalition of people with arthritis, health professionals, business leaders and educators. This coalition, in addition to the Oklahoma Arthritis Network Advisory Council and the Oklahoma Arthritis Network Steering Committee, helps guide the work throughout the state.

The Oklahoma Arthritis Network raises awareness about arthritis and the benefits of programs that help people better manage their arthritis. The network works with the Arthritis Foundation to provide training workshops for leaders and to promote arthritis awareness programs.

A physical activity workshop series was implemented to educate Oklahomans about the importance of physical activity for those with arthritis, particularly in the areas of pain relief and weight control. The Centers for Disease Control and Prevention Spanish health communications campaign Buenos Dias, Arthritis! No Me Venceras El Dia De Hoy! was also previewed in Oklahoma City between September and November 2005. Approximately 63 percent of our target population confirmed that moderate physical activity, three or more days a week, at least 10 minutes at a time, is good for their arthritis.

Funding
The Oklahoma Arthritis Network was developed by and is funded by the Oklahoma Arthritis Prevention and Education Program, Oklahoma State Department of Health.

For More Information
Additional information is available online: http://www.ok.gov/health/Community_Health/Community_Development_Service/Arthritis_Prevention_and_Education_Program/
Pioneering Healthier Communities
YMCA OF THE USA

Purpose
To develop a community-driven project to address the public health crisis in the United States

Target Population
All populations in the 64 participating communities

Goals
- To raise awareness and strengthen the framework for communitywide and national movements to reverse such unhealthy trends as physical inactivity and obesity
- To find cost-effective ways to educate and mobilize communities and replicate the success of other community-based initiatives
- To identify practical, replicable and sustainable tools for healthy living and informed decision making
- To build complementary local and national efforts
- To develop and initiate public policy priorities for communities, states and the nation

Years in Operation
2004 – present

Structure and Operations
All participating communities have implemented programs to reach out to their target populations. Communities must attend the national conference, build an action plan, and implement change. A training institute has also been established to provide a place where community leaders can learn from other participating communities and share ideas.69 Specific examples include:
- Clearwater, Fla. — Changes made in local after-school programs ultimately led to state legislation requiring that all public school elementary students receive at least 150 minutes of physical education per week.
- Attleboro, Mass. — The YMCA of Attleboro worked to change zoning laws within the town to include more sidewalks in development projects, because sidewalks spur physical activity and create safe routes for children to walk to school.70

Funding
Funding for the program has been included the President’s budgets; communities also receive funding from local grants and other key partners.

For More Information
Additional information is available online: http://www.ymca.net/activateamerica/activate_americaLeadership.html
Purpose
To encourage local park and recreation agencies and professionals to step up and take a leadership role in their community in the fight against the nation’s obesity epidemic.

Target Population
All members in participating communities

Goals
- To improve the existing assets and programs of a community or organization
- To advance collaboration with other stakeholders
- To engage citizens on individual, family, neighborhood and community levels

Years in Operation
2005 – present

Structure and Operations
Step Up to Health was developed to support Healthy People 2010. From January 2005 to May 2006, a 32-city Step Up to Health Summit Tour was conducted, reaching more than 2,200 people who represent more than 800 organizations. These people were trained on community mobilization and the Step Up to Health curriculum. Step Up to Health has continued to engage participants as “change agents” within their communities. Examples of community successes are:
- Bellevue, Wash. — Fit & Active Bellevue grants city employees free access to its fitness equipment. Bellevue is also creating a wellness committee to focus on the health, nutrition and wellness of city employees.
- Gainesville, Ga. — Gainesville Parks and Recreation (GPR) has educated children on physical activity benefits and increased their opportunity to be active in the summer day camp program. In 2005, more than 200 children signed a Healthy Lifestyle Pledge.
- Rockville, Md. — The Rockville Department of Recreation and Parks planned the Walk Rockville program to allow participants to be physically active in their own neighborhoods. Fourteen one- and two-mile walking paths were designed within the city around schools, parks, neighborhoods and businesses.

Funding
Step Up To Health receives a grant from the National Football League Youth Football Fund and is supported through a partnership with the Centers for Disease Control and Prevention.

For More Information
Additional information is available online:
http://www_nrpa.org/content/default.aspx?documentId=1765
Purpose
To lower the rate of obesity in the community

Target Population
All community residents (including kids 13 and older)

Goals
- To prevent obesity and obesity-related diseases and conditions

Years in Operation
2007 – present

Structure and Operations
Team Lean is a free 12-week communitywide weight loss competition involving both individuals and teams of five. The program offers free educational programs on healthy eating, staying active and more. Everyone participates in weekly weigh-ins, and free blood tests for cholesterol and triglycerides. Fasting glucose levels are taken pre- and post-competition. Participants pay $5 each week at the weigh-in, a $5 penalty if they skip a weigh-in, and $1 for each pound gained. Proceeds are distributed to the winners, determined by the greatest percentage of weight lost.

The YMCA waives membership fees for any Team Lean participants joining the YMCA during the competition. At the end of the 12 weeks, winners receive prizes at a community celebration. Additional prizes can be won at a weigh-in held six months later.

The program attracted more than 900 participants each year. Participants lost an average of 17 pounds each. Clinical indicators for the 2007 competition showed an average eight-point drop for cholesterol, 30-point drop for triglycerides, and four-point drop in fasting glucose levels.

Funding
Participants, with support from Memorial Hospital and Manor, and the YMCA.

For More Information
Additional information is available online: http://www.mh-m.org/Content/Default/6/58
Action Communities for Health, Innovation, & EnVironmental ChangE (ACHIEVE)

Purpose
To provide small grants to local public health agencies and YMCAs to bring together local leaders and stakeholders to build healthier communities by promoting policy and environmental change strategies with a focus on obesity, diabetes, heart disease, healthy eating, physical activity, and preventing tobacco use

Target Population
Ten community partnerships across the country

For More Information
Additional information is available online: http://www.achievecommunities.org

Active Living By Design

Purpose
To establish innovative approaches to increase physical activity through community design, public policies, and communications strategies

Target Population
Twenty-five community partnerships across the country

For More Information
Additional information is available online: http://www.activelivingbydesign.org
Chronic Disease Programs
U.S. Centers for Disease Control and Prevention

Purpose
To improve the nation’s health by preventing chronic diseases and their risk factors; these programs provide national leadership by offering guidelines and recommendations and by helping state health and education agencies promote healthy behaviors.

Target Population
General population

For More Information
Additional information is available online: http://www.cdc.gov/nccdphp/programs/index.htm

Chicago Moves Day
Mayor’s Fitness Council, the City of Chicago and the Chicago Park District

Purpose
To encourage people of Chicago to start moving to fight obesity

Target Population
City employees and residents

For More Information
Additional information is available online: http://www.mayorsfitnesscouncil.com
Coping Skills Training: Helping Youths and Their Families Deal with Diabetes

**Yale School of Nursing**

**Purpose**

To teach those with — or at risk for — diabetes to manage their lives in the context of the disease, rather than just how to manage diabetes, to enhance self-management

**Target Population**

Middle-school-age youths

**For More Information**

Additional information is available online: http://nursing.yale.edu and http://www.aannet.org/i4a/pages/index.cfm?pageid=3303

Get Fit Maryland

**Purpose**

To promote physical activity through a 12-week wellness program that gives participants pedometers to track how many steps they take each day

**Target Population**

All Maryland residents

**For More Information**

Additional information is available online: http://www.getfitmaryland.org
Guiding Stars
HANNAFORD BROTHERS

Purpose
To make it easy for shoppers to identify and choose more nutritious foods

Target Population
Residents of Maine with access to Hannaford stores

For More Information
Additional information is available online: http://www.hannaford.com/guiding_stars/index.htm

Healthy Hawks Program
UNIVERSITY OF KANSAS MEDICAL CENTER

Purpose
To provide Kansas City with a comprehensive pediatric obesity treatment program

Target Population
Children and adolescents ages 2 to 18

For More Information
Additional information is available online: http://www2.kumc.edu/kids/HealthyHawksProgram.htm
Healthy Homes, Head Start

Purpose
To address indoor and outdoor environmental factors that may contribute to asthma

Target Population
Homes within the community, through assessments conducted by Western Idaho Community Action Partnership Head Start

For More Information
Additional information is available online: http://www.wicaphs.com/default.htm and http://www.healthandwelfare.idaho.gov/DesktopModules/ArticlesSortable/ArticlesSRTView.aspx?tabID=&itemID=278&mid=10403&wversion=staging

Healthy People 2010

Purpose
To increase quality and years of healthy life and to eliminate health disparities

Target Population
Nationwide

For More Information
Additional information is available online: http://www.healthypeople.gov
INShape Indiana

Purpose
To provide a framework for a personal or organizational fitness initiative

Target Population
All Indiana residents

For More Information
Additional information is available online: http://www.in.gov/inshape

Integration of Funding Initiative

Healthy Maine Partnerships, Maine Bureau of Health

Purpose
To facilitate the coordination and collaboration of the four Bureau of Health and Department of Education programs responsible for planning, implementing and evaluating the program activities funded by the tobacco settlement:

- Maine Cardiovascular Health Program
- Community Health Program
- Partnership for a Tobacco Free Maine
- Coordinated School Health Program

Target Population
Residents of Maine

For More Information
Additional information is available online: http://www.healthymainepartnerships.org
**LiVe Campaign**
**INTERMOUNTAIN HEALTHCARE**

**Purpose**
To help teens reach and maintain a healthy weight

**Target Population**
Children in Utah ages 11 to 15

**For More Information**
Additional information is available online: http://www.intermountainlive.org

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**MetroWest Community Health Care Foundation**

**Purpose**
To improve the health status of our community, its individuals and families through informed and innovative leadership

**Target Population**
Community-based and community-driven programs in Massachusetts

**For More Information**
Additional information is available online:
http://www.metrowestkids.org/aboutthefoundation.php
**Places for Physical Activity**  
**U.S. Centers for Disease Control and Prevention**

**Purpose**  
To implement interventions that create or enhance access to places where people can be physically active, and to provide related informational outreach activities in community settings, in order to increase physical activity

**Target Population**  
Children and adolescents

**For More Information**  
Additional information is available online:  
http://www.cdc.gov/nccdphp/dnpa/physical/index.htm

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**Rails to Trails**

**Purpose**  
To create a nationwide network of trails from former rail lines and connecting corridors to build healthier places for healthier people

**Target Population**  
All ages

**For More Information**  
Additional information is available online: http://www.railtrails.org/index.html
YMCA Activate America

Purpose
To empower local communities with proven strategies and models that will allow them to create and sustain positive, lasting change around healthy living

Target Population
American communities

For More Information
Additional information is available online: http://www.ymca.net/activateamerica


8 Alabama Department of Public Health, Enhancing Fitness with EnhanceFitness: An Evidence-Based Intervention for Older Adults & People with Chronic Disease [webcast], http://www.adph.org/alphthn/470handouts.pdf (accessed 6 May 2008).


10 E. Schneider, op. cit.

11 Alabama Department of Public Health, op. cit.


14 Partnership for Prevention, op. cit.


16 Ibid.


18 J.W. Krieger et al., op. cit.


20 America’s pharmaceutical companies and the HealthyFresno and HealthyJackson Blue Ribbon Commissions, A Blueprint for Community Health: Lessons Learned from HealthyFresno and HealthyJackson [draft] (March 2008).


24 National Heart, Lung, and Blood Institute, *Hearts N’ Parks*, op. cit.


29 Ibid.

30 Ibid.


34 Ibid.


36 Ibid.

37 Community-Campus Partnerships for Health, op. cit.


40 Ibid.


46 Centers for Disease Control and Prevention, *CDC's Steps Program: About Steps*, op. cit.


53 M. Huhman *et al.*, *op. cit.*

54 F. Wong *et al.*, “VERB: A Social Marketing Campaign to Increase Physical Activity Among Youth,” *Preventing Chronic Disease Public Health Research, Practice, and Policy* 1, no. 3 (July 2004): A10.


Ibid.


YMCA of the USA, Statewide Advocacy in Support of Health and Well-Being (Chicago: YMCA of the USA, 29 January 2008).


Ibid.


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Memorial Hospital and Manor, Team Lean History, http://www.mh-m.org/content/default/6/73/58 (accessed 14 May 2008).

Ibid.

Memorial Hospital and Manor, Team Lean History, http://www.mh-m.org/content/default/6/58 (accessed 14 May 2008).

Memorial Hospital and Manor, Team Lean History, op. cit.
Wellness in the workplace is not just good for employee health, but it can improve the bottom line for the employer as well. Employers realize that health coverage costs are just part of the equation, and when employees are absent, or if they come to work when they are unwell, productivity, safety, and overall operations can suffer. Employee-based wellness programs have become a major tool to manage costs, improve productivity, reduce absenteeism, and can even positively influence the health of employees' family members. Workplace programs that succeed in improving health and managing costs are operating in both large and small workplaces nationwide, as the examples that follow demonstrate.
# WORKPLACES

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Asheville Project
CITY OF ASHEVILLE, NC

Purpose
To lower health care costs by improving health of employees with chronic health problems, including diabetes, asthma, hypertension and high cholesterol, through better self-management and treatment adherence.

Target Population
Employees and retirees of the city of Asheville, N.C., as well as their dependents with chronic diseases.

Goals
- Reduce the impact of diabetes, asthma, hypertension and high cholesterol on city employees and their dependents.
- Provide pharmacists the opportunity to serve on the frontline of patient care, allowing them the opportunity to contribute to clinical improvement.
- Foster collaboration and innovation that will collectively lead to reduced health care costs.
- Lower or eliminate cost barriers from the standpoint of employers.

Years in Operation
1996 – present

Results
- Participants in the Asheville Project experienced improvements in clinical and health care outcomes. For example, at every follow-up, more than 50 percent of patients experienced improvement over baseline A1C levels. Additionally, at all follow-ups, researchers observed an increase in the number of patients with optimal A1C values.
- Mean costs for insurance claims decreased by $2,704 per-patient per-year (PYPD) in the first follow-up year, and by $6,502 PYPD in the fifth follow-up year. During the same periods, mean prescription costs increased by $656 to $2,188 PYPD, with diabetes-related prescriptions accounting for more than half of the increase.
- Similar collaborative care programs for asthma and cardiovascular disease have yielded both clinical improvements and cost savings.
- The Asheville Project inspired a new payer-driven and patient-centered model for individuals with chronic conditions. Other employers across the Midwest and East Coast have also adopted this approach as an additional health care benefit to empower their employees to control their chronic diseases, reduce their health risks and ultimately lower their health care costs.

Funding
Funding is provided by the city of Asheville.
Key Partners

Community pharmacies in and around Asheville; the city of Asheville; Mission-St. Joseph’s Diabetes and Health Education Center

What Works and Why

The Asheville Project is a collaborative care model that relies on the following:

- The employer drives collaboration (serving as leverage point, if needed) among providers.
- Appropriate patient incentives are built into the program. Incentives are clearly identified, and the benefits of participation are explained to program participants.
- Benefits are realized for employers through lower costs, and for insurers by providing an edge against the competition.
- Provider integration and collaboration is present, with providers’ being paid for their time — the stronger the integration, the better the program.
- Strong relationships are built with the patient. Pharmacists are accessible, are part of the community and are the most knowledgeable regarding medication services.
- The patient is held accountable. Patients know they will be meeting with their pharmacist coaches, who will know if they are not taking their medications, checking their blood sugar, etc.

Structure and Operations

Local pharmacists are trained to provide counseling to patients in the program. Individuals meet regularly (at first monthly, and then quarterly) with their pharmacist coaches who check the patients’ disease management, refer patients to physicians if problems are identified, and, when recommended, preventive services are due.

Programs vary depending upon the employer. Pharmacists meet individually with participants in the programs. Participants receive educational training on their diseases and how to manage them. Copayments for chronic disease medications are waived or significantly lowered to encourage compliance among participants.

Barriers to Success

- Patients’ not complying with pharmacy visits or taking the time to visit with the pharmacists.
- Pharmacists’ not connecting with the target population.
- Providers’ not collaborating.

For More Information

Additional information is available online:
http://www.aphafoundation.org/programs/Asheville_Project
Bridges to Excellence
OPERATIONAL IN AR, CA, CO, DC, GA, KY, MA, ME, MD, MN, NC, NJ, NY, OH, VA, WA

Purpose
To improve the quality of care by recognizing and rewarding health care providers who demonstrate that they have implemented comprehensive solutions in the management of patients, and deliver safe, timely, effective, efficient, equitable and patient-centered care.

Target Population
Health care providers

Goals
- Encourage the investments needed to transform health care processes to reduce mistakes
- Reduce waste and inefficiency through significant reductions in defects (misuse, underuse, overuse)
- Increase accountability and quality improvements through the development and release of comparative provider performance data to consumers

Years in Operation
2003 – present

Results
- Incentives that reward physicians for adopting better systems of care result in physician practice reengineering and adoption of health information technology.
- Incentives that reward physicians for delivering good outcomes to patients with diabetes result in physicians’ changing the way they provide care — from reactive to proactive — and in patients’ getting better care.
- Physicians who are recognized for adopting better systems of care, and physicians who deliver better outcomes for patients with diabetes are more cost-efficient (on a severity and case-mix adjusted basis) than physicians who are not recognized.
- Performance measures that focus on intermediate outcomes for patients with diabetes, hypertension, hyperlipidemia, coronary artery disease, and cardiovascular disease, and measures of effective treatment protocols for patients with recent cardiac events hold the highest clinical and actuarial value of most measures of ambulatory care.

Funding
Funding is provided by participating employers and health plans. Providers fund the investments needed to adopt information technology and other practice improvements.
**Key Partners**

Health care providers; health plans; employers; patients

**What Works and Why**

Providers are offered meaningful monetary incentives and recognition for meeting program objectives. The costs and benefits of participating in the incentive program are explained to the providers at the outset. Providers must perform self-assessments of performance and receive third-party validation for award eligibility. This effort has proven a powerful agent of change.

**Structure and Operations**

Bridges to Excellence (BTE) is a not-for-profit organization developed by employers, physicians, health care services, researchers and other industry experts. The program relies upon offering physicians sufficient incentives to adopt new technology and change practice patterns to achieve better health outcomes. Both the amount of the reward and the achievements required to attain reward levels are described at the outset. Provider rewards are paid per BTE patient seen by the provider. Participating practices make the changes needed and conduct rigorous self-assessments of their performance. An independent, reputable third party validates the assessment. Currently, BTE has programs to reward changes in adoption of health information technology, diabetes care, cardiac care, spine care, and providing a medical home. BTE is also piloting a new program to reward comprehensive care.

**Barriers to Success**

Maintaining sufficient incentives as additional programs are added contributes to complexity for providers. Having a sufficiently large patient population to tempt providers to participate can be difficult.

**For More Information**

Additional information is available online: http://www.bridgestoexcellence.org
Caterpillar, Inc.

Purpose
To reduce projected direct health care cost increases by identifying health risks early, and intervening to reduce those risks and accompanying costs

Target Population
Employees (80,000) and others covered by Caterpillar health plans (120,000 total)

Goals
- Identify health risks early
- Promote risk reduction and disease/care management
- Achieve 80 percent employee engagement in health improvement activities by 2010
- Engage providers in collaborative care network
- Improve clinical and financial outcomes over time

Years in Operation
1997 – present

Results
- Ninety percent health-risk assessment participation\(^7\)
- For diabetes management program: 50 percent experienced HbA1C reduction; 96 percent are measuring A1C levels; 72 percent are meeting Surgeon General’s activity recommendations; 98 percent are on aspirin therapy
- 50 percent reduction in disability days
- Smoking cessation rate of 35 percent, even after 3 years

Funding
Caterpillar funds the programs.\(^8\)

Key Partners
Caterpillar employees, retirees and dependents; company and union leadership; providers

What Works and Why
Caterpillar relies on data specific to its employees to evaluate and identify health risks and develop its risk management strategy. It provides employees with incentives to participate in health risk assessments and health promotion activities. The company also removes barriers to participation in disease/care management and employee assistant program offerings. Caterpillar tracks both clinical and financial outcomes, and shares information with employees about their current health status compared with employees overall and about improvements made over time.
Structure and Operations

Caterpillar determined that coronary, diabetes and stroke events were driving claims costs as well as disability, and developed a focused risk-management strategy to identify those at highest risk. The company encourages participation in health-risk assessments by providing a $900 reduction on yearly insurance for each employee, spouse and retiree under age 65 who participates. Caterpillar also removes barriers to disease/care management and its employee assistance program, which resulted in 80,000 enrollees. The company encourages healthy choices in the cafeteria by subsidizing healthier meal options. Employees receive a personal scorecard that shows their improvement against the aggregate employee health status and employee improvement over time. Caterpillar engaged with providers to enroll in collaborative risk/disease/case management for employees relying on integrated claims, pharmacies and a self-report database. The company tracks both clinical and financial outcomes over time.9

Barriers to Success

The size and diversity of the international workforce make tailoring programs difficult and costly.

For More Information

Additional information is available online: http://www.vbhealth.org/Caterpillarv3.pdf
Health Care University
PITNEY BOWES

Purpose
To improve employee health and lower costs by providing health services demand manage-
ment, disability management and disease management/prevention, utilizing a network of
prevention programs and onsite primary care clinics.

Target Population
Pitney Bowes’ more than 35,000 worldwide employees

Goals
- Enhance health outcomes
- Avoid cost shifting/reward healthy behaviors
- Measure impact
- Enhance benefits
- Educate health care consumers
- Promote efficiency in utilization and purchasing practices
- Provide resources to achieve individual employees’ objectives

Years in Operation
Various forms of disease management involvement since the 1950s; the wellness program,

Results
- Comparing program participants to non-participants, covered expenses were 7 percent
  higher in the non-participant group ($2,317 compared to $2,173). Additionally, the trend for
  participants showed an actual decrease of 5 percent over three years, while non-participants
  showed a 2 percent increase in costs.
- Participants averaged fewer than 0.1 emergency visits per year, while non-participants
  averaged more than 0.2 visits.
- Pre- and post-participation comparison of onsite fitness center members showed that they
  had: fewer sick days (47 percent fewer); reduced smoking prevalence (10 percent reduction);
  and better fitness status (20 percent of participants improved).
- Twenty percent of participants report improved nutritional habits, and 50 percent report
  increased work productivity.
- Overall analyses reveal a 2.8 to 1 cost savings for HCU.
- Lowering pharmacy copays for diabetes and asthma medicines improved compliance and
  reduced overall medical costs by $1 million in the first year and $2.5 million in the third year.
Funding

The program is funded through the Pitney Bowes corporate operations budget.\textsuperscript{16}

Key Partners

Health coaches; onsite medical staff; disease management staff

What Works and Why

Significant investment in integrated data systems and analysis enables Pitney Bowes to target resources and monitor progress effectively. The analysis uses online, individual-level data, including three years of medical claims information.

Structure and Operations

Pitney Bowes supports good health by emphasizing prevention, early detection, wise consumerism, and appropriate, timely care for individuals at all levels of health. Integration of health initiatives creates simplicity, efficient resource use, and consistency for participants. Preventive care is fully integrated with onsite medical and fitness facilities, ergonomic programs, the Employee Assistance Program, and disability and benefit areas. Resources, referral and data analysis link these to create a unified, coordinated “Total Health” approach. Convenient access is assured through use of technology, such as kiosks equipped with health monitoring equipment and onsite resources.

The HCU program motivates employees by providing credits for participation in selected activities. If an employee earns six credits during the term (September–June), he or she is awarded $25 toward future benefit purchases. Many activities are provided onsite for convenience, and/or are fully covered under the medical plan, if a physician’s office visit is required.

Pitney Bowes’ integrated health care strategy consists of three major building blocks: education, efficiency and employer design. Pitney Bowes’ goal is to educate the health care consumers to provide for more efficient utilization and purchasing. It will provide employer support and guidance for these objectives internally and externally through plan design, programming, and support of internal and community health care resources. For example, starting in 2001, Pitney Bowes restricted its pharmacy benefit to move asthma, hypertension and diabetes medicines to the lowest copay to encourage compliance. Based on that success, the company has since reduced other pharmacy copays and added medical clinics at worksites to offer preventive services and regular medical care.\textsuperscript{17}

Barriers to Success

With such a broad and comprehensive program, directing employees to the appropriate resources without overloading them with information.

For More Information

Additional information is available online: http://healthproject.stanford.edu/koop/pitneybowes/description.html
**Hip-Hop to Wellness**

**CITY OF FARMERS BRANCH, TX, AND FARMERS BRANCH PARKS AND RECREATION**

**Purpose**
To lower health insurance costs by promoting employee health and wellness.

**Target Population**
Farmers Branch employees

**Goals**
- Get employees more active
- Employee completion of a health risk assessment
- Increase use of preventive care and screenings

**Years in Operation**
2006 – present

**Results**
After the first year, the city’s health insurance renewal rate dropped from 15 percent for 2005–2006 to 8.5 percent for 2006–2007.

**Funding**
The program is funded by the city.

**Key Partners**
City departments; hospitals; schools; elected officials; medical community

**What Works and Why**
Employees were offered the incentive of a free annual membership to the Farmers Branch Recreation Center for completing a specific set of wellness activities each year. The program updated employees regularly about opportunities to participate, highlighted employee accomplishments in communications about opportunities to engage, and offered convenient, organized activities that accommodated various activity levels. The city manager and assistant city managers support the program and are regular participants in the classes offered.

**Structure and Operations**
Employees received a free annual membership to the Recreation Center by: completing an online health risk assessment; participating in three free health screenings provided by the city each year; receiving a preventive exam from a health care provider; and participating in four Hip-Hop activities during the year.
The fitness programmer provided employees a monthly calendar of upcoming events that the city included in employees’ paychecks. The calendar included an “Employee Spotlight” to celebrate employee accomplishments in relation to health and fitness.

The Parks and Recreation Department offered free lunchtime group exercise classes and organized a monthly walking program to make being active more convenient.

Since its inception, the program has expanded, through partnerships with local health professionals, to include lectures and screenings to the community and city employees.

**Barriers to Success**
Sustainability of incentives and ability to expand program to dependents is not clear.

**For More Information**
Additional information is available online:
http://www.nrpa.org/content/default.aspx?documentId=6984
Purpose
To improve the health and productivity of its employees and manage health care costs by supporting better health resource utilization and shared accountability for health performance20

Target Population
U.S. employees (130,000) and others covered by IBM health plans (500,000 total)

Goals
- Encourage employees to rethink their health motivation and encourage positive health behaviors
- Help employees manage chronic conditions
- Maintain lower-than-average health care coverage costs
- Drive appropriate health care utilization choices
- Elevate personal health management to a job expectation

Years in Operation
Long-term program (Web-based personal health records available from 2006 – present)

Results
- Improved health-risk levels across IBM contributed up to $20 million in savings in 2005.
- IBM employees had fewer emergency room visits and hospital admissions, and lower medical and pharmacy costs.
- Overall, health and well-being programs drive more than $175 million in savings for IBM.
- IBM health care premiums are 6–15 percent lower than industry norms, and employees pay 26–60 percent less than industry levels.

Funding
IBM funds the programs.

Key Partners
IBM employees, retirees and dependents; C-suite executives; health plans

What Works and Why
IBM treats the health and well-being of its employees as vital to its financial success. They have visible leadership at the executive level for positive health management. The company motivates employee engagement in healthy behaviors through rebates and other incentives. They have made significant investments to provide employees with a Web-based personal
health record that helps them to track claims data and they eventually will provide lab data and link into providers’ offices, clinics and hospitals, as well.21

Structure and Operations
IBM provides coverage from the first day of employment, and provides incentives, including rebates, for completing health-risk assessments, exercise and nutrition program participation, and smoking cessation. IBM relies on an outside vendor to provide disease management, but builds in accountability by tracking performance, documenting milestones and rewarding achievement. Employees share in the cost-savings, as employee premiums are 26–60 percent lower than average industry levels. To facilitate appropriate choices in health resource utilization, IBM provides each employee with a Web-based personal health record to track his or her medical and pharmacy claims.

Barriers to Success
The size and diversity of the workforce make tailoring programs difficult.

For More Information
Additional information is available online:
Johnson & Johnson Health&Wellness Program (formerly known as “LIVE FOR LIFE”)

Purpose
To optimize medical services, and the health and productivity of J&J employees worldwide and to provide sustainable and effective services to improve the health of J&J employees while helping to control health care costs. Promote and sustain a “global culture of health.”

Target Population
Johnson & Johnson’s 120,000 employees worldwide (46,000 US based)

Goals
- Make Johnson & Johnson employees the healthiest in the world
- Provide appropriate intervention services before, during and after major health-related events
- Emphasize awareness among employees, through health education, prevention activities, self-responsibility and self-care
- Maximize employee functioning and optimal return to work
- Optimize health, resulting in a reduction in health care utilization and medical care expenditures

Years in Operation
1979 – present (“H&W Program” since 1993)

Results
A long-term study of the impact of Johnson & Johnson’s “LIVE FOR LIFE” program in the US, found a large reduction in medical care expenditures — approximately $224.66 per employee per year — over the 4-year study period. These savings came from the following areas, most of which were accrued in years 3 and 4 after program initiation:
- $119.67 reduction – inpatient hospital use
- $70.69 reduction – mental health visits
- $45.17 reduction – outpatient service use
- Overall, Johnson & Johnson’s Health & Wellness Program has saved the company more than $38 million between 1995 and 1999.

Funding
The program is funded by Johnson & Johnson.

Key Partners
Johnson & Johnson’s board of directors, executive team, and operating company human resources/environment health & safety contacts
What Works and Why

- Company-provided financial incentives to employees who participate in the program and take advantage of its various offerings in the US (up to $500 in benefit credits).
- A message of prevention permeated across all major health & benefit programs, increasing each program's success and avoiding duplication of services.
- A concentration on changing individual behavioral and psychosocial risk factors, instead of solely focusing on the treatment of symptoms.
- Planning and programming varies by country, region, and company location, due to different health care systems, diseases, disease states, culturally specific behaviors, and accessibility to services.
- Expansion of services while integrating with the cultural and business needs of the Operating Companies around the world.

J&J works to ensure that the program continues to be modified as knowledge increases regarding how to incentivize employees to live healthier and become more productive employees.

Structure and Operations

In 1993, Johnson & Johnson restructured its wellness program into one that focuses on the shared services concept — integrating employee health, wellness, disability management, employee assistance and occupational medicine programs. These integrated services placed an even greater emphasis on health promotion and disease prevention than the previous LIVE FOR LIFE program. Since 2004, there has been a major effort to globalize and deploy the health & wellness programs worldwide.

Barriers to Success

Sustainability of company-provided financial incentives, which were crucial to attaining participation levels above 90 percent. Global expansion of wellness and prevention programs and identification of reliable country and region specific health resources remains a challenge.

For More Information

Additional information is available online: http://healthproject.stanford.edu/coop/Johnson%20and%20Johnson/pdf/Longterm%20Impact%20JandJ.pdf
Purpose
To focus on reducing annual increases in health care costs by increasing employees’ engagement in their health care decision-making

Target Population
Alegent’s 8,500 employees

Goals
- Provide 100 percent free preventive health care (based on guidelines from the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices and the American Academy of Pediatrics)
- Allow employees to choose how they want to spend their health care dollars: by enrolling in either a Health Reimbursement Account or Health Savings Account (HSA)
- Provide employees incentives for Healthy Lifestyle changes
- Offer free health coaching
- Encourage enrollment in the programs by offering $20 per pay-period premium subsidies to employees with base salary of $14.42 an hour or less

Years in Operation
2006 – present

Results
- As a result of employees’ changing their spending patterns and engaging in healthier behaviors, Alegent Health returned $700,000 in savings to employees during 2006. Each eligible employee received a $100 rebate for improving his or her health.
- Number of employees enrolling in HSA or Health Reimbursement Account plans has risen from 79 percent in 2006 to 88 percent in 2007.
- Generic prescription use is up among employees in the Health Reimbursement Account and HSA plans.
- Incentives help employees reach healthy life goals (e.g., 42 percent of employees participated in an electronic health checkup program; high utilization of personal health coaches among those who could benefit).

Funding
Alegent HealthCare funds the new initiatives through savings accrued by the new programs.
Key Partners
Health care systems participating in Power to the Patient include: Aurora Health Care, Milwaukee, Wis.; Elliot Health System, Manchester, N.H.; Martin Memorial Health Systems, Stuart, Fla.; Mercy Medical Center, Cedar Rapids, Iowa; North Shore LIJ Health System, New York, N.Y.; Provena Health System, Joliet, Ill.; Sisters of Mercy Health System, St. Louis, Mo.; St. John’s Health System, Springfield, Ill.; Via Christi Health System, Wichita, Kan.

What Works and Why
Alegent’s success is due, in part, to communicating frequently about the new plan. For example, focus groups were conducted to help with plan design, and more than 57 employee information sessions were held when the new plans were being introduced. Additionally, Alegent Health hosted benefit fairs and provided opportunities for family members to learn more about the plans, especially how to access preventive care.

Participation in Alegent’s plans was promoted by executive leadership, who supported the development of the infrastructure necessary to make the plans successful, such as making available health coaches, e-checkups, Web-based information and online tools, and comprehensive disease management programs.

Structure and Operations
Basic new benefit plan types include two health reimbursement accounts, two health savings accounts, and a preferred provider arrangement. In addition to paying for preventive care, Alegent Health also provides a contribution for employees, based on their coverage elections. Eligible prescription drugs are covered under all of the plans.

In each of the plan options, Alegent Health determined it would cover 100 percent of costs for preventive care, ranging from annual checkups and routine childhood immunizations to mammograms and prostate specific antigen (PSA) tests. While nationally, 2.8 percent of health care dollars were being spent on preventive care, Alegent Health spent 7 percent.28

Barriers to Success
- The program experienced a lack of enrollment among people who could benefit from the new disease management and wellness programs offered through the new health plan.
- Additionally, the company underestimated the overall number of employees who would be interested in the program.

For More Information
Additional information is available online: http://powertothepatient.alegent.com
Take Care of Your Health
USAA

Purpose
To promote health and wellness among USAA employees

Target Population
USAA employees and dependents

Goal
- Enhance the health and productivity of its workforce through an integrated wellness program
- Embed wellness into USAA’s culture by creating an environment that promotes health and wellness

Years in Operation
2002 – present

Results
- Overall wellness program participation increased to 68.5 percent companywide in 2005.
- Forty-five percent of current active employees have completed at least one health-risk assessment.
- Program participants have experienced statistically significant decreases in weight, smoking rates, and health-risk factors.
- Participants have seen statistically significant increases in worksite productivity.
- Workers’ compensation has seen reductions of 3 percent in frequency, 8 percent in rate, and 24 percent in severity, with 427 days of potential-gained productivity.
- Workplace absences have decreased, with an estimated three-year savings of more than $105 million.
- USAA’s medical plan cost trend (5.6 percent in 2005) continues to outperform the national average.

Funding
The program is funded by USAA.

Key Partners
USAA Wellness Council

What Works and Why
The program offers employees financial incentives — up to $350 per year — to help with wellness-related expenses, defined to include weight management and smoking cessation programs, as well as purchasing certain gym equipment. Barriers to participation are reduced
by, for example, minimal membership costs to onsite fitness centers and free onsite screenings and online risk assessment tools. The program is data-driven, with comprehensive reporting and evaluation reaching the family, as well as the employee. Evaluation incorporates data from medical claims, absences, disability and workers’ compensation claims. Communications are organized around clear, simple messages and support program components at multiple levels, e.g., “don’t smoke” message is underpinned by a campus-wide smoking ban, health-risk assessment and messaging, and individual coaching programs.

Structure and Operations
USAA’s program provides an integrated wellness program that encompasses more than 20 unique wellness initiatives and activities, ranging from onsite fitness centers and healthy food choices in cafeterias to integrated disability management and health-risk assessments. USAA’s wellness program instituted a cross-company team of partners and stakeholders, including fitness, food services, corporate safety and corporate communications. This team, referred to as the “USAA Wellness Council,” meets regularly to strategize, plan and review program results. A customized data warehouse pulls together the full spectrum of employee health and wellness information by capturing demographic information, population health consumption data, health and wellness participation data, and intervention outcomes. Data analysis provides ongoing opportunities to fine-tune all wellness initiatives and benefits programs in order to continue improving the health of employees and their families.

Barriers to Success
Continued ability to sustain program funding through accrued savings from disease management/wellness initiatives.

For More Information
Additional information is available online:
Washoe County Good Health Incentive Program
WASHOE COUNTY SCHOOL DISTRICT, WASHOE COUNTY, NV

Purpose
To improve employees’ health by increasing their awareness of risk factors for chronic illness and implementing health promotion programs

Target Population
Washoe County School District employees and retirees

Goals
- Create better role models for students
- Reduce or stabilize the county’s share of annual increases in health insurance costs
- Financially incentivize employees to participate in health-risk-reducing activities, while generating resources to support health promotion efforts

Years in Operation
1994 – present

Results
- Nonparticipants in the voluntary health programs had 20 percent higher rates of illness-related absenteeism than did employees who participated.31
- A cost-benefit analysis revealed that the school district saved $15.60 for every dollar spent on the wellness programs. The program saved the district $2.5 million in two years, and employees enjoyed dramatically improved health and quality of life.32

Funding
The program is self-funded by the wellness contribution employees make monthly. Employees who participate in wellness activities can lower their contribution to $0.

Over a 10-year period, the self-funded program has generated $1.4 million. Annual program income in 2001 exceeded $300,000, all largely generated by payments from people who decided not to participate in screenings or address risk factors. These funds support all of the district’s health promotion activities, including educational activities, physical fitness programs, screenings, the employee assistance program, educational materials, professional consultation, and stipends for site coordinators.

No district or other public funds support the program.33
Key Partners
Washoe County School District’s Superintendent’s Executive Cabinet; Washoe County School District’s Insurance Committee

What Works and Why
Programs focused on a variety of population health activities, such as brushing and flossing teeth, sensible eating during the holidays, the importance of drinking enough water, reducing TV time, getting the right amount of sleep, exercising, seatbelt safety, brain functioning and fitness challenges. Individuals have financial incentives to participate.

Structure and Operations
All members and spouses of the district’s health plan have a $40 per month contribution to the Wellness Program. This contribution can be reduced to zero by engaging in healthy actions each year aimed at achieving ideal blood pressure, decreasing tobacco use and maintaining a healthy body mass index.

Every step taken toward improved health reduces the monthly contribution by $10. For example, overweight employees who receive an annual health screening pay $30 each month. If those same employees also participate in one of the program’s weight loss activities, they pay $20.

With up to eight annual activities, the program is funded mostly by the 7.5 percent of the district’s employees who do not take any preventive health measures, and another 7.5 percent who pay a small contribution — roughly $10 each month — for not addressing a specific health risk, such as high blood pressure. About 6,000 employees pay nothing, while the other 700 contribute $40 per month.

Barriers to Success
This plan operates mostly on self-reporting — employees confirm their own participation in many of the wellness activities. Employee honesty is paramount to this program’s success.

For More Information
Additional information is available online: http://www.washoe.k12.nv.us/wellness/access.html
Buffalo Supply, Inc.

**Purpose**
To maintain a healthy workforce, improve productivity and manage future health care costs.

**Target Population**
Buffalo Supply, Inc’s 21 employees and their families.

**Goals**
- To promote prevention
- To improve productivity
- To manage health care coverage costs

**Years in Operation**
N/A

**Structure and Operations**
- Pays the total premium for employees and their families for a high-deductible policy with a Health Savings Account
- Provides 100 percent coverage and no copay for all medicines or services once the deductible is met
- Covers preventive care at 100 percent with no deductible
- Pays for flu shots administered onsite
- Provides monetary incentives to employees who stop smoking
- Participates in a larger risk-pool with other employers

**Funding**
Funding is provided through Buffalo Supply, Inc.

**For More Information**
Additional information is available online: http://prevent.org/content/view/30/57
Diabetes Ten City Challenge
COMMUNITIES IN CA, CO, FL, GA, HI, IL, MD, PA, SC, WI

Purpose
To align incentives to focus on wellness, patient self-management and workplace cost savings for patients with diabetes by creating a collaborative team of employers, employees, pharmacists, physicians and diabetes educators

Target Population
Employees and beneficiaries with diabetes (within participating employers)

Goals
- Educate and support employees to manage their diabetes actively
- Center care around the patient
- Reduce unscheduled absenteeism and associated costs
- Improve overall health by controlling diabetes and obtaining recommended preventive care
- Save health care dollars by investing in keeping people healthy, instead of paying for care once ill

Years in Operation
2005 – present

Structure and Operations
- Self-insured employers in 10 different cities across the U.S. agreed to contract with the American Pharmacists Association’s Foundation to establish the voluntary benefit program.
- Employers waive copays on diabetes monitoring supplies and medications, and can offer waivers for participation.
- Community pharmacists are trained to “coach” patients on how to manage their diabetes (goal setting, medication adherence, tracking conditions and follow-up care). Pharmacist coaches meet regularly with patients to track treatment compliance and outcomes.
- Collaborative care teams of pharmacists, diabetes educators and physicians from the community are educated on the program, and receive compensation for their involvement.
- Both clinical and financial outcomes are tracked at the national and community levels.

Funding
The Diabetes Ten City Challenge is supported by a grant from GlaxoSmithKline.

For More Information
Additional information is available online:
http://www.aphafoundation.org/Programs/Diabetes_Ten_City_Challenge
DonahueFavret Contractors, Inc.

Purpose
To promote the health and well-being of employees

Target Population
DonahueFavret’s 55 employees

Goals
• To promote wellness
• To improve productivity
• To reduce accidents
• To manage health care coverage costs

Years in Operation
N/A

Structure and Operations
• Offers Health Care Savings Account and point-of-service coverage at differing levels of premium support
• Provides healthy lunch on Mondays, usually prepared by the CEO
• Paid smoking cessation programs and paid time off to attend
• Paid time off earned for participation in wellness programs
• Monetary rewards for employees with safe work records
• Ergonomic design of all workspaces

Funding
Funding is provided by DonahueFavret Contractors, Inc.36

For More Information
Additional information is available online: http://prevent.org/content/view/30/57
GlaxoSmithKline (GSK)

**Purpose**
To provide an employee wellness program that offers comprehensive preventive care with 100 percent coverage and value-based health purchasing to maximize chronic disease outcomes.

**Target Population**
GlaxoSmithKline’s 25,000 U.S. employees and their families

**Goals**
- To offer prevention programs that keep employees well and recognize health hazards before they become chronic conditions
- To offer quality health interventions
- To use innovation in its employees’ health care by using the newest prevention tools and treatments

**Years in Operation**
2006 – present

**Structure and Operations**
- Covers the entire cost of preventive care, including physicals and well-child visits for its 25,000 U.S. employees
- Pays 100 percent of the cost of medications and counseling that help employees quit smoking
- Pays $100 cash incentive to any worker who participates in a health assessment questionnaire
- Offers health fairs at the most populated GSK sites to make it easier for employees to receive health screenings
- Has fitness centers and clinics at GSK worksites
- Offers preventive screenings, physical exams and health plan benefits covering medically necessary treatments
- Offers medication compliance programs
- Has an initiative to combat cancer through risk-reduction, early diagnosis and access to quality care
- Conducts a variety of public programs such as a Diabetes Ten City Challenge and a Center for Value-based Health Management

**Funding**
Funding is provided through GlaxoSmithKline.

**For More Information**
Additional information is available online: http://www.centervbhm.com/lb/news_files/GSK%20Press%20Release%2008.28.07%20GSK%20Shares%20Results%20of%20Internal%20Analysis.pdf
Healthy Incentives Plan

Safeway

Purpose
Improve employee health through free preventive care, rewards for good behavior, and employee empowerment.

Target Population
All non-union Safeway employees

Goals
- Allow employees to have greater involvement and responsibility in managing their health care, through the use of health reimbursement and flexible spending accounts
- Cover 100 percent of preventive care
- Offer free wellness programs and provide incentives for healthy behavior
- Institute health-risk questionnaires/assessments, followed by pro-active care management programs
- Provide 24-hour hotline and online educational and counseling services

Years in Operation
2006 – present

Structure and Operations
- Safeway’s Healthy Incentives Plan started in 2006, with 44 percent of the non-union workforce enrolling in the program. In 2007, enrollment climbed to 71 percent of the non-union workforce. Employee interest in the program has been fueled by comprehensive preventive care benefits, including 100 percent coverage of annual physicals, well-baby and -child care, and other age-appropriate procedures, such as breast and prostate cancer exams, and colonoscopies.
- Employees are also provided with a wealth of health education resources, including a Lifestyle Management Program that provides incentives for tobacco cessation, weight loss, stress reduction and healthy behaviors.
- Incentives for healthy behavior include premium discounts for healthy decisions and higher premiums for non-compliance.

Funding
Safeway fully funds the Healthy Incentives Plan.

For More Information
Additional information is available online:
http://www.coalition4healthcare.org/about/stories/?_adctlid=v%7Cskins_je1znt10gpps1en%7C04i7k0qqv4tia
NC HealthSmart
NORTH CAROLINA STATE EMPLOYEE PREVENTION PROGRAM

Purpose
To empower healthy members to stay healthy and to help those with chronic diseases or risk factors better manage their health

Target Population
NC HealthSmart services are available to members whose primary health insurance is through the North Carolina State Health Plan, and who are not on COBRA

Goals
• To encourage health promotion and education, and worksite wellness
• To enable members to take a Health-Risk Assessment (HRA)
• To encourage members to use the health coaching and Web site
• To help members with disease management and high-risk case management

Years in Operation
2005 – present

Structure and Operations
The HealthSmart integrated platform of tools and services includes:
• Preventive Care Benefits — Mammograms, colonoscopy and immunizations are provided at the lowest cost possible.
• Health Coaches — Specially trained health care professionals are available to speak with members about a variety of medical and lifestyle issues, such as diabetes and depression.
• HRA — Members who take the HRA will receive a personal action plan to help them identify their personal health risks.
• Disease and Case Management — To help members with chronic diseases or disease risk factors to manage their conditions better.
• Health Education Programs and Tools — A telephone audio library with more than 475 topics, free videos for members facing a major medical decision, and print information that can be sent to the member’s home.
• NC HealthSmart Personal Health Portal, featuring WebMD® — Web-based programs are available to help members improve their health (e.g., smoking cessation).
• Worksite Wellness Programs — Tools to support the member in joining or starting a wellness program at work.

Funding
NC HealthSmart is part of the State Employee Health Plan.40

For More Information
Additional information is available online: http://statehealthplan.state.nc.us/nc-healthsmart.html
**NC State Tobacco Cessation**
**The State Health Plan of North Carolina**

**Purpose**
To help members quit smoking through the NC Quitline and nicotine patch copay waiver program

**Target Population**
Members of the State Health Plan of North Carolina

**Goals**
To help members quit smoking

**Years in Operation**
2007 – present

**Structure and Operations**
- NC Quitline at 1-800-QUIT-NOW helps members with quitting smoking, goal setting, medication questions and locating local tobacco cessation resources.
- The waiver program enables members to receive a copay waiver for prescription, generic, and over-the-counter nicotine patches, once they have received a prescription from their health care providers.

**Funding**
N.C. State Tobacco Cessation is part of the NC State Employee Health Plan.41

**For More Information**
Additional information is available online:
**School Employee Wellness Program**  
**Steps to a HealthierNY, Jefferson County, NY**

**Purpose**
To increase the health and wellness of school personnel

**Target Population**
School personnel in Jefferson County, N.Y.

**Goals**
- Increase the number of employees who are at a healthy weight
- Decrease the number of employees who are at risk for diabetes
- Increase the percentage of employees who consume a healthy diet
- Increase the percentage of employees who participated in regular physical activity
- Decrease the number of employees who use tobacco products

**Years in Operation**
2004 – present

**Structure and Operations**
- The Steps to a HealthierNY program in Jefferson County, N.Y., partnered with rural school districts to establish a School Health Advisory Committee. 
- Assessments of schools using the School Health Index, an effective tool for establishing needed health policies and practices, revealed staff wellness as an area in need of improvement, and facilitated the development of action plans for school wellness program implementation.
- Examples of activities included after-hours walking groups, classes on healthy eating, and full days devoted to staff health, courtesy of the Board of Education.
- Specific examples of impact include:
  - In one school district, the success of the school employee wellness program allowed the Board of Education to waive one month of insurance premiums for all employees, a total of almost $300,000 in savings.
  - There is a documented decrease in expenditures by one district’s self-funded health care plan, and now program funding is at its highest level ever.

**Funding**
The School Employee Wellness Program is funded through a grant from the U.S. Centers for Disease Control and Prevention.

**For More Information**
Additional information is available online: http://www.ncsteps.org
SouthernLifeStyle
SOUTHERN COMPANY

Purpose
To promote a culture that embraces healthy lifestyle choices by providing tools and resources to increase awareness and influence behavior.

Target Population
Southern Company employees and their families

Goals
- Assist employees in identifying their individual health risks and conditions
- Provide tools to eliminate and minimize those risks
- Maintain low health-risk rates among employees

Years in Operation
2005 – present

Structure and Operations
- The program is comprised of four main divisions: lifestyle programs, health management, health education and fitness services.
- Employees have access to Web-based, onsite, and printed health risk assessments; Web- and phone-based lifestyle behavioral change support; the bi-annual magazine; quarterly preventive reminders; monthly worksite health education; and 24/7 telephone- and Web-based support.
- Interventions are tailored to meet the needs of employees who fall in one of three categories: healthy, at-risk or chronic. These interventions include online lifestyle management programs, personal health coaching, newsletters and the chronic condition management model, among others.
- APS HEALTH CARE administers the program and tracks participation in APS CareConnection.
- Annual participation data and quarterly and annual reports are created to monitor the program.

Funding
SouthernLifeStyle is a healthy promotion program within the Southern Company.

For More Information
Additional information is available online:
http://www.southerncompany.com/careerinfo/total_reward.asp
Employee Wellness and Obesity Treatment Services
HARRIS COUNTY, TX, HOSPITAL DISTRICT

Purpose
To promote nutrition, exercise, and health education among hospital employees

Target Population
Employees of Harris County Hospital District

For More Information
Additional information is available online:
http://www.hchdonline.com/health/employeewellness.htm

Fire Service Joint Labor Management Wellness-Fitness Initiative
INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS

Purpose
- To provide a holistic approach to wellness for employees and retirees that includes medical, fitness, injury and behavioral health components
- To utilize the fire chief, department physician, physiologist and fitness coordinator to measure and evaluate health status and counsel on how to create an individualized program
- To lower worker’s compensation, disability and health care costs long-term

Target Population
Fire fighters and retirees for ten participating departments in the following states: Texas, Ala., N.C., Va., Ind., Calif., Fla., N.Y., Ariz. and Wash.

For More Information
Additional information is available online: http://www.iaff.org/HS/Well/wellness.html
Gold Standard
CEO Roundtable on Cancer

Purpose
To encourage companies to develop and implement initiatives that reduce the risk of cancer, enable early diagnosis, facilitate better access to best-available treatments, and hasten the discovery of novel and more effective diagnostic tools and anti-cancer therapies

Target Population
Employer organizations; employees

For More Information
Additional information is available online: http://www.cancergoldstandard.org/

Healthy You Fitness Challenge
Fiserv, Inc.

Purpose
To promote physical activity and weight management

Target Population
Fiserv, Inc. employees

For More Information


12. The Health Project, *op cit.*

13. J. Mahoney, *op cit.*

14. The Health Project, *op cit.*


16. The Health Project, *op cit.*


24 Ibid.

25 Ibid.

26 Ibid.


28 Ibid.


30 Ibid.


32 Ibid.


36 Ibid.


38 Ibid.

39 Coalition to Advance Health Care Reform, http://www.coalition4healthcare.org/about/stories/?_adctlid=v%7Cskins_jel1znt10gpps1en%7Ctxt0kqqv4tia (accessed 15 May 2008).


43 Ibid.

44 Southern Company, “Improving Health of a Population through Comprehensive Health and Wellness, Disease, and Work-Site Wellness,” [PowerPoint presentation].
With the alarming rise in childhood obesity, communities are increasingly looking to school-based programs to fight this trend by providing an essential foundation about the importance of good nutrition, physical activity, and making healthy choices. Schools, however, are not just a focus of primary prevention efforts, but also help kids manage chronic conditions, such as asthma and diabetes. School-based programs in communities across the U.S. are working together with parents, teachers, school nurses, pediatricians and others to address both the prevention and better management of chronic diseases, and to improve the health of children. The programs that follow provide working illustrations of school-based programs making a difference for children.
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Action for Healthy Kids

Purpose
To foster sound nutrition and physical activity in children, youth and schools

Target Population
All children

Goals
- Systematic, sustainable changes of sound nutrition and good physical activity occur in all schools
- Schools, families and communities engage to improve eating and physical activity patterns in youth
- Action for Healthy Kids is the trusted, recognized authority and resource on creating health-promoting schools that support good nutrition and physical activity

Years in Operation
2002 – present

Results
- Action for Healthy Kids has played a role in educating the public on the epidemic of childhood obesity and the role schools play in addressing the epidemic. The program has also mobilized government agencies and legislators at the federal, state and local levels to address the issue. A wide variety of organizations, both nonprofit and for profit, are now working with Action for Healthy Kids to reverse the current trend in obesity.
- Action for Healthy Kids currently has organized 9,000 volunteers on Action for Healthy Kids teams nationwide. Health and education leaders have been recruited as team leaders and are actively contributing their expertise to further the program’s goals.
- Action for Healthy Kids organized national “Healthy Schools Summits” in 2002 and 2005, hosted by the U.S. Surgeon General and First Lady Laura Bush. These summits served to highlight the grassroots efforts of Action for Healthy Kids partners and volunteers nationwide.

Funding
This program is funded by contributions from donors. In 2007, the National Dairy Council and the National Football League were “Guardian” supporters; the organizations contributed more than $500,000 each.

Key Partners
National Dairy Council; National Football League; Robert Wood Johnson Foundation; Kellogg’s Corporate Citizenship Fund; Kraft, Inc.; Pfizer Animal Health; Anthem Blue Cross Blue Shield Foundation; Aetna Foundation; United States Department of Agriculture
What Works and Why
Action for Healthy Kids has been successful in part because it was founded on the principle of collaboration with diverse groups, individuals and organizations that work to curb childhood obesity. Action for Healthy Kids Teams and members of the Partner Steering Committee (a committee formed of national partner organizations who oversee the program) represent more than 55 national organizations and government agencies. Partner Steering Committee members state that their involvement with the program helps them make school wellness a high-priority issue within their organizations. Specifically, 97 percent of committee members report that they use the program for knowledge, model approaches, programs, and materials supporting school wellness practices. Alternatively, in keeping with the collaborative approach between participating organizations and Action for Healthy Kids, 79 percent of committee members have provided guidance to the program on major initiatives.1

Structure and Operations
• Action for Healthy Kids periodically publishes special reports about children's health and ways to take action to foster health-promoting schools.
• Action for Healthy Kids facilitates and participates in events, such as the National Healthy Schools Summit, which launched the nationwide Action for Healthy Kids initiative in 2002.
• Other Action for Healthy Kids programs include:
  • Campaign for School Wellness — A comprehensive approach to supporting wellness in schools is necessary to help students develop lifelong behaviors of good nutrition and physical activity. Action for Healthy Kids works with schools to improve school wellness practices and achieve sustainable change to improve the health and learning of students.
  • Game On! The Ultimate Wellness Challenge — This is a yearlong program that challenges America's youth, their families, and schools to incorporate healthy food choices and physical activity into their daily lives. A series of four theme-based challenges spaced throughout the school year promotes, engages and recognizes students for their efforts to make better food choices and move more.
  • Recharge! — This is a kit that promotes national standards for health education, physical activity, and family involvement, as well as the 2005 Dietary Guidelines for Americans. Each ReCharge! kit includes an instructor's notebook with 29 hands-on lesson plans, equipment to implement the lessons, a training DVD, and more for educators and families.

Barriers to Success
• Action for Healthy Kids must contend with escalating childhood obesity statistics nationwide.
• Schools have countless priorities and therefore require a great deal of assistance in order to fulfill their roles in the Action for Healthy Kids program.
• Community engagement is vital, and must be continuous, for the success of the program.

For More Information
Additional information is available online: http://www.actionforhealthykids.org
Assessment of Childhood and Adolescent Obesity in Arkansas
ARKANSAS CENTER FOR HEALTH IMPROVEMENT

Purpose
To halt the progression of childhood obesity in Arkansas

Target Population
School-age children in Arkansas

Goals
- Improve access to healthier foods and beverages in schools
- Create local committees to promote physical activity and nutrition
- Report each student’s body mass index (BMI) to his or her parents

Years in Operation
2003 – present

Results
Since the first year of this program, the percentage of overweight children and adolescents in Arkansas has decreased (from 20.9 percent to 20.6 percent), and the percentage of children and adolescents at risk for becoming overweight held steady at 17.2 percent. In addition, the total number of students assessed increased from 347,753 to 366,801.

Funding
The Arkansas Center for Health Improvement (ACHI) had an operating budget of more than $4.5 billion in FY 2007. This funding came largely from grants and contracts, and to a lesser extent from corporate sponsors and philanthropic support. Grants specific to the Assessment of Childhood and Adolescent Obesity program include:

- Defining and Classifying Diseases and Risks Linked to Childhood Obesity: Robert Wood Johnson Foundation – $2.3M
- Healthy Achievement Through Awareness and Action: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion – $249,999
- Strategic and Logistic Planning for Arkansas BMI Database: Robert Wood Johnson Foundation – $135,824

Key Partners
Local school districts; Arkansas Department of Education; U.S. Department of Health and Human Services; staff from the Arkansas Children’s Hospital; University of Arkansas for Medical Sciences’ College of Public Health; Community Health Nurses
What Works and Why

In 2003, leaders in Arkansas developed a unique and comprehensive approach to address childhood obesity in public schools and local communities. Among other provisions, the new law called for improved access to healthier foods and beverages in schools, the creation of local committees to promote physical activity and nutrition, and confidential reporting of each student’s BMI to his or her parents. Over the past four years, public schools across the state have embraced the importance of working with families and communities to provide a healthy learning environment by improving nutrition and finding ways to increase physical activity. In addition, ACHI continued to improve methods for reporting BMI of students.

Structure and Operations

In 2003, the Arkansas General Assembly passed and Gov. Mike Huckabee signed Act 1220 into law. Among its provisions, Act 1220 mandates that parents shall be provided with an annual BMI by age for their child, as well as an explanation of what BMI means and the health effects associated with obesity.

The Arkansas Child Health Advisory Committee, a committee mandated by Act 1220 and charged with making recommendations on its implementation, decided that parents will receive information regarding their child’s BMI on a confidential health report.

ACHI was asked to take the responsibility of developing and implementing standardized statewide BMI assessments and reporting. To accomplish this, ACHI put together a BMI Task Force in partnership with local school districts, the Arkansas Departments of Education, the U.S. Department of Health and Human Services, staff from the Arkansas Children’s Hospital, and the UAMS College of Public Health. The BMI Task Force developed a timeline and a strategy for implementation. Comparison testing on assessment equipment was done at nearly every school with multiple measures being taken.

Following a successful pilot program in 2005–2006, all schools were able to report student BMI data via a paperless, Web-based system for the 2006–2007 school year. Use of the system included the capacity to immediately generate confidential Child Health Reports for parents.

Barriers to Success

The number of BMI assessment forms valid for analysis increased each year over the first three years of reporting, reaching 85.5 percent in 2005–2006. In 2006–2007, the number decreased to 77.6 percent. The majority of invalid forms contained no measurement information for students. A contributing factor to the decrease in valid forms may have been the uncertainty surrounding the BMI assessment process that was created by proposed state legislation during the 2007 General Assembly. The uncertainty caused some schools to delay conducting their BMI measurements, and these delays prevented some schools from completing their measurements before the end of the school year.

For More Information

Additional information is available online: http://www.achi.net/index.asp
Purpose
To bring schools, families and communities together to teach children healthy behaviors and reinforce those behaviors through a coordinated approach in the classroom, in physical education (PE) classes, at home, and at after-school programs.

Target Population
School-age children, particularly grades K–5

Goals
- Identify, practice and adopt healthy eating and physical activity habits
- Significantly increase physical activity levels of students during PE class, and provide a variety of learning experiences for students of all abilities
- To get students, parents and extended family members involved in practicing and adopting healthy eating and physical activity behaviors at home

Years in Operation
1991 – present

Results
- The CATCH Program has scientifically demonstrated that school environments that effect healthy behavioral changes in children can be created. More specifically, CATCH:
  - Reduced total fat and saturated fat content of school lunches
  - Increased moderate-to-vigorous physical activity during PE classes
  - Improved students’ self-reported eating and physical activity behaviors
- The CATCH Program has been successful in being implemented in a growing number of schools. It began as an 18-school pilot intervention in 1998. By 2006, it had successfully grown to 162 elementary schools in 14 school districts, including parochial and private schools, reaching an estimated 70,000 children and their families.
- CATCH has been shown to successfully slow the epidemic of overweight children or children at risk for being overweight.

Funding
The original research study began in 1991 and was funded by the National Institutes of Health National Heart, Lung, and Blood Institute. Today, CATCH is disseminated and sold through FlagHouse, Inc., to communities and schools throughout the United States.

Key Partners
University of Texas; Tulane University; University of Minnesota; University of California; National Institutes of Health National Heart, Lung, and Blood Institute
What Works and Why

CATCH works via a process that brings a school community together to teach children to be healthy for a lifetime. Effective coordinated school programs reinforce positive healthy behaviors throughout the day and show that good health and learning go hand in hand. School staff training is also a key factor in changing school culture. Physical education and child nutrition staff who did not feel empowered to change the school health environment before participating in CATCH gained a sense of purpose and involvement within this new culture. This in turn led to successful implementation of the program and positive outcomes among children.

Structure and Operations

CATCH has four main program components:

- **Go for Health Classroom Curriculum** — The CATCH Go For Health series is a classroom health education curriculum that teaches children to identify, practice and adopt healthy eating and physical activity habits. The Go For Health series encourages changes in behavior that support healthful eating and physical activity patterns — primary risk factors for heart disease, osteoporosis, high blood pressure, and obesity. CATCH Go For Health utilizes a variety of educational strategies, such as whole language, individual practice, and cooperative learning groups.

- **CATCH PE** — CATCH PE develops health-related fitness, skill competency, and cognitive understanding about the importance of physical activity for all children. CATCH PE instruction provides a variety of learning experiences that address the wide range of student ability in physical education class. CATCH PE content enhances movement, sports skills, physical fitness, and social development, and subsequently promotes lifelong physical activity.

- **Eat Smart School Nutrition Guide** — Children learn, practice and utilize healthy eating habits during school lunchtime. The CATCH Eat Smart program provides children with tasty meals that are lower in fat and saturated fat, maintains required levels of essential nutrients, coordinates healthy nutrition messages with other areas of the school, and guides the entire campus toward creating a healthy school environment.

- **Family Home Team Activities** — The CATCH Family component is designed to get students, parents and extended family members involved in adopting healthy eating and physical activity behaviors at home. The goal of this component is for the home environment to become an extension of the CATCH Program at school.

Barriers to Success

The major barriers to success in implementing CATCH as a statewide program include the need for support from opinion leaders, the need for community networking, the ability to show positive experiences resulting from use of the program, the appropriate handling of program costs, and adequate training for program administrators.7

For More Information

Additional information is available online: http://www.catchinfo.org
Coronary Artery Risk Detection in Appalachian Communities — CARDIAC
State of West Virginia

Purpose
To combat the unacceptably high prevalence of heart disease and diabetes in West Virginia through a chronic disease risk surveillance and intervention initiative.

Target Population
- Initial population: Students in fifth grade (CARDIAC Kid)
- 2003–2004: Expanded to students in kindergarten in five counties (CARDIAC Kinder)
- 2005–2006: Expanded to students in second grade (CARDIAC Too)
- Parents and school staff have also received free fasting lipid profiles to assess their personal risk.

Goals
- Reduce heart disease mortality to no more than 200 deaths per 100,000 population (baseline age-adjusted rate of 323.5 in 1998), West Virginia’s Healthy People 2010 flagship objective
- Provide the opportunity for West Virginia’s health science students to learn concepts of health promotion/disease prevention at the local community level (West Virginia Rural Health Education Partnership)
- Partner with state government, secondary and higher education, and the private sector to reverse the obesity epidemic in West Virginia.

Years in Operation
1998 – present

Results
- CARDIAC Kid: Since 1998, almost 45,000 fifth-graders have been screened: 27.1 percent of all children were overweight, and 18.4 percent were at risk for becoming overweight. Fifth-graders had a fasting lipid profile, and almost 20 percent (19.4 percent) had abnormal blood lipids. Almost 5 percent (4.6 percent) of children had a rash on the back of the neck, which could possibly mean insulin resistance.
- CARDIAC Kinder: Since the inception of the program, 1,844 students have been screened (43.5 percent of those eligible): 18.1 percent had a body mass index (BMI) over the 95th percentile and were considered overweight. An additional 16.9 percent of children were at risk for overweight, with BMIs in the 85th–94th percentiles.
- CARDIAC Too: In the program’s pilot year, 627 second-grade students were screened: 17.4 percent of all children were overweight, and 17.4 percent were at risk for becoming overweight. In addition, 35 percent of students also had a positive family history of heart disease.
- Children and their parents received screening results in the mail along with information about interpreting the results, and educational materials about making healthy choices to reduce health risks.
Funding
CARDIAC funding from the state each year; additional funding comes from the federal government and private grants.

Key Partners
West Virginia Rural Health Education Partnership; West Virginia Department of Education; Bureau of Public Health; Partnerships for Healthy West Virginia; West Virginia Medical Association; West Virginia Hospital Association; West Virginia Public Employees Insurance Agency

What Works and Why
Not only is surveillance of children and their families needed for CARDIAC to be successful, but other interventions are needed to make children and their families well aware of the critical nature of unhealthy behaviors. Interventions occur at both the community and the school levels to reach the targeted population on multiple levels. It is also important that the program has partnered with health sciences students to allow the students first-hand experience in seeing the plight of those living in West Virginia and what behaviors need to be changed to improve health.

Structure and Operations
The CARDIAC Project, in conjunction with the West Virginia Rural Health Education Partnership, 13 site coordinators, 640 preceptors, and hundreds of health science students, work to identify children and their families at risk of cardiovascular disease. West Virginia health sciences students are required to have three months of rural-based clinical training and spend 20 percent of their time in community service. Participation in CARDIAC provides health sciences students with the opportunity to learn about and actively engage in health promotion at the community level. CARDIAC staff and local school nurses train the health sciences students to conduct blood pressure, anthropometrical, and blood lipid testing.

All children in the target populations are eligible to participate in the program. Before the screening, parents complete forms related to family and child demographics and family history of cardiovascular risk factors in addition to a screening/consent form to record the child's height, weight, body mass index, and BMI percentile. All screening information is sent to the child's home in a comprehensive health report. Each report has additional information on how to interpret the screening results and what services beyond screening may be needed. The report also includes recommendations on how to maintain a healthy lifestyle.

Barriers to Success
Identifying children at risk depends upon a parent/guardian's providing a family history. Also, follow-up and reducing risk factors depends on a parent/guardian's receiving, understanding and acting on the screening results provided.

For More Information
Additional information is available online: http://www.cardiacwv.org
The Delta H.O.P.E. Tri-State Initiative
MISSISSIPPI ALLIANCE FOR SELF-SUFFICIENCY

Purpose
To combat the epidemic of children who are overweight and at risk for becoming overweight in the Delta Region of Mississippi, Louisiana and Arkansas

Target Population
30,000 students enrolled in grades K–5 and 1,500 of their teachers in the Mississippi Delta Region

Goals
• Address childhood obesity and children who are overweight
• Implement a comprehensive, school-based nutrition and activity program
• Educate children about healthy lifestyles before they become overweight or obese

Years in Operation
2003 – 2007

Results
• During the 2003–2004 school year, 185 classrooms (approximately 3,559 students) from schools in the Delta region utilized the OrganWise Guys/Take 10! materials, detailed below.
• Student knowledge assessments indicated that, in all grade levels, at least 50 percent of the students achieved full mastery of objectives on nutrition, physical activity, and general health and safety. \(^{10}\)

Funding
• The program is funded by a four-year, $1.57 million grant from the W.K. Kellogg Foundation. \(^ {11}\)
• Additional evaluation funding is provided by the U.S. Department of Agriculture’s Delta Nutrition Intervention Research Initiative.

Key Partners
Mississippi State University Extension Service Family Nutrition Program; Mississippi Department of Education Child Nutrition Programs; Mississippi Department of Agriculture; University of Arkansas Division of Agriculture Cooperative Extension Service; Louisiana State University AgCenter Research and Extension; International Life Sciences Institute’s Center for Health Promotion

What Works and Why
The curriculum includes activities meant to help younger children focus and to reinforce learning skills. Children are encouraged to sing chants as they move to help them count, recite information, and practice beginning sounds.
The program also offers physical activity in a structured setting in schools that may not have a physical education teacher. Unlike recess, which is mostly free play, the program provides children with a fun way to learn how to exercise effectively.

The OrganWise Guys are an effective way for communicating health issues and inciting behavior change in an age-appropriate manner.

Structure and Operations
The Delta H.O.P.E. Tri-State Initiative uses the OrganWise Guys/Take 10! program to facilitate its goals of reducing childhood obesity and improving awareness of physical health among children. The OrganWise Guys/Take 10! program consists of innovative educational materials such as books, activity books, videos, CD-ROMs and more.

- The OrganWise Guys comprise a cast of characters that bring the body to life and facilitate the communication of important health issues in a manner understood by children.
  - They include such characters as Hardy Heart, Luigi Liver, the Kidney Brothers, Peter Pancreas, Madame Muscle and Calci M. Bone.
  - The “characters” reside in a large doll called Little Organ Annie or Little Organ Andy.
  - The OrganWise Guys are meant to teach children about the four roles of healthy living: low fat, high fiber, lots of water, and exercise.
- To best communicate the intended health information to children, OrganWise Guys are linked to grade-level expectations (GLEs).12
- Take 10! is a classroom-based, grade-specific educational tool that encourages short bouts of physical activity integrated with academic lessons. Teachers receive curricular materials and training for specific grade levels. The material includes learning activities that incorporate movement to reinforce academic concepts. The activity cards provided in the curricular materials are linked to the content standards and benchmarks established by the Louisiana Department of Education. The curriculum is currently being matched to GLEs.13
- The BodyWalk component is a 40 foot by 40 foot walk-through of the human body with learning stations that teach children how to make healthy choices. BodyWalk also includes take-home activity books, parent information sheets, and a school health kit, valued at $1,200.14

Barriers to Success
One main barrier to success is allocating management resources to optimize program and staff assignments. Other barriers include procuring resources and material (state versus private-sector funding), providing funds for staff rewards, and having enough staff to implement the program.15

For More Information
Additional information is available online: http://www.organwiseguys.com/pdf/CooperInst.award.pdf
**Eat Well and Keep Moving**
**Harvard School of Public Health**

**Purpose**
To equip children with the knowledge and skills they need to lead more healthful lives by choosing nutritious diets and being physically active.

**Target Population**
Fourth- and fifth-grade students in six intervention and eight match-control elementary schools in Baltimore, Md.

**Goals**
- Decrease students’ consumption of total and saturated fat
- Increase intake of fruits and vegetables
- Reduce television viewing
- Increase moderate and vigorous physical activity

**Years in Operation**
1995 – present (first four years were part of the demonstration program)

**Results**
The demonstration took place in 14 Baltimore elementary schools. All teachers who responded to the demonstration said that they would utilize the program in the future, and most students thought favorably of the lessons and activities. Of the 479 students for whom data was collected, there was a decrease in percentage of total calories from fat ($P = 0.04$) and saturated fat ($P = 0.05$), an increase in the consumption of fruits and vegetables ($P = 0.01$), and a small reduction in television viewing ($P = 0.06$).

**Funding**
The original demonstration project was funded by a Department of Education – PEP Grant and by the Walton Foundation. Currently, the Baltimore Department of Education is sustaining the program on its own. Today, the program is available nationally through Human Kinetics.\(^\text{16}\)

**Key Partners**
Baltimore City Department of Education

**What Works and Why**
Eat Well and Keep Moving was well-received during its four-year demonstration program. Principals of participating schools gave the program priority and helped ensure its integration throughout the school. Teachers and other educators liked that the curriculum focused on the health and well-being of the whole child — the physical, social, emotional and intellectual dimensions.
Structure and Operations

The Eat Well and Keep Moving curriculum is taught by elementary school teachers who use an interdisciplinary approach, including the curriculum in all class subjects (e.g., math, reading, science, social studies). Lessons are taught on nutrition and physical activity concepts. Some physical activity lessons involve students’ practicing a “safe workout,” while others have nutrition and food as themes for physical activity lessons. Schools have also included cafeteria and lunchtime programs in conjunction with the lessons. Concepts from the program are reinforced at home through the distribution of flyers and newsletters on nutrition and physical fitness information. Teachers also participate in wellness training activities.

Barriers to Success

All participating schools in the demonstration program observed a minimal effect from the physical education programs and from the after-school programs. Safety concerns as well as a lack of community facilities or organizations to promote activity also hindered the success of the program. Another barrier may have been the validity of self-reported results. Students may have misreported their results or changed their results based on other students’ results.

For More Information

Additional information is available online: http://www.hsph.harvard.edu/prc/proj_eat.html
FUN 5
HAWAII MEDICAL SERVICE ASSOCIATION

Purpose
To promote physical activity and nutrition in the After-school Plus (A+) program and encourage children to develop lifelong commitment to physical activity and healthy dietary habits

Target Population
Children in elementary school

Goals
- To encourage kids to exercise five days per week and eat five servings of fruits and vegetables every day
- To help kids form positive ideas about healthy lifestyle habits

Years in Operation
2003 – present

Results
Fun 5 has increased active time during the A+ program by 140 percent (from 13 to 31 minutes during an average A+ day) and significantly increased the frequency of moderate physical activity during leisure time (from 3.1 days per week to 3.6 days per week outside of school or A+). Due to the pilot’s success, Fun 5 now is offered for statewide dissemination. Seventy-two sites were trained (more than 9,000 students) in the first dissemination semester (Fall 2004), with planned RE-AIM evaluation. (RE-AIM evaluation is a behavioral health research tool that measures the translatability and public health impact of initiatives such as Fun 5.) Currently 12 of the 13 pilot sites continue implementation.¹⁷

Funding
Funding for Fun 5 is provided by in-kind donations in conjunction with support from the Hawaii Medical Service Association (Blue Cross Blue Shield of Hawaii) and the Departments of Health and Education.

Key Partners
Hawaii State Department of Education; Hawaii Medical Service Association (Blue Cross Blue Shield of Hawaii); University of Hawaii; Trimoving LLC; Mililani Wal-Mart; Ice Place/Stadium Partners; Action for Healthy Kids; Jan Inc.; Curves for Women – Manoa
What Works and Why

Educators find Fun 5 successful because it is comprehensive and covers the necessary health, nutrition and physical activity information in a child-friendly manner. The program also engages adult educators, and, as one site director noted, when adult leaders are having fun the kids have a better time. Fun 5 also works because it can be used easily by educators who do not have previous training in physical education.

Structure and Operations

Fun 5 is designed for elementary school kids and can be incorporated into the A+ program or elementary school lessons. Components of the program include:

- Training workshops and follow-up by certified trainers
- Ready-to-use activities and lesson plans
- SPARK (Sports, Play & Active Recreation for Kids) activities
- Kid-friendly sports equipment
- Sessions for staff to share ideas and offer support
- Evaluations to document success

Barriers to Success

None noted.

For More Information

Additional information is available online:
Open Airways for Schools
AMERICAN LUNG ASSOCIATION

Purpose
To help improve self-management and support for school-age children with asthma

Target Population
Schoolchildren ages 8–11 diagnosed with asthma

Goals
• To improve asthma self-management skills
• To decrease asthma emergencies
• To raise asthma awareness among parents or guardians
• To promote broader asthma management coordination among physicians, parents and schools

Years in Operation
1992 – present

Results
Evaluation and testing by the original researchers has shown that asthma health education delivered to children in the school setting increases asthma management skills, reduces asthma symptoms (through trigger avoidance), and improves school performance.19

In the first five years, local Lung Associations were able to reach more than 400,000 children in greater than 30,000 schools throughout the United States. Subsequent evaluations of the program confirmed the original findings and also found that implementing Open Airways for Schools reduced both absences and the use of health care services. For example, a control study of school-based asthma case management among inner-city students in Memphis, Tenn., found that students receiving the Open Airways program and other support missed half as many school days and had significantly fewer emergency department visits and hospital stays than those in the control group.20

Funding
The program is funded by the American Lung Association.

Key Partners
American Lung Association national and local affiliates; school personnel and school district officials; parents; local providers
What Works and Why
The program is integrated into the school setting. Program instructors must complete a standard training program from a certified trainer. Instructors work with local American Lung Association affiliates to deliver the programs, which helps to maintain consistency in delivery, preserve the program’s integrity, ensure use of the most up-to-date materials and information, and obtain support to attain optimal results.

Structure and Operations
The Open Airways for Schools curriculum consists of six 40-minute group lessons for children with asthma. The lessons are held during the school day. The curriculum incorporates an interactive teaching approach — group discussion, stories, games and role play — to promote students’ active involvement in the learning process. Topics covered include basic information about asthma, recognizing and managing asthma symptoms, using medication, avoiding asthma triggers, getting enough exercise, and doing well at school. The Open Airways for Schools classroom kits contain easy-to-use teaching materials, including posters and hand-outs. Each lesson includes materials for the children to take home to their parents.

The program is available through local Lung Association affiliates to schools and school districts and organizations or individuals interested in providing instructors for the program. Instructors must complete a full-day facilitator training workshop conducted by a certified Open Airways for Schools trainer. The training includes basic information about asthma, modeling of appropriate skills, a thorough review of the Open Airways for Schools curriculum, and tips for working with children.

The Open Airways for Schools curriculum includes a pre-test and a post-test that allow evaluation of the program’s impact.

Barriers to Success
The time demands of school make incorporating additional curricula a challenge.

For More Information
Additional information is available online:
http://www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=44142
PATHWAYS
JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

Purpose
To evaluate the effectiveness of a school-based, multi-component intervention to prevent or reduce excess weight gain in elementary schoolchildren

Target Population
Students in grades 3–5 in schools serving Native American communities in Arizona, New Mexico and South Dakota

Goals
Develop, implement and evaluate a culturally-appropriate, school-based intervention to promote healthful eating behaviors and increased physical activity, and to prevent obesity in Native American children

Years in Operation
1993 – 2001

Results
The primary measure of intervention effectiveness was the mean difference between intervention and control schools in percent body fat (adjusted for baseline percent body fat) at the end of the fifth grade. Percent body fat was estimated using an equation developed during the feasibility phase using measurements of height, weight, skinfold thickness, and bioelectrical impedance.

Secondary outcomes included improved changes in terms of physical activity, dietary intake, knowledge, attitudes and behavior.

While the program had significant effects on several components of knowledge, attitudes and behavior, it did not reduce the students’ percentage body fat.

Funding
The project received funding through the National Heart, Lung, and Blood Institute.

Key Partners
Navajo Nation; Gila River Indian Community; Tohono Oodham Nation; White Mountain Apache Tribe; San Carlos Apache Tribe; Oglala Lakota Nation; Sicangu Lakota Nation; Johns Hopkins University; University of Arizona; University of Minnesota; University of New Mexico; University of North Carolina
What Works and Why

The program had significant effects on several components of knowledge, attitudes and behavior. Positive outcomes of the study may be attributed to:

- Earning the trust and cooperation of the communities by developing a genuine partnership with nonscientist Native Americans
- Involving Native American leaders in the decision-making process and enabling them to contribute to the creation of a culturally-acceptable and scientifically-rigorous intervention

Structure and Operations

- PATHWAYS had three main components:
  - **Physical Activity** — PATHWAYS encouraged schools to increase high-energy activities in physical education classes and recess, emphasizing traditional Native American games. Activity was measured via a recall questionnaire and an accelerometer.
  - **Food Service** — PATHWAYS investigators, nutrition staff, and food service personnel at the four intervention schools developed the food service program that provided nutritious, low-fat cafeteria meals. Through educational materials, trainings, and kitchen visits, nutrition staff helped food service personnel at each intervention school to develop and implement specific food preparation and selection guidelines.
  - **Classroom Curriculum** — The classroom curriculum, designed for third-, fourth-, and fifth-grade children, addressed certain high-risk behaviors identified during the formative assessment. Using social learning theory, the curriculum committee developed stories and activities based on the journey of two fictional Native American children, Amanda and Daryl White Horse, through the six PATHWAYS nations. This curriculum also reinforced a rich cultural heritage of healthful eating and physical activity.

- PATHWAYS also emphasized family support via three primary strategies:
  - **Family fun nights** — These involved dancing, healthy eating activities, and other family-friendly healthy activities.
  - **Family take-home “action packs” and “snack packs”** — These included written suggestions for meals and physical activities to involve the whole family.
  - **School-based family advisory councils**

Barriers to Success

Project outcomes showed that:

- A significant reduction in percentage of calories from fat did not result in a reduction in dietary caloric intake.
- A combination of global and targeted interventions may be needed.
- School-based interventions need to be complemented by community and household programs.

For More Information

Additional information is available online: http://www.jhsph.edu/chnResearch/pathways.html
SPARK PE
SAN DIEGO STATE UNIVERSITY

Purpose
To encourage health-related physical education (PE) by maximizing physical activity participation during school activities to improve student fitness, skills and enjoyment.

Target Population
Students in pre-kindergarten to 12th grade

Goals
- To create, implement and evaluate programs that promote lifelong wellness
- To improve the health of children and adolescents by disseminating evidence-based physical activity and nutrition programs that provide curricula, staff development, follow-up support, and equipment to teachers

Years in Operation
1989 – present

Results
- Up to 80 percent of schools that adopted SPARK PE reported sustained use up to four years later.
- Program outcomes show that SPARK PE had positive effects on quality and quantity of teacher instruction of PE, physical activity in class, and components of physical fitness, sports-related skills, and academic achievement.
- Schools with no previous standard PE program in place were more likely to continue using SPARK than schools with a PE curriculum.
- Physically active teachers and teachers who had not received PE-related academic credits in recent years were more likely to continue using SPARK PE.21

Funding
SPARK PE was originally developed by a team at San Diego State University and funded by the National Heart, Lung, and Blood Institute from 1989 to 1996. SPARK curricula, equipment and training can now be purchased by communities and schools on the SPARK Web site.

Key Partners
Teacher Education Program, University of California, San Diego; College of Education, California State University, San Marcos; Center for Research in Disease Prevention Stanford University School of Medicine; Department of Preventive Medicine, University of Tennessee, Memphis; West Virginia University Physical Education Department; California Obesity Prevention Initiative; Project LEAN; SPORTIME International; San Diego State University Foundation; National School Fitness Foundation; American Council on Exercise; Governor’s
What Works and Why
A recent study evaluating the sustainability of SPARK found that up to 80 percent of schools that had received SPARK curriculum books, training and follow-up had sustained use of the program up to four years later. Schools using SPARK were found to have more frequent PE classes, which translated directly into enhancing students’ physical activity and opportunities for skill practice. SPARK encourages support from school principals and administration, and schools that garnered high amounts of support from these stakeholders had higher rates of physical education. SPARK also requires schools to provide sufficient PE equipment. Schools participating in the study used PE equipment more often and maintained the equipment well.

Structure and Operations
SPARK focuses on the four main school levels: early childhood, elementary, middle school, and high school. Additionally, SPARK has an after-school program and a Healthy and Wise Middle School Coordinated Health Program. SPARK is also researching and developing a SPARK Coordinated Health Program.

The SPARK curriculum covers three main areas:

- Physical education — This program component consists of 24 core activity units; suggestions for managing children in PE classes; and instructions for inclement weather activities, strength and conditioning warm-up, and a fitness self-testing program.
- Classroom curriculum — This program consists of teaching behavioral self-management skills that would assist students in developing regular physical activity skills outside of school.
- Staff development program — This program enhances teachers’ commitment to health-related PE, helps teachers understand SPARK curricular units and activities, develops teachers’ management and instructional skills needed for effective program implementation, and assists teachers in overcoming barriers to full implementation. The staff development program also further develops the skills of PE specialists and provides basic PE skills for classroom teachers.

The curriculum is also tailored to meet the needs of the specific age groups targeted by SPARK.

Barriers to Success
In a study performed on the effectiveness of the elementary school program, teachers viewed the self-management curriculum less positively than the physical education curriculum. Teachers were observed implementing an average of 65 percent of curriculum elements, which may have contributed to the limited effects of the self-management program.

For More Information
Additional information is available online: http://www.sparkpe.org
Alhambra Unified School District
Nutrition Network
ALHAMBRA UNIFIED SCHOOL DISTRICT, ALHAMBRA, CA

Purpose
To provide students and adults with opportunities to make healthy eating choices and increase physical activity

Target Population
Students in grades pre-K to 12 and their families who have low incomes or are at less than 180 percent of the federal poverty level

 Goals
• Encourage individuals to eat a variety of colorful fruits and vegetables
• Incorporate physical activity daily (30 minutes for adults and 60 minutes for children)
• Support participation in food assistance programs

Years in Operation
2001 – present

Structure and Operations
The Nutrition Network develops lessons and disseminates standards-based curricula that empower youth to make healthier choices and be physically active.\(^2^6\) The Nutrition Network has incorporated a variety of programs to address physical activity and healthy eating:

• Nutrition Olympics — A field day designed to encourage children to increase their consumption of fruits and vegetables through games and physical activity.
• School Gardens — Students learn how fruits, vegetables and herbs are grown in their own “living laboratories.”
• Culinary Connections — Professional chefs teach students how to incorporate fruits and vegetables when cooking.
• Nutrition/Physical Activity 101 — A workshop that teaches participants how to use the Dietary Guidelines and the food pyramid to guide healthier eating.\(^2^7\)

Funding
Principal funding provided by the U.S. Department of Agriculture’s Food Stamp Program. To be eligible, 50 percent or more of students must be enrolled in the free and/or reduced-price meal program.\(^2^8\)

For More Information
Additional information is available online: http://www.ausdnutrition.com
Fruit and Vegetable Program

Purpose
To distribute fresh fruit, dried fruit, and fresh vegetables to all students throughout the state.

Target Population
Students in funded schools in kindergarten to 12th grade.

Goals
To improve fruit and vegetable consumption among Iowa’s school-age children by offering free fruits and vegetables at various times using various methods throughout the school day.

Years in Operation
2002 – present

Structure and Operations
Participating schools in Iowa’s Fruit and Vegetable Program have various strategies for distributing fruits and vegetables to students throughout the school day, including:

- Service Delivery Mechanism — Some schools have centrally located kiosks that provide the fresh fruit and/or vegetables; others provide fruits and vegetables in the classrooms.
- Timing of Service Delivery — Fruits and vegetables can be distributed to students before or after school, at lunch, or at different snack times throughout the school day.
- Educational or Promotional Activities — Beyond the pilot activities, some schools have integrated the purpose of the Fruit and Vegetable Program into other school activities and events in addition to the normal classroom routine.

Students are provided a multitude of fruits and vegetables, a majority of those being apples and bananas. Pilot schools also introduce new fruits and vegetables into a student’s diet, including kiwi and different varieties of fruit they like. Most of the fruits and vegetables served are single serving or pre-packaged.

Funded schools are also able to use some of their funds to provide nutrition education. Nutrition materials may be purchased, but no new materials may be created.29

Funding
The Nutrition Title of the Farm Security and Rural Investment Act of 2002 (Public-Law 10-171) provided $6 million in funding for a pilot program in four states. The 2004 Omnibus Bill provided the Iowa State Education Agency with an additional $1 million to continue the pilot program.30,31

For More Information
Additional information is available online: http://www.iowa.gov/educate/content/view/368/434
Healthy Living Cambridge Kids
HEALTHY CHILDREN TASK FORCE – CAMBRIDGE, MA

Purpose
To help children eat better and be more active through innovative programs developed by the Cambridge Public Health Department and partners throughout the city.

Target Population
Children in Cambridge, Mass.

Goals
- To increase fruit and vegetable consumption to five or more servings per day
- To reduce television viewing time to two or fewer hours per day
- To exercise for one hour every day

Years in Operation
2000 – present

Structure and Operations
Key components of the Healthy Living Cambridge Kids intervention include:
- Improved physical education; a Health and Fitness Progress Report that documents body mass index for age and fitness scores
- FITtogether family outreach nights
- Farm to school activities
- School nutrition policy (e.g., vending machine guidelines); partnerships with school nutritionists, and; CitySprouts school garden program
- Expanded extracurricular nutrition and fitness programming and staff training
- Public health outreach and community partnerships (e.g., Cambridge Youth Sports Commission)

The Healthy Children’s Task Force also produces a community guide, Cambridge Moves, for families and children. The guide provides ideas on where and how to participate in local physical activity programs. The Institute for Community Health provides the research, monitoring and evaluation for the Healthy Children Task Force and Healthy Living Cambridge Kids.

Funding
Healthy Living Cambridge Kids is funded by the Cambridge Public Health Department in conjunction with the Cambridge Health Alliance.

For More Information
Additional information is available online:
http://www.icommunityhealth.org/ichprojectshealthychildren.shtml
Healthy Schools Program Framework
ALLIANCE FOR A HEALTHIER GENERATION

Purpose
To empower schools to adopt policies that will help reduce childhood obesity

Target Population
Schools

Goals
- To stop the nationwide increase in childhood obesity by 2010
- To empower kids nationwide to make healthy lifestyle choices

Years in Operation
2005 – present

Structure and Operations
The program includes a Healthy Schools Program Framework that is developed as both a needs-assessment tool and as a benchmark for the national recognition program.

The Healthy Schools Program Framework identifies eight different categories for schools to implement best practices in: systems and policy, school meals, competitive foods and beverages, health education, physical education, physical activity, before- and after-school programs, and school employee wellness.

In addition, the framework provides Healthy Schools Builder, which serves as a resource to help create a healthier school and determine if a school qualifies for an award.

The program outlines six steps to a healthier school environment:
- Convene school wellness council
- Complete inventory
- Develop an action plan
- Identify resources
- Take action
- Celebrate your success

Funding
The Alliance for a Healthier Generation is funded by the American Heart Association and the William J. Clinton Foundation. Funding for the Healthy Schools program is also provided through a grant from the Robert Wood Johnson Foundation.

For More Information
Additional information is available online: http://www.healthiergeneration.org
Indoor Air Quality Tools for Schools

ENVIRONMENTAL PROTECTION AGENCY

Purpose
To reduce exposures to indoor environmental contaminants in schools through the voluntary adoption of sound indoor air quality management practices

Target Population
Schools

Goals
• Improve indoor air quality at schools
• Help school staff identify, correct and prevent indoor air quality problems

Years in Operation
1995 – present

Structure and Operations
The program provides products, materials and tools at no cost to help schools implement an indoor air quality management program. In addition, specialized fact sheets, brochures and software programs are available to provide in-depth information on environmental topics.

A complementary program, School Nurse Asthma Management Program, provides training for school nurses to lead development of school asthma management plans.

Schools demonstrating environmental excellence compete for the Indoor Air Quality (IAQ) National Excellence Award. Ridgefield (Conn.) Public Schools recently won for its achievements:

*Mold found on carpeting, requiring a series of renovation and construction projects, gave Ridgefield Public Schools incentive to implement IAQ Tools for Schools in 2003. The district immediately hired an IAQ Coordinator along with two heating, venting and air conditioning mechanics. Each school then established an IAQ team that received training from the Connecticut Department of Health. Since implementation, the district has noticeably cleaner and drier buildings, fewer teacher and staff health problems, fewer student visits to the school nurse for breathing difficulties, and a decrease in absenteeism each year.\(^{34}\)

Funding
EPA funds the tools. Schools fund any improvements needed.

For More Information
Additional information on the EPA Indoor Air Quality Tools for Schools program is available online: http://www.epa.gov/iaq/schools/index.html. Additional information about school nurse training is available online: http://www.nasn.org/Portals/0/education/flyernamp.pdf
**Mississippi Healthy Students Act**

**Purpose**
To require all public schools throughout Mississippi to provide increased amounts of physical activity and health education instruction for elementary, junior high, and high school students.

**Target Population**
Mississippi students in grades K–12

**Goals**
- Reduce the rate of obesity in children and adolescents
- Reduce physical inactivity in children and adolescents

**Structure and Operations**
The *Healthy Students Act* requires schools to provide at least 150 minutes of physical activity-based instruction as well as 45 minutes of health education instruction per week for students in kindergarten through eighth grade. In addition, the legislation requires students in grades 9 through 12 to complete a ½ Carnegie unit of physical education or physical activity before qualifying for graduation.

Every school in Mississippi is required to produce and adopt a school wellness plan for health promotion activities. Each school will hire a physical activity coordinator to monitor that the school abides by the legislation and is implementing health promotion activities.

Each school board will also form a local school health council, which will recommend appropriate practices for:
- Health and physical education
- Nutrition services
- Parental involvement
- Tobacco prevention
- Staff wellness

The *Healthy Students Act* also requires that the State Board of Education review each school district’s compliance with the Child Nutrition School Breakfast and Lunch Programs.

**Funding**
The state funds the programs pursuant to the Mississippi *Healthy Students Act*. The state Department of Education also employs a physical activity coordinator to assist districts with current and effective practices and with implementation of physical education and physical activity programs.35

**For More Information**
Additional information is available online:
Partnership for Play Every Day
YMCA-USA, National Recreation and Park Association, and National Association for Sport and Physical Education

Purpose
To ensure that all children in the U.S. have at least 60 minutes of physical activity every day

Target Population
Children in America

Goals
- Increase the number of youth participating in 60 minutes per day of quality physical activity before, during and after school
- Increase the number of adequate spaces for youth to engage in physical activity in any setting
- Increase the number of voices supporting expanded opportunities for physical activity at the local, state and national levels

Years in Operation
2007 – present

Structure and Operations
The forming organizations have a legacy of providing physical education, physical activity, child care, after-school programs, and youth sports to millions of children throughout the United States. The challenge today is to reach all kids, especially those who may not have the opportunity to live in a community with safe playgrounds or walking trails, or attend schools that require physical education. Through collaboration with more than 30 of the nation’s leading nonprofits, government agencies, academic organizations, and corporations, Partnership for Play Every Day works to reach as many youth as possible in communities across the country.

Funding
Partnership for Play Every Day is funded by its partner organizations. These organizations provide grants to the forming organizations to provide physical activity and health promotion activities to youngsters in the U.S.

For More Information
Additional information is available online: http://www.playeveryday.org
**Take 10!**  
**INTERNATIONAL LIFE SCIENCES INSTITUTE**

**Purpose**  
To reduce sedentary behavior and to promote short periods (10 minutes) of physical activity in the elementary school classroom; to link physical activity to academic objectives

**Target Population**  
Students in kindergarten to fifth grade

**Goals**  
- Help children meet recommended daily physical activity requirements  
- Reduce sedentary behavior during the school day  
- Help children develop lifelong healthy behaviors

**Years in Operation**  
1999 – present

**Structure and Operations**  
Take 10! is a physical activity program created by teachers for students and teachers. It is meant to complement, but not replace, physical education and recess as part of the normal school day. Take 10! allows teachers to determine the best time to add the 10-minute moderate-to-vigorous physical activity during the school day (e.g., homeroom, lunch, end of day). Program materials include: activity cards, student worksheets, a tracking poster and reward stickers, student health knowledge assessments, and a teacher training video. Behavioral strategies such as prompting, self-monitoring, goal-setting, and barrier-reduction are also used to help implement the program. Take 10! programs include:  
- Animal Trackers — A physical activity program that integrates movement with pre-school learning objectives; materials consist of 10 chapters that focus on specific gross motor skills.  
- Stepping Through Middle School — This program takes students on an imaginary journey across regions of the United States. A tracking poster is posted in each classroom for the students to count their number of steps. Each student is provided a pedometer to monitor his or her physical activity throughout the day. The program also includes lessons for 10 weeks related to math, social studies and nutrition.

**Funding**  
The program is funded by the International Life Sciences Institute's Physical Activity and Nutrition Program.

**For More Information**  
Additional information is available online: http://www.take10.net
Walking School Bus Program
SEATTLE PUBLIC SCHOOLS

Purpose
To encourage children to walk to school under the supervision of parents or other adults who teach and reinforce safe pedestrian skills

Target Population
Elementary and middle school students in Seattle Public Schools

Goals
- To reduce sedentary lifestyles in school-age children
- To provide an active and safe commute to school

Years in Operation
2004 – present

Structure and Operations
The Walking School Bus Program is coordinated by a part-time staff person and includes: an education program led by parents; low-cost traffic safety improvements on the urban roads; and encouragement efforts coordinated with the Robert Wood Johnson Foundation's Active Seattle project. Instead of riding in a car or bus to school, students will join the program at different points in the school's neighborhood. Students walk together with family members and staff along set routes. Children who normally ride the bus or ride with their parents to school can be dropped off at the starting point to walk to school.

Three safe walking routes were established at Bailey Gatzert (the first funded school), and significant increases in the proportion of children walking to school with an adult were observed. After a successful year at the pilot school, Seattle has incorporated the program at other schools.39

Funding
The city of Seattle’s first school to participate in the program, Bailey Gatzert Elementary, was funded through a state grant. Additional participating schools are funded through private partnerships and foundations.40

For More Information
Additional information is available online: http://feetfirst.info
Diabetes Management at School
AMERICAN DIABETES ASSOCIATION

Purpose
To promote a healthy, productive learning environment for students with diabetes; reduce absences of students with diabetes; reduce classroom disruption; help assure effective response in case of diabetes-related emergency; and promote full participation in all areas of school curriculum and extra-curricular activities

Target Population
Children with diabetes across the country

For More Information
Additional information is available online:

Healthy Kids Network
AMERICAN CANCER SOCIETY

Purpose
Making school health a priority for all children working within a network of parents, caregivers, school personnel, community leaders, and members of the faith community

Target Population
School-age children

For More Information
Additional information is available online: http://www.schoolhealth.info
Healthy Youth
U.S. Centers for Disease Control and Prevention

Purpose
To promote healthy lifestyles among teens, promote health education, and disseminate information on the health of teens nationwide

Target Population
Teens and the general population of the United States

For More Information
Additional information is available online: http://www.cdc.gov/healthyYouth

H.A.N.D.S.: Helping to Administer to the Needs of the Student with Diabetes in School
National Association of School Nurses

Purpose
To provide school nurses with the knowledge, skills and resources to ensure safe and effective diabetes management at school

Target Population
School nurses

For More Information
Additional information is available online: http://www.nasn.org/Default.aspx?tabid=411
**Keystone Healthy Zone**  
**Pennsylvania Advocates for Nutrition and Activity**

**Purpose**
To publicly recognize Pennsylvania schools for their commitment to creating and maintaining healthy school environments by equipping them with the tools and information they need to make health easy

**Target Population**
Schools in Pennsylvania

**For More Information**
Additional information is available online:  

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**KidPower! Newsletter**  
**New Hampshire Department of Health and Human Services**

**Purpose**
To encourage daily physical activity for children and provide helpful tips about safety, good health, and wellness

**Target Population**
Parents and teachers in New Hampshire

**For More Information**
Additional information is available online:  
http://www.dhhs.state.nh.us/DHHS/NHP/LIBRARY/Newsletter/kidpower-news.htm
**KidsWalk-to-School**  
**U.S. Centers for Disease Control and Prevention**

**Purpose**
To increase opportunities for daily physical activity by encouraging children to walk to and from school in groups accompanied by adults

**Target Population**
School-age children

**For More Information**
Additional information is available online: http://www.cdc.gov/nccdphp/dnpa/kidswalk

**New York State Chronic Disease Management Initiatives**  
**New York State Department of Health**

**Purpose**
To fight childhood obesity in New York state through seven key approaches: Healthy Schools Act; results measurement; comptroller audits; increased funding for diabetes self-management education; increased funding for asthma self-management education; new funding for community coalitions; and improved Medicaid protocols

**Target Population**
Children in New York state

**For More Information**
Additional information is available online: http://www.ny.gov/governor/sos/fact_sheet3.html
School-based Physical Education
U.S. Centers for Disease Control and Prevention

Purpose
To increase physical activity among children and adolescents in physical education class

Target Population
Children and adolescents

For More Information
Additional information is available online: http://www.cdc.gov/HealthyYouth/keystrategies/index.htm

School Nurse Childhood Obesity Prevention Program
National Association of School Nurses

Purpose
To provide strategies for school nurses to assist students, families and the school community in addressing the challenge of obesity and overweight

Target Population
School nurses

For More Information
Additional information is available online: http://www.nasn.org/Default.aspx?tabid=435
ENDNOTES


9 Ibid.


15 Ibid.

16 S. L. Gortmaker et al., “Impact of a School-Based Interdisciplinary Intervention on Diet and Physical Activity Among Urban Primary School Children,” Archives of Pediatric and Adolescent Medicine 153, no. 9 (September 1999): 975–983.


M. Dowda et al., op. cit.

Ibid.


Partnership for Prevention, op. cit.


Iowa Department of Education, op. cit.


