Examples of Successful Community-Based Public Health Interventions (by subject matter)

The Steps to a HealthierUS (now Healthy Communities program) is a Centers for Disease Control and Prevention (CDC) initiative that provides funding to communities to identify and improve policies and environmental factors influencing health in order to reduce the burden of obesity and other chronic diseases, and to encourage people to become more physically active, eat a healthy diet, and not use tobacco.

The Racial and Ethnic Approaches to Community Health Across the U.S. (REACH U.S.) is a CDC-funded national program whose goal is to eliminate racial and ethnic health disparities in the United States. In 2007, just 40 communities were funded through the REACH program.

These kinds of programs can be cost-effective. A study by Trust for America’s Health, entitled *Prevention for a Healthier America*, found that investing $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use, could save the country more than $16 billion annually within five years. Out of the $16 billion in savings, Medicare could save more than $5 billion, Medicaid could save more than $1.9 billion, and private payers could save more than $9 billion.

Below are examples of successful community-based interventions that these and other primarily publicly-funded programs have supported. The House tri-committee health reform draft and the Senate HELP Committee proposal, by enhancing our investment in community-based prevention, would enable us to expand the reach of successful, evidence based programs like the ones described below.

**Chronic Disease Prevention (with multiple interventions/conditions):**

- Data from selected Steps Communities indicate progress toward changing behaviors. For example, in 2004, the percentage of adults in Steps Communities who have diabetes and reported having a foot exam in the past year was 71.1 percent; this increased to 77.2 percent in 2006, surpassing the national average of 71.1 percent. The proportion of adults living in Steps Communities who have asthma and report days on
which they experienced no asthma-related symptoms increased from 23.9 percent in 2004 to 28.6 percent in 2006, exceeding the national average of 26.2 percent.

• In the River Region of Alabama, the Steps trained diabetes wellness advocates to help diabetics set wellness goals and manage their condition. From 2004-2007, emergency room visits among participants decreased more than 50 percent.

• CDC’s REACH for Wellness program in Georgia works to improve cardiovascular health of Atlanta Renewal Community residents and to eliminate health disparities among minority groups. The program offers free, community-based services such as nutrition education classes, physical activity programs, and empowerment groups. Results of the program include a decrease in the percentage of African American adults who currently smoke from 25.8% in 2002 to 20.8% in 2004. Over the two years, 10.1% more adults reported having their blood cholesterol level checked and medication adherence among adults with high blood pressure also increased. Additionally, the percentage of adults who are not physically active decreased from 32.6% in 2002 to 30.6% in 2004.

• The REACH 2010 Latino Health Project in Massachusetts, funded by the CDC, works to raise people’s awareness about diabetes, teach them how to eat a healthy diet and be more physically active, and help them to understand that diabetes can be prevented and controlled. Outreach is provided through local health education centers, community groups, health care providers, and a media campaign. In 2006, the percentage of participants with total cholesterol levels <200mg/dL increased from 75% to 80%. In addition, the percentage of Latinos receiving services at the Greater Lawrence Family Health Center who reached their blood sugar goal (A1C level <7) increased from 20.7% in 2002 to 43.4% in 2006. Finally, the percentage of Latinos receiving services at the GLFHC who had an annual flu shot increased from 44.2% in 2005 to 55% in 2006.

• The REACH Detroit Partnership conducts interventions to help residents prevent and manage diabetes through health education classes and bilingual health information. The Family Intervention targeted two groups. In the first group, the percentage of participants with blood sugar levels >7 dropped 13.5%. In the second group, participants were divided into two subgroups, with one receiving interventions immediately and the other receiving interventions 6 months later. Participants in subgroup 1 showed a mean decrease of 1.2 in the blood sugar levels, compared with 0.02 for subgroup 2. Subgroup 1 participants also showed improvements in diabetes-related depression and consumption of high-fat foods.

• As a result of the REACH 2010 grant, the La Vida Program was created to serve Hispanics living in New Mexico who have or are at risk of contracting diabetes by offering diabetes education classes, support groups, community outreach, grocery store tours that teach how to read food labels, and a restaurant intervention to teach people to make healthy eating choices. The program also includes a physical fitness program called Active and Alive that is available at local health clubs, home visits, and one-on-
sessions. After initial involvement in the program, Hidalgo Medical Services patients had an average hemoglobin A1c level of 8.2, compared with the national average of 9.0 for Hispanics. After 9-12 months of involvement, patients’ average A1c levels dropped to 7.6.

- The Charlotte REACH 2010 Coalition has implemented interventions that focus on physical activity, nutrition, smoking cessation, tobacco use prevention, and systems and environmental changes to prevent the onset of heart disease and diabetes. As a result, a farmer’s market was opened in 2001. Since then, 73% of residents say they are eating more fresh fruits and vegetables each day. Also, 72% of residents say they are being more physically active and 67% say they have reduced the amount of fat in their diet.

- Cherokee Choices is a CDC funded REACH program working to confront environmental and biological factors that put Cherokee people in North Carolina at a higher risk for diabetes. Mentors work with elementary school children and staff to develop lesson plans on self-esteem, cultural pride, conflict resolution, etc. In addition, nutritionists, dieticians, and fitness workers help tribal members participate in activities at their churches and work sites to help them reduce stress, eat healthier, and increase physical activity levels. After the implementation of this program, 96% of school participants said they know how to make healthier choices.

- To overcome health disparities, the REACH 2010 Charleston and Georgetown Diabetes Coalition has developed a comprehensive community action plan that includes walk-talk groups, home and telephone visits, educational sessions, health care visits, health and information fairs, support groups, grocery store tours, and Internet access at local public libraries. From 1999-2004, the percentage of African Americans who had their blood sugar level checked annually increased from 77% to 97%, while the percentage who had their blood cholesterol level checked increased from 47% to 81%. Kidney testing increased from 13% to 53% and foot exams increased from 64% to 97%. Additionally, emergency room visits decreased by about 50% for people who have diabetes but do not have health insurance.

- The Nashville Health Disparities Coalition developed a community action plan as a part of the REACH 2010 initiative to address health disparities among African Americans who have or are at risk of developing diabetes, heart disease, or high blood pressure. After the implementation of the plan in 2000, more than 4,000 people have been screened for diabetes, heart disease, and associated risk factors.

- In the Seattle and King County areas of Washington, the REACH 2010 Coalition implemented an intervention plan to prevent diabetes among minority communities. The percentage of people participating in the interventions who were able to keep their blood sugar level under control increased from 48% to 56%. The percentage of participants who said they were confident they could stick to their diet increased from 56% to 69%. The percentage of participants who reported being more physically active increased from 75% to 86%.
• The National Kidney Foundation's Kidney Early Evaluation Program (KEEP) is a free, community-based, health screening designed to identify and educate individuals at increased risk of developing kidney disease. Participants are measured for height, weight, waist circumference and body mass index (BMI). A health questionnaire and a diagnostic panel of urine and blood tests are conducted to assess evidence of diabetes, kidney damage/disease and other related health complications. Consultation with a clinician is offered to all participants at the end of the screening event and additional follow-up is conducted with participants after the program. As a result, nearly 30% of KEEP participants were identified with kidney disease, yet less than 4% were aware they might be at risk for kidney disease. Thirty percent of KEEP participants have diabetes and 45% of those with diabetes have elevated glucose values, even though the majority are under the care of a healthcare provider, highlighting the need for better education and management. 56% of KEEP participants with diabetes have microalbuminuria, an early indicator of kidney damage.

• The Minnesota Arthritis Program [with funding from CDC] is partnering with the Elderberry Institute Living at Home Block Nurse Program, which delivers community services that help older adults remain at home as long as possible. This partnership allowed the arthritis program to significantly expand the reach of self-management education and exercise program across the state. For example, the number of new participants in the Arthritis Foundation Self-Help Program increased 229% in 2006. The number of new participants in the Arthritis Foundation Exercise Program increased 125%. These programs are now available in 50 of the state’s 87 counties. (CDC. Arthritis: Meeting the Challenge, At a Glance 2009)

• Several large research studies,10 including the U.S. Diabetes Prevention Program (DPP) have now shown that over HALF of new cases of type 2 diabetes can be avoided by structured lifestyle intervention programs that help individuals with PRE-diabetes to lose just 11 – 15 pounds and to participate in daily physical activity such as brisk walking. (YMCA)

• Multiple prediction models have now demonstrated that a structured lifestyle intervention at the YMCA to prevent diabetes can be COST SAVING within 2 to 3 years time if the direct costs of the intervention can be reduced to $250 - $300 per year (this estimate contrasts with a cost of more than $1400 for the original DPP intervention)

• Emerging research and demonstration projects developed by Indiana University researchers show that a carefully designed group lifestyle intervention at the YMCA can be delivered for less than $250 per year in community settings and can achieve similar weight loss results as more costly programs in adults with PRE-diabetes.

• In Pawtucket, Rhode Island, the Pawtucket Heart Health Program conducted an intervention to educate 71,000 people about heart disease through a mass media campaign and community programs. Five years into the intervention, the risks for cardiovascular disease and coronary heart disease had decreased by 16 percent among

• The Stanford Five-City Project used a mass media campaign and community programs to target a population of 122,800 people. At five years, risk for coronary heart disease had decreased by 16 percent, cardiovascular disease mortality risk had decreased by 15 percent, prevalence of smoking was down 13 percent, blood pressure was down 4 percent, resting pulse rates were down 3 percent, and cholesterol was down 2 percent among members of the randomly selected intervention population. (Farquhar JW, Fortmann SP, Flora JA, Taylor CB, Haskell WL, Williams PT, Maccoby N, Wood PD. 1990. Effects of communitywide education on cardiovascular disease risk factors. The Stanford Five-City Project. JAMA 264(3):359-65.)

• WISEWOMAN, a CDC-funded lifestyle intervention program, provides low-income uninsured women aged 40 to 64 with chronic disease risk factor screenings, lifestyle interventions, and referral services in an effort to prevent coronary heart disease and improve health. Over the course of a year, WISEWOMAN participants improved their 10-year risk of coronary heart disease by 8.7%, and there were significant reductions in the percent of participants who smoked (11.7%), had high blood pressure (15.8%), or had high cholesterol (13.1%). (Finkelstein EA, Khavjou O, Will JC. 2006. Cost-effectiveness of WISEWOMAN, a program aimed at reducing heart disease risk among low-income women. J Womens Health (Larchmt) 15(4):379-89.)

• In an effort to combat the rise in childhood obesity, the Choosing Healthy and Rewarding Meals (CHARM) School Program was developed to address adolescents in one of Washington, DC’s most underserved communities. Through a series of classes covering topics ranging from healthy cooking to physical activity, the CHARM School led to changes in self-reported consumption of fruits, vegetables, and fast food while decreasing the number of hours of TV watched by the 81 participating youth. These successes occurred in the context of enhancing access to a pediatric medical home.

• The National Center for Healthy Housing in Columbia, Maryland, is using support from the Blue Cross and Blue Shield of Minnesota Foundation to demonstrate how green building principles can improve health. The center is tracking the health impact of the green renovation of an affordable 60-unit apartment complex in Worthington, Minnesota. Residents are primarily low-income minority families employed in the food processing industry. Results of this project can inform local zoning decisions and building codes. This is the first time the effect of green building principles will be measured against health outcomes over time. Early results include a majority of adults and children reporting improved health in just one year post-renovation. The adults made large, statistically significant improvements in general health, chronic bronchitis, hay fever, sinusitis, hypertension, and asthma. The children made great strides in
general health, respiratory allergies, and ear infections. Overall, there were improvements in comfort, safety, and ease of housecleaning.¹

- Opening in March 2008, the Sabathani Community Center is a non-for-profit community organization in Minneapolis with the mission of building community capacity and strengthening youth, children, and families. The center provides much-needed social services, as well as adult, dental, and now pediatric primary care. Since receiving a Community Access To Child Health (CATCH) Program grant from the American Academy of Pediatrics, the pediatric clinic has served over 100 children, providing immunizations to more than 50% of patients and screening nearly 1/3 for lead toxicity. The clinic continues to succeed in delivering health care to Minneapolis children who need it the most.

- Founded by a group of medical students in 1984, the Chicago Youth Program (CYP) serves children and youth living in inner-city Chicago, and area where 65% of families with children live below the Federal Poverty Level. In addition to serving as the medical home for youth, CYP provides a myriad of social services. The Healthy Tomorrows grant provided by the American Academy of Pediatrics and the federal Health Resources and Services Administration supported the development of the Parent Run Evening Preschool (PREP) program, intended to prepare children for school while simultaneously teaching their mothers parenting skills to enhance self esteem. The program was met with widespread success, boasting a 77.5% overall program retention rate for participants. Youth in PREP had a 95% graduation rate, compared with 51% in surrounding areas, an over 75% college/trade school placement rate, and lower teen birth rates compared to the general population. Following the pilot, PREP was expanded to 4 additional sites and continues to serve Chicago’s at-risk youth today.

Physical Activity & Nutrition:

- In December 2008, the American Journal of Preventive Medicine published a study that evaluated the cost-effectiveness of population-wide strategies to promote physical activity in adults and follow disease incidence over a lifetime. In particular, the study focused on four strategies: community-wide campaigns, individually adapted health behavior change, community social-support interventions, and the creation of or enhanced access to physical activity information and opportunities. The study found that all of the evaluated physical activity interventions appeared to reduce disease incidence, to be cost-effective and— compared with other well-accepted preventive strategies—to offer good value for money.

- The Steps Program in Pinellas County, Florida, implemented a program in schools to increase fruit and vegetable consumption, and a local vegetable distributor set up farmers’ markets on school grounds. More than 3,700 students and staff increased their fruit and vegetable intake, and 84 percent of schools and 90 percent of their students

and staff are participating in the farmers’ markets. In 2007, the school district was rated first in the nation among large school districts on the Physicians Committee for Responsible Medicine’s School Lunch Report Card.

- The YMCA of Santa Clara Valley and the Steps Program worked together on a number of activities including: a school lunch walking campaign at six schools; family nights offering physical activities and healthy recipes at six schools; a YMCA Healthy Kids Day in which local resources and health providers introduced families to wellness concepts; a YMCA 5K; and a reduced rate YMCA family membership. The program also helped sustain efforts made under a Carole M. White PEP grant to the district, as 81 percent of students who could not pass a fitness gram in the fall passed in the spring. Fifty-one percent of families surveyed said they increased family physical activity, and 425 families reported they were practicing healthier eating.

- Healthy Eating, Active Communities (HEAC) was created as a part of the REACH 2010 grant to reduce disparities in obesity and diabetes by improving food and physical fitness environments for school-age children in California. HEAC seeks to bring healthy changes to schools, afterschool programs, the health care sector, local neighborhoods, and marketing and advertising practices. All school districts in HEAC areas improved their physical education curricula, and as a result, students report more activity throughout the day. Survey data also show that students are consuming fewer servings of chips, candy, and soft drinks during the school day, and they aren’t eating more of these unhealthy products at home. Generally, there’s about a ~7% increase in self-reported activity and a ~4% reduction in unhealthy food consumption.

- In 2006, a small group of local mothers from California—many of them Spanish-speaking farm workers—formed a local walking group (Greenfield Walking Group (Bakersfield, CCROPP)) to improve their fitness levels and connect with friends and neighbors. They met at a nearby park—Stiern Park—which was poorly lit and littered with used hypodermic needles and broken bottles. The paths at Stiern Park were so cracked and run down that they were impossible to navigate with a baby stroller, effectively rendering them unusable for new mothers. The Walking Group organized, inviting police, parks officials, and other community leaders to walk the park with them, so they could see and understand the extent of the problem. Ultimately, the local Chamber of Commerce agreed to support park improvements and more than 100 volunteers installed a new walking path in a single day. The Greenfield Walking Group is now a community institution. Several members have experienced significant weight loss (up to 80 pounds) and report significant improvements in their personal health and quality of life. (funded by CDC)

- South Los Angeles is a classic “food desert,” where fast food outlets and junk food filled convenience stores dominate the local retail environment, and full service supermarkets and farmers markets are rare. Six local high students decided to do something about it—one store at a time, (South Los Angeles Corner-Store Conversions (South LA, HEAC). Starting with the stores nearest to their schools, the students persuaded local market owners to make over their stores, showcasing healthy snacks like oranges and bananas and pushing chips and soda to the back. The students
documented their success in a series of short videos, collectively titled, *Where Do I Get My Five?* The students grew into local advocates and were instrumental in helping to pass a local fast food moratorium through the Los Angeles City Council, which imposed a temporary ban on new fast food restaurants in the area. (funded by CDC)

- LiveWell Colorado is a statewide initiative, funded by the CDC, aimed at reducing overweight and obesity rates and related chronic diseases in Colorado. LiveWell Colorado works with community initiatives, such as LiveWell Colorado Commerce City, to promote equal opportunities for healthy eating and active living through policies, programs and environmental changes. Around 450 youth and adults (2% of the Commerce City population) are involved in relatively intensive cooking classes and other educational programs that might be expected to produce measurable behavior change. Another 1200 people (4% of the population) have come to one-time events such as walkability assessments or been contacted by LWCC outreach specialists. One third (34%) of the 330 respondents from Commerce City reported eating five or more servings of fruits and vegetables each day, and 38% were meeting the recommended levels of physical activity.

- The Steps Program in Broome County, New York, reached families in rural areas by implementing a walking program that enrolled more than 50,000 people. The percentage of adults walking for more than 30 minutes on five or more days each week increased from 47 percent to nearly 54 percent in one year. The Program also worked with fifteen school districts that together were able to buy healthy foods at lower costs. As a result, fresh fruit and vegetable consumption increased 14 percent in participating schools.

- The Rochester Area Family YMCA and the Steps Program developed and implemented a program called “Fit WIC, the Y’s Way.” A Women, Infants, and Children (WIC) fitness class teaches best practices to parents while children play in a Y class. Families receive activity ideas, balls, bean bags and resource guides. An evaluation of the program showed that parents indicated an increase in their own moderate and vigorous physical activity by about 10 percent over a six-month period. Children and adults reported that they exercised more often and for longer periods of time at post test.

- The REACH Promotora Community Coalition developed a community action plan in Texas that use promotores (promoters) with the same socioeconomic background, language, and culture as the community they serve to promote healthy behaviors. As a result, moderate walking increased by 25% among community residents. Before the intervention, baseline data showed that 24.5% of patients with diabetes drank whole milk. Afterward, patients reported a 14% decrease in their consumption of whole milk.

- The Briggs Community YMCA in Washington worked with the Steps Program to implement a program called “Steps that Count.” Twenty-three worksite teams from city, county and state agencies, in addition to businesses, schools and churches were created in order to increase physical activity. Informational packets, self-tracking forms and pedometers were distributed. Overall, employees logged over 21 million
steps in the three-month program, and the program continued to grow.

- In January 2008, Preventing Chronic Disease released a study that investigated the relationship between use of an insurance plan-sponsored health club program for older adults (Silver Sneakers) and health care costs over a two-year period. The study found that, by year 2, compared with controls, Silver Sneakers participants had significantly fewer inpatient admissions and lower total health care costs. Furthermore, Silver Sneakers participants who averaged at least two health club visits per week over 2 years incurred at least $1252 less in health care costs in year 2 than did those who visited on average less than once per week.

- In 2000, The Physician and Sportsmedicine published a study that investigated the relationship between annual medical expenditures and physical inactivity among adults. The research showed that active adults spent $330 (using 1987 dollars) less than their inactive counterparts. The study concluded that increasing participation in regular moderate physical activity among the more than 88 million inactive Americans over the age of 15 might reduce annual national medical costs by as much as $29.2 billion in 1987 dollars—$76.6 billion in 2000 dollars.

- Researchers at Ohio State University recruited 60 women in their forties for a 12-week walking program that took place on the college’s campus. At 3 months, the intervention group saw a 1 percent decrease in body mass index (BMI), a 3.4 percent decrease in hypertension, a 3 percent decrease in cholesterol, and a 5.5 percent decrease in glucose. (Haines DJ, Davis L, Rancour P, Robinson M, Neel-Wilson T, Wagner S. 2007. A pilot intervention to promote walking and wellness and to improve the health of college faculty and staff. J Am Col Health 55(4):219-25.)

- Funded by the Centers for Disease Control and Prevention, Shape Up Somerville: Eat Smart. Play Hard. was a 3-year (2002-2005), environmental change intervention designed to prevent obesity in culturally diverse, high-risk, early-elementary school children. The Shape Up team developed and implemented strategies designed to create energy balance for 1st-3rd graders in Somerville. In before-, during-, and after-school environments, interventions were focused on increasing the number of physical activity options available to children throughout the day and on improving dietary choices. The program included improved nutrition in schools, a school health curriculum, an after-school curriculum, parent and community outreach, collaboration with community restaurants, school nurse education, and a safe routes to school program. After one year, on average the program reduced one pound of weight gain over 8 months for an 8 year old child. On a population level, this reduction in weight gain would translate into large numbers of children moving out of the overweight category and reducing their risk for chronic disease later in life. (Economos CD, Hyatt RR, Goldberg JP, Must A, Naumova EN, Collins JJ, Nelson ME. 2007. A Community Intervention Reduces BMI z-Score in Children: Shape Up Somerville First Year Results. Obesity 15(5): 1325-1336.)
In 2004, the Food Trust in Philadelphia, PA, in partnership with The Reinvestment Fund and the Greater Philadelphia Urban Affairs Coalition, identified a strong need for government investment to finance supermarkets, grocery stores, and other healthy food retailers in underserved communities. This led to the first statewide fresh food financing initiative. The Pennsylvania Legislature allocated $10 million in its annual appropriations in 2004, with additional funds allocated in 2005 and 2006, to establish a grant and loan program to encourage supermarket development in underserved areas. The Reinvestment Fund leveraged the investment to create a $120 million initiative composed of state dollars, federal tax credit dollars, and private investments. To date, the initiative has provided $63.3 million in grants and loans for healthy retail projects, resulting in the creation of and improvements to 68 stores that offer fresh foods. These projects have generating 3,734 jobs and 1.44 million square feet of floor space.\(^2\) It is now seen as a model and is being replicated in other US communities.\(^3\)

**Tobacco Use Prevention & Cessation:**

- The Steps Program of the Cherokee Nation in Oklahoma helped schools reduce tobacco use by implementing the School Health Index (SHI) and creating a healthier school environment for American Indian youth. In 2004, the Program provided SHI training to 65 school administrators, teachers, staff, and partner organizations. As a result, nine schools developed and implemented 24/7 tobacco-free environment policies. All 19 schools with a predominantly American Indian student enrollment made other changes in the school, including developing wellness policies, offering healthier food choices in cafeterias and vending machines, and providing better lighting and access to exercise facilities after school.

- The Steps program in Chautauqua County, New York, worked with a local hospital to change its policy on asking patients about tobacco use and implementing a two-minute tobacco cessation intervention. Total calls to the New York State Smokers’ Quitline from health care provider referrals increased four-fold during 2005-2006, and county data show a decrease in smoking rates in Chautauqua County, from nearly 29 percent in 2004 to less than 24 percent in 2006.

- California launched its new Tobacco Control Program in 1989. California’s comprehensive approach has reduced adult smoking significantly. Adult smoking declined by 35 percent from 1988 to 2007, from 22.7 percent to 13.8 percent. If every state had California’s current smoking rate, there would be almost 14 million fewer smokers in the United States. Between Fiscal Year 1989-90 and Fiscal Year 2006-07, per capita cigarette consumption in California declined by 61 percent, compared to just 41 percent for the country as a whole, during this same time period. Between 1988 and 2004, lung and bronchus cancer rates in California declined at 3.8 times the rate of decline as the rest of the U.S. Researchers have associated these declines with

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California’s program. (California Tobacco Control Update, 2009. California Department of Public Health, California Tobacco Control Program)

• In 1997, Maine established a comprehensive tobacco prevention program known as the Partnership for a Tobacco-Free Maine. Prior to launching this effort, Maine had one of the highest youth smoking rates in the country. Now, it has one of the lowest. Smoking among Maine’s high school students declined a dramatic 64 percent between 1997 and 2007, falling from 39.2 percent to 14 percent. (Nationally, smoking among high school students declined by 45 percent over this same time period). The Maine Department of Health (DOH) has calculated that, as a result of these declines, there are now more than 26,000 fewer youth smokers in Maine and more than 14,000 youth will be saved from premature, smoking-caused deaths. Based on estimates that smokers, on average, have $16,000 more in lifetime health care costs than non-smokers, the DOH calculated that these declines will save Maine more than $416 million in long-term health care costs.

• New York began implementing a comprehensive state tobacco control program in 2000. Between 2000 and 2006, smoking among middle school students declined by 61 percent, (from 10.5 percent to 4.1 percent), and smoking among high school students declined by 40 percent, (from 27.1 percent to 16.3 percent). Nationally, over this same time period, smoking among middle school students declined by 43 percent and smoking among high school students declined by 30 percent. (California Tobacco Control Update, 2009. California Department of Public Health, California Tobacco Control Program)

• The Washington State Tobacco Prevention and Control program was implemented in 1999. Since the program began, adult smoking has declined by 30 percent, from 22.4 percent in 1999 to 16.5 percent in 2007, one of the lowest smoking rates in the country. Washington’s dramatic decline in adult smoking translates to more than 240,000 fewer smokers in the state, saving about $2.1 billion in future health care costs.

• Rates of tobacco use, both cigarettes and spit, have historically been higher in Alaska than in the rest of the nation. To address this health problem, the Alaska Department of Health and Social Services has implemented a comprehensive tobacco control program based upon CDC’s Best Practices for Comprehensive Tobacco Control Programs—2007. Program components include counter marketing, community-based programs, youth and school programs, eliminating exposure to secondhand smoke, eliminating health disparities, cessation, a free quit line, and evaluation. Thousands of Alaskans have called the quit line since it was established in 2002, and a 2007 study documented a 40% quit rate. Alaska has seen progress as a result of its efforts. Data from the 2008 Alaska Behavioral Risk Factor Surveillance System showed a significant reduction in tobacco use. The percentage of adult smokers in Alaska has declined by one-fifth since 1996 to 21.5% in 2007. This figure represents more than 27,000 fewer smokers and is expected to result in almost 8,000 fewer tobacco-related deaths and $300 million in averted medical costs. (CDC. Tobacco: Targeting the Nation’s Leading Killer, At a Glance 2009.)
A worksite intervention program targeting approximately 800 high-risk employees who smoked provided the individuals with worksite health promotion, cardiovascular risk factor screenings, and individualized counseling. At 3.7 years, the intervention group realized a 12.6% decrease in the amount smoked, a 3.3% decrease in diastolic blood pressure, and a 7.8% decrease in cholesterol, decreasing the individuals’ risks for developing cardiovascular disease. (Prior JO, van Melle G, Crisinel A, Burnand B, Cornuz J, Darioli R. 2005. Evaluation of a multicomponent worksite health promotion program for cardiovascular risk factors-correcting for the regression towards the mean effect. Prev Med 40(3):259-67.)

**Infectious Disease Prevention:**

- The Immunize LA Kids Coalition, which was funded by the CDC during the REACH 2010 initiative, in California implemented a community action plan with culturally appropriate interventions that seek to overcome barriers to immunization by working to improve practices in health care provider settings. They also strove to provide reminders for parents about immunizations. By April 2006, 82% of WIC clients in the service area were up to date with recommended immunizations at age 2.

- The Coalition to Reduce HIV (funded by CDC) designed an intervention to reduce the transmission of HIV in young adults in the African American, Caribbean, and Hispanic communities in the 12 Florida ZIP codes with the highest numbers of HIV cases. Strategies of the coalition included outreach to residents, businesses, and community leaders; efforts to educated individuals and mobilize communities; and efforts to build capacity for community groups and enhance the public health infrastructure. As a result, the percentage of self-reported sex without condoms declined from 26.3% in 2001 to 21.5% in 2005 among the project’s target population. Among the Caribbean population, self-reported condom use at least once in the past year increased steadily from 51.8% in 2001 to 65.8% in 2005.

- The North Manhattan Start Right Coalition (funded by CDC through the REACH initiative) works to promote immunization through existing community programs that serve the needs of parents of young children. The program developed a five-part training program for community health workers. Between 2002-2006, the program increased the immunization rate to 76% for children of all ages enrolled in the program, with 86.5% of children up to date by age 3.

- The Healthy Living Project aimed to reduce the risk of transmission among people living with HIV through behavioral intervention. More than 450 individuals each participated in a 15-session, individually delivered, cognitive behavioral intervention that included modules on stress, coping, and adjustment; safer behaviors; and health behaviors. The participants and the members of a control group completed follow-up assessments at 5, 10, 15, 20, and 25 months after randomization. Overall, a significance difference in mean transmission risk acts was shown between the intervention and control arms over 5 to 25 months. The greatest reduction occurred at the 20-month follow-up, with a 36% reduction in the intervention group compared with the control

**Oral Health:**

- CDC funded Colorado’s Oral Health Unit to develop a state plan, convene a statewide coalition, and develop community prevention efforts. State officials also are working to provide sealants to all Colorado children at greatest risk for tooth decay. In 2009, the Oral Health Unit will expand its *Be Smart & Seal Them!* program to include all urban schools with a student population of 50% or more who qualify for the federal free or reduced lunch program and rural school districts that serve families with a median income at or below 235% of the federal poverty level. During the 2007–2008 school year, more than 1,200 schoolchildren in Denver were screened for dental problems, and 971 received sealants. Children in rural areas received preventive services, such as sealants and fluoride varnish, as well as other dental treatments. Many of these children had never seen a dental provider before. (CDC. Oral Health: Preventing Cavities, Gum Disease, and Tooth Loss.)

- Established under a Healthy Tomorrows Partnership for Children program grant (from the American Academy of Pediatrics and the federal Health Resources and Services Administration), the San Diego County Children’s Dental Health Initiative began with a community needs assessment which highlighted the high numbers of uninsured children and the significance of dental care needs. A collaboration of public and private organizations, the initiative was the first Healthy Tomorrows dental grant and facilitated the incorporation of oral health into various medical programs. Delivering emergency dental care through a network of over 300 volunteer dental providers, the program provided dental health services to 1900 children and sealant treatments to an additional 2200. Today, the program continues to impact 10,000 youth per year via outreach activities alone.

**Injury Prevention:**

- CDC “Core” PHISPP injury and violence prevention funding is critical for sustaining services of the Division of Injury and Violence Prevention (DIVP) in the South Carolina Department of Health and Environmental Control (SCDHEC). Those services include fatal and non-fatal injury surveillance, violent death reporting, child death review, strategic planning, and education and prevention activities. The core funding also provides a stable base from which the Division can work to acquire supplemental funding for valuable and successful injury and violence prevention programs. An important SCDHEC DIVP prevention program is the SC Residential Fire Injury Prevention Program, funded by CDC’s Smoke Alarm Installation and Fire Safety Education (SAIFE) program. In 2008, four fires were reported in homes that participated in the SC Department of Health and Environmental Control's Residential
Fire Injury Prevention Program and eleven lives, eight months to 89 years of age, were saved in those events. In each home, a smoke alarm provided through the SC Residential Fire Injury Prevention Program alerted residents of fire and everyone escaped without injury. Also, local fire departments were quickly notified and minimal damage to the homes was reported.

**Public Health Preparedness and Response:**

- The Latino Health Initiative of Montgomery County, Maryland and its health promotion program, *Vías de la Salud*, and the Montgomery County Advanced Practice Center for Public Health Emergency Preparedness and Response (Montgomery APC), a program of the Montgomery County Health Department, in collaboration with the University of Maryland, School of Medicine—developed, implemented, and assessed a cultural and linguistic intervention to increase the awareness, knowledge, and practices of emergency preparedness among the low-income Latino community. This intervention included the development of a training curriculum, the training of health promotion specialists, and conducting community-based education sessions. Over a two month period, teams of Vías promoters conducted two pilot interventions at two collaborating community agencies that serve Latinos. At each site, the promoters held educational sessions addressing “What is an Emergency?” and the three steps of emergency preparedness (initiate a conversation about emergencies; develop a family emergency plan; and prepare an emergency supply kit of nine essential items). This intervention resulted in the following:

  - Increased perception of participants that their families were prepared to deal with an emergency situation (from 8% at the pre-test to 69% at the post-test);
  - Increased engagement in emergency preparedness activities—on the final post-test, 100% of participants reported to have discussed with their families about emergencies and the need to develop an emergency plan (compared to 23% and 33% respectively, on the pre-test);
  - More than 90% of participants reported to have stored water, food, and other supplies at the final post-test;
  - Participants reported that they found the sessions to be interesting, valuable, clear, and motivating; and
  - Several participants indicated the need to inquire about the emergency plan at their children’s schools, and to consider medication for chronic illnesses when planning for an emergency.

- Local health officials responded to the outbreak of H1N1 in Greater Cleveland/Cuyahoga County by coordinating a group of local preparedness leaders including police and fire department, emergency coordinators from area hospitals, infectious disease physicians, the Cuyahoga County Coroner and the Cuyahoga County Emergency Manager. One of the most important functions of the local health department was to make sure that up to date and accurate information was provided to the public and community leaders. Frequent conference calls were held with community partners from hospitals, nursing homes, safety forces, schools and
universities, daycares and businesses. A regular email briefing was established for local elected officials. In short order, local health officials activated response plans, mobilized staff for surge capacity, assured continuity of normal daily operations at the health department, and established a link to the media and the public to provide trusted information. These actions demonstrated the formal integration of the local health department as an essential partner in the community emergency response system.

- After identifying a cluster of salmonella cases among residents of Boston’s Chinese communities the Boston Public Health Commission developed a culturally competent survey to conduct the investigation. The survey identified live poultry markets in Boston as a potential source of this cluster. Inspections by USDA, Massachusetts Food Safety Program, and Boston Inspectional Services identified a number of unsafe practices that could have contributed to the illnesses. The outbreak strain of salmonella was narrowed down to the live bird market. These findings have resulted in improvements in retail practices in Boston’s live poultry markets. In addition, this investigation identified high risk food handling practices in the Chinese community. A food safety summit with community members identified knowledge, attitudes, and beliefs related food safety and resulted in a recommendation for a food safety video for the this community. The Boston Public Health Commission produced a food safety video that is now available in both Cantonese and Mandarin.

**Cancer Screening:**

- The Alabama REACH 2010 Breast and Cervical Cancer Coalition (ABCCC) created a community action plan to address the barriers that prevent African American women over 40 from receiving breast and cervical cancer screenings. The plan created a core working group of volunteers and health professionals, awarded grants to non-profit groups that targeted screenings, conducted outreach activities, and distributed educational materials. Within 2 years after instituting the plan, 14% more women participating in the intervention reported having a mammogram. Additionally, 11% more women reported receiving a Pap test within 2 years of the intervention. The disparity in mammography screening between African American and white women also decreased 11% between 2001-2003.

- The REACH project in New Mexico and Colorado worked with the Ramah Band of Navajo Indians to create partnerships between tribal health programs, tribal leaders and nontribal groups to address the rising incidence of breast and cervical cancer among American Indian women. The project developed Mammography Days and transported women to the nearest hospital, about 45 miles away. As a result, 130 women received mammograms for the first time in their lives. Tribal health care providers also received training in public health topics, cancer screening techniques, and surveillance methods to improve their patient care.

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- The Albuquerque Area Indian Health Board, Inc. worked with the Ramah Band of Navajo Indians, with funds from CDC, to create a program called Mammography Days to encourage more tribal women aged 40 or older living in the pilot community to get screened for breast cancer. Mammograms were scheduled for tribal women at a nearby hospital. The women were provided with health information that reflected the women’s tribal culture and language and were transported to the hospital in groups to create social support. The program also trained tribal health care providers in public health topics and cancer-screening techniques. As a result, 130 women received a mammogram, some for the first time in their lives.

- During 2000-2004, the Vietnamese REACH for Health Initiative (VRHI) Coalition in California implemented a cervical cancer action plan that included a multimedia campaign, outreach by lay health workers, a Pap test registry and reminder system, along with other interventions. Results of the program showed that 47.7% of participants who had never had a Pap test received one after meeting with a lay health worker. Additionally, 52.1% of participants had a repeat Pap test within 18 months.

- During 2004-2007, the Vietnamese REACH for Health Initiative (VRHI) Coalition implemented a breast cancer action plan that included a multimedia campaign, outreach by lay health workers, along with other interventions. Results of the program showed that 17.9% of participants received a mammogram and 27.9% received a clinical breast exam after meeting with a lay health worker, compared with 3.9% and 5.1%, respectively, of women who did not meet with a lay health worker.

**Worksite Wellness:**

- In Austin, Texas, the Steps Program established a worksite wellness program with Capital Metro. Employees received health assessments and health action plans. Employee absences decreased more than 44 percent during 2004-2006, and the use of healthy choice options in the cafeteria increased 172 percent. Annual health care costs increased by nine percent during 2004-2005, compared with 27 percent during 2003-2004.

- International Truck and Engine Corporation implemented a workplace wellness program that included Integrated Health Risk Appraisal (HRA) screening; financial incentives linking health promotion efforts to health care premiums; Multifaceted
health promotion offerings; onsite fitness centers and health club subsidy reimbursement program; and onsite medical services. The program resulted in:

- Flat or reduced company health care costs since 2004;
- 75% participation in HRA screening;
- 68% of telephonic health coaching participants reported improvement or elimination of at least one health risk;
- 54% of disease management participants have documented improvement in quality indicators; and
- 53% of eligible smokers enrolled in a smoking cessation program—85% have quit.4

- In 2007, a report commissioned by Transport for London reviewed seventeen studies focused on the relationships between physical activity and employee absenteeism, and physical activity and employee productivity. The report found the following: three studies suggested that workplace health promotion programs can lead to increases in physical activity and reductions in absenteeism with a 12 month commitment; ten studies suggested that workplace exercise intervention programs can lead to long term increases in levels of physical activity and reductions in absenteeism, one study suggested that counseling sessions to promote physical activity (and dietary changes) can lead to self-reported increases in physical activity and observed increases in fitness in the short term, and limited evidence from two studies suggested that physical activity levels affect both short (up to 1 year) and long term (over 1 year) health care costs (and implicit absenteeism rates), including among the obese and sedentary.

- In 2005, a report released by the Western Australia Department of Sport & Recreation reviewed workplace health and physical activity programs. In part, the report reviewed the available literature relating to workplace health and physical activity programs. The report found that workplace health and physical activity programs are associated with the following economic benefits: reduced absenteeism, decreased workers’ compensation claims, a reduction in workplace costs, and a potential increase in productivity.

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