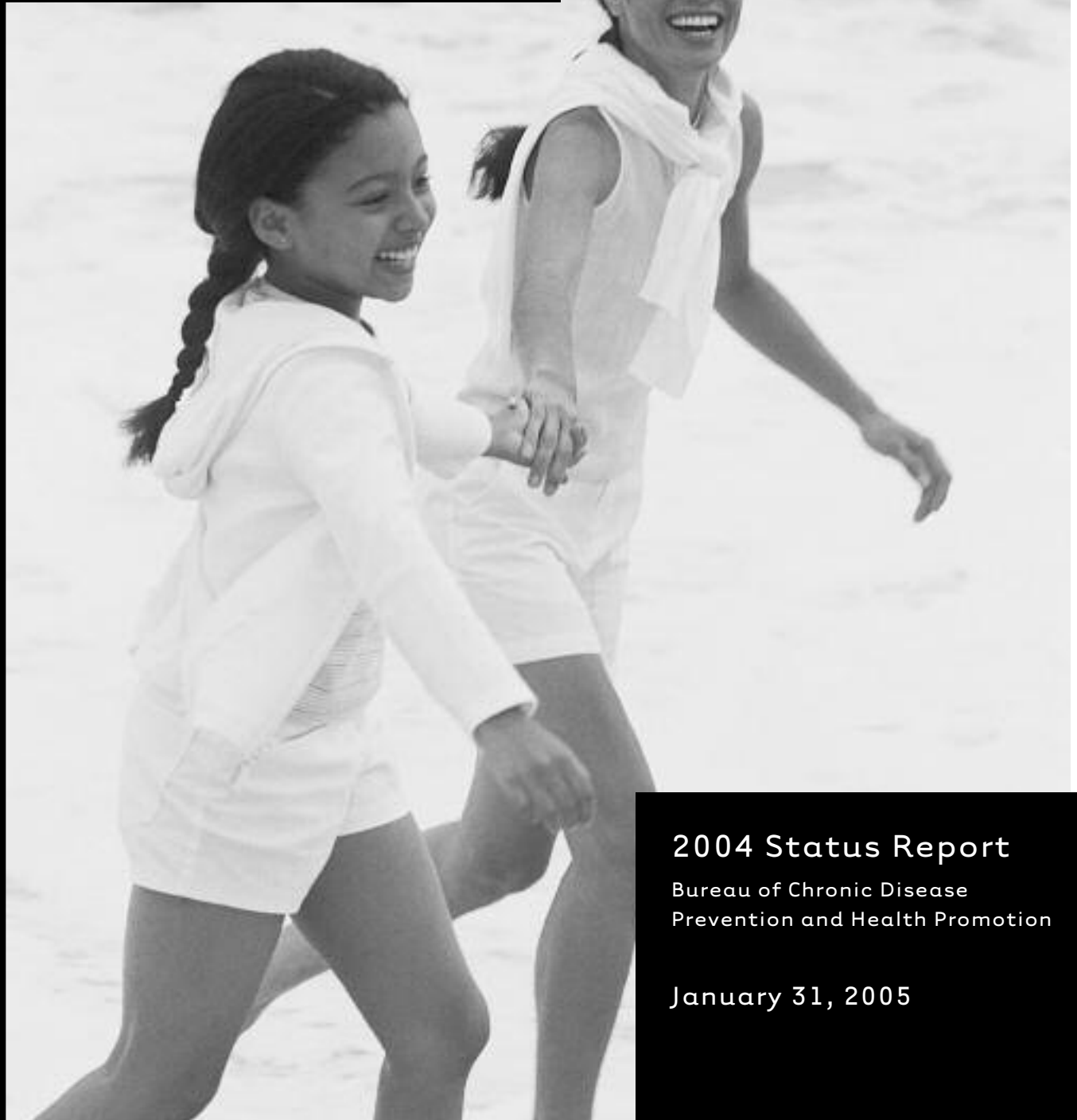


Healthy Communities, Healthy People Initiative



2004 Status Report

Bureau of Chronic Disease
Prevention and Health Promotion

January 31, 2005

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EXECUTIVE SUMMARY

Through the enactment of section 408.604, Florida Statutes (F.S.), in 1992, the Department of Health was directed to develop a Healthy Communities, Healthy People

Program, a comprehensive and community-based health promotion and wellness program designed to reduce major behavioral risk factors associated with chronic diseases. The department accepted this responsibility as a challenge and an opportunity.

The statute further directed the department to consolidate and use existing resources, programs, and program data to develop the Healthy Communities, Healthy People Program. No specific funding was appropriated. As a result, there is not a single Healthy Communities, Healthy People Program, but a group of programs—each retaining the name required by its funding source—that together comprise the Healthy Communities, Health People initiative.

Effective in 2004, the legislature directed the department to submit this status report based on the monitoring and assessment of the programs in the Healthy Communities, Healthy People initiative to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive committees of the Legislature.

This report provides information about the status and effectiveness of Florida's Healthy Communities, Healthy People initiative and specifically includes:

- **The focus of the initiative.**
- **A description of the system in which the programs are developed and implemented.**
- **A history of program development from 1970 to present.**
- **An explanation of the methods for determining program effectiveness.**
- **The key indicators for chronic disease prevention and health promotion programs, and state-level summary of each indicator.**
- **Information about current program activities and key successes.**

The Healthy Communities, Healthy People initiative has grown substantially since first authorized in 1992. It began with a single program covering 14 counties and now includes that same program expanded to cover all 67 counties and an additional eight other programs.

The focus of the Healthy Communities, Healthy People initiative is to reduce deaths due to chronic diseases and related unhealthy behaviors. Age-adjusted death rates for the three leading causes of death in Florida — coronary heart disease, cancer, and stroke — have all declined since 1992. The most dramatic change was in the age-adjusted death rate for coronary heart disease, which declined from 227.2 deaths per 100,000 population to 157.5 deaths per 100,000 population. The prevalences of smoking and physical inactivity have remained relatively stable since 1992. However, the rates of overweight and obesity have nearly doubled, mirroring national trends.

The Department of Health has modeled chronic disease health outcomes after the national Healthy People 2010 program. Healthy People is the prevention agenda for the nation. Most objectives of programs in the Healthy Communities, Healthy People initiative have projected completion dates of 2010. Even though we are only 30 percent of the way to that target date, progress toward targeted outcomes have far exceeded expected progress. Of 21 proposed objectives, 11 are at least 25 percent closer to meeting the expected target or have already exceeded the expected target.

In addition, programs in the Healthy Communities, Healthy People initiative have been so successful in their activities that all federally funded programs have received continuation funding and several have received an increase in funding.

The effects of the obesity epidemic impact several chronic diseases. To effectively address diabetes and cardiovascular disease, extra emphasis must be placed on effecting policy and environmental changes to prevent and control overweight and obesity.

Key recommendations based on the findings of this report include:

- **Identify a mechanism and necessary funding to collect behavior data at the county level on a regular basis.**
- **Implement the recommendations of the Governors Task Force on Overweight and Obesity.**

- **Identify and focus resources on reducing risk factors for cardiovascular disease including high blood pressure, high cholesterol, tobacco use, and overweight.**
- **Continue and expand partnerships with employers, the faith community, healthcare providers, and insurers to promote healthy behaviors.**
- **Develop and support policies at the state and local level that support healthy environments and healthy behaviors – limit smoking in public places, promote healthful nutrition, and support a physically active environment.**

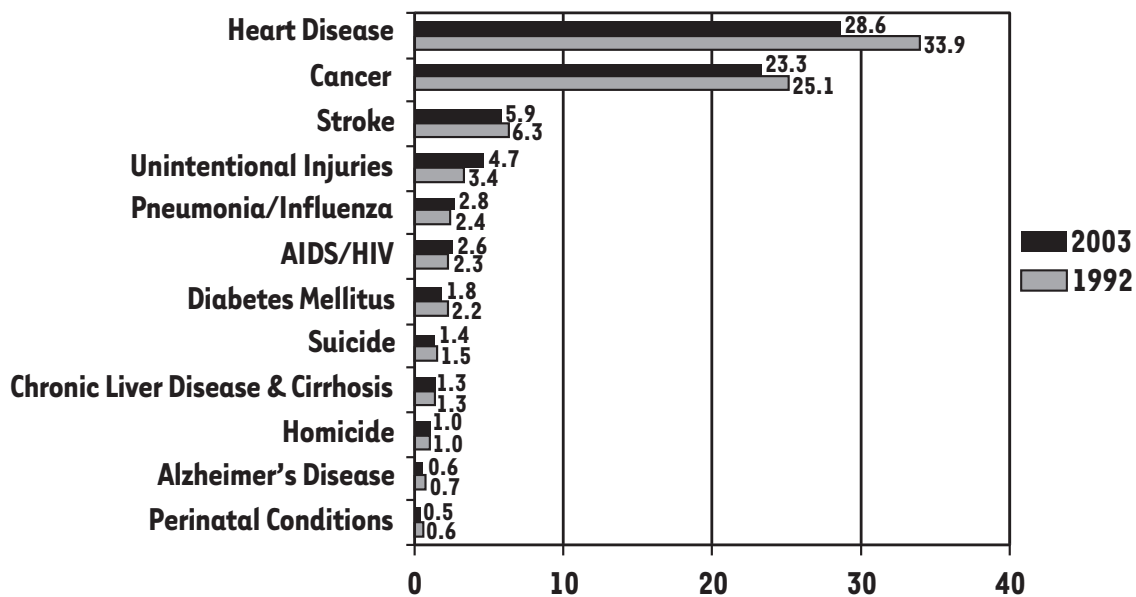
INTRODUCTION

Healthy Communities, Healthy People is more than a legislatively mandated program in Florida. Healthy people in healthy communities are the vision for

public health in America. As the lead agency responsible for the public's health in Florida, the Department of Health aspires to realize this vision in every facet of its operation. The health of a community is affected by a myriad of factors including the quality of air and water, access to a healthcare system, the availability of jobs and adequate affordable housing, the physical safety of the community, and sufficient opportunities to support healthy behaviors. The Florida Healthy Communities, Healthy People legislation, section 381.734, F.S., provides a specific focus for the department, which is to develop and implement programs designed to reduce major behavioral risk factors associated with chronic diseases.

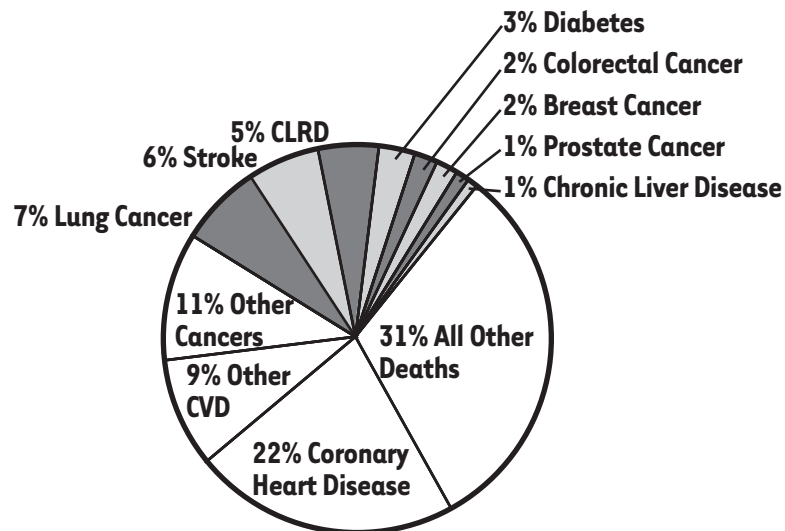
Chronic diseases are generally characterized by unknown or complex etiologies, long latency periods, and long courses of illness. They do not typically resolve spontaneously and a complete cure is not common. During the 12 years since the legislation was passed (1992), the department has developed programs that focus on heart disease, cancer, stroke, hypertension, diabetes, renal disease, chronic lower respiratory disease (CLRD), and arthritis. These chronic diseases, excluding hypertension, represent the most prevalent chronic diseases in Florida and five of the 10 leading causes of death in Florida both in 1992 and today. (See Figure 1) In 2002, the leading causes of death varied somewhat in rank by race or ethnicity. For example, among non-Hispanic Blacks, after coronary heart disease, the leading causes of death in order are stroke, HIV/AIDS, lung cancer, and diabetes while among non-Hispanic Whites, the leading causes of deaths in order are lung cancer, stroke, and CLRD.

Figure 1: Top 10 Causes of Death, by Percent 1992 and 2003



Overall, in Florida in 2002, approximately 69 percent of all deaths were due to chronic diseases (Figure 2). Cardiovascular disease (including coronary heart disease and stroke) accounted for 37 percent of all deaths, or about one out of three. All cancer types accounted for approximately 23 percent of all deaths, or about one out of five.

Figure 2: Selected chronic disease-related deaths as a percent of all deaths, Florida 2002



In addition to causing the most deaths in Florida, chronic diseases have an enormous economic impact on Floridians. Considering only hospitalization charges, cardiovascular disease and cancer are the first and second leading causes of hospitalization. Hospitalization charges for cardiovascular disease alone in Florida increased 70 percent between 1990 and 2002, from about \$7.6 billion (C\$) to \$12.9 billion, even though the average length of hospital stay declined during that time. The price tag for cancer-related hospitalizations increased from \$2.5 billion (C\$) in 1990 to \$2.8 billion in 2002. Hospitalization days for cancer decreased substantially during that time, but the average charge per day increased from \$3,534 (C\$) to \$5,925.

Although chronic diseases are among the most common and costly health problems, they are also among the most preventable. The key to preventing and reducing complications and deaths due to chronic diseases is to address the risk factors. Risk factors are genetic, behavioral, or environmental factors that are likely to increase an individual's susceptibility to disease. Researchers have identified several factors that increase the risk for chronic diseases, including smoking, exposure to secondhand smoke, high-fat diet, lack of regular physical activity, poverty, and for some chronic diseases, air pollution, or long-term exposure to certain cancer-causing substances.

The major behavioral risk factors for chronic diseases are physical inactivity, tobacco use, and overweight and obesity (which results in part from poor nutrition). These three risk factors, identified as priority areas in Healthy People 2000, are considered leading health indicators in Healthy People 2010. Developing programs to address one or more of these indicators can positively affect the rates of several chronic diseases simultaneously and have a profound effect on increasing the quality of life and the years of healthy life, and on sustaining healthy people in healthy communities.

A SYSTEMS APPROACH

In 1988, the Institute of Medicine defined public health as “what we as a society do collectively to assure the conditions in which people can be healthy.” To achieve

the best possible public health or healthy communities and healthy people, it is necessary to identify and engage the public health system. The public health system is comprised of a complex network of governmental entities, organizations, and individuals. In developing and implementing the Healthy Communities, Healthy People initiative, the department collaborates with public, private, and voluntary organizations such as the American Heart Association, the American Diabetes Association, the Florida Dietetic Association, the state universities, the Florida Pediatric Society, the Area Health Education Association network, the Florida Osteopathic Society, and state departments including the Department of Education, Department of Elder Affairs, Agency for Healthcare Administration, and Department of Transportation. The department establishes and participates in councils and partnerships that include organizations and individuals. The synergistic effect of multiple programs working together at different levels, in communities and in government, to reduce similar risk behaviors has a powerful impact on health.

The Centers for Disease Control and Prevention (CDC) is recognized as the lead federal agency for protecting the health and safety of people, providing credible information to enhance health decisions, and promoting health through strong partnerships. The CDC serves as the leader for developing and applying disease prevention and control, ensuring the environmental health, and developing health promotion and education activities designed to improve the health of the people of the United States. The CDC engages and provides leadership for state and local health departments in collective action to enhance health. The CDC is the primary contributor to chronic disease prevention activities in Florida through cooperative funding agreements, setting national health priorities, spearheading research to practice initiatives, and identifying best practices for prevention and control.

Legislative- and Governor-appointed task forces and councils bring invaluable benefits to the department in its Healthy Communities, Healthy People efforts. The councils and task forces bring attention to chronic disease prevention activities and expertise beyond the normal reach of the department’s resources. Guidance provided by these entities drives program efforts and spearheads community efforts. The department has previously supported task forces on women and heart disease, obesity, health disparities, and prostate cancer, and currently provides on-going support to councils on diabetes, cancer, and physical activity.

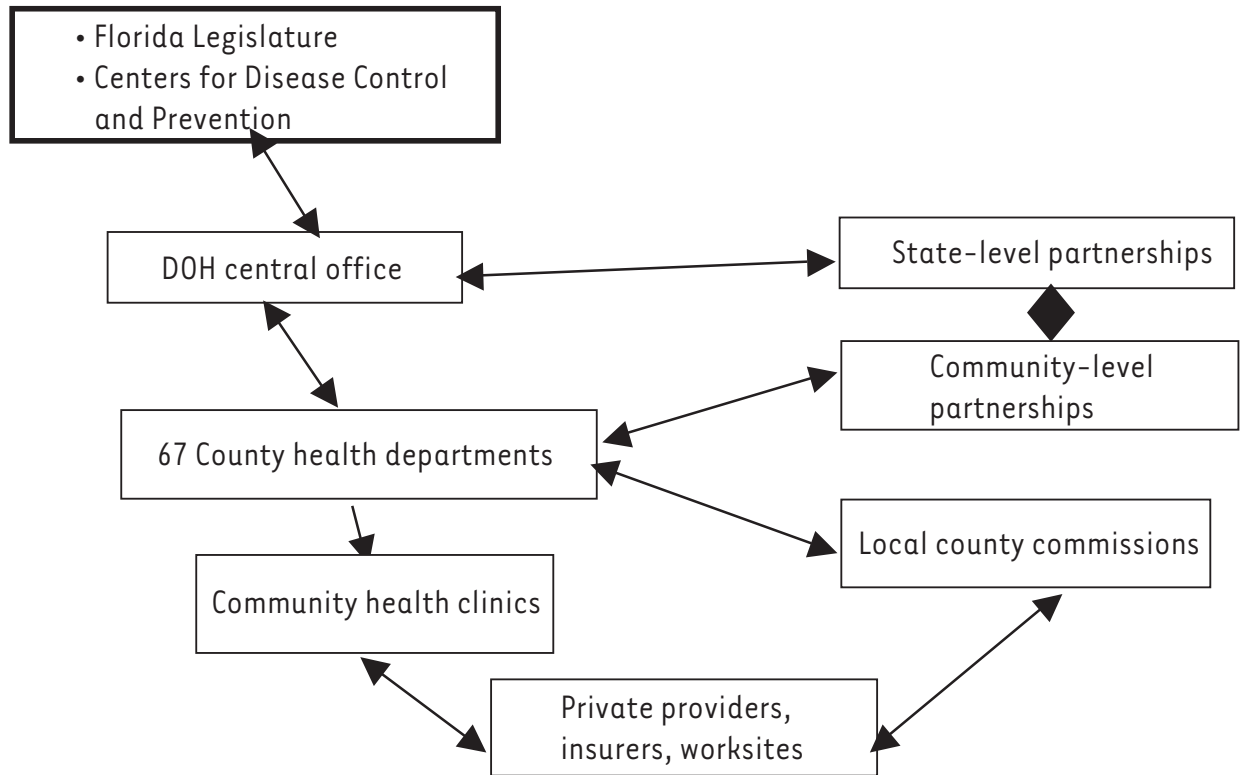
Within the department, the central office in Tallahassee and the 67 county health departments (CHD) develop and implement Healthy Communities, Healthy People programs. The central office is responsible for assessing the health of the state; developing and implementing policy; providing statewide direction, technical assistance, and guidance in the implementation of policy; securing funding through federal resources to fill gaps in service delivery; and assuring the quality of services delivered. The central office also develops state-level partnerships with other state government agencies and the private sector to fill unmet needs and improve the effectiveness of services and facilitates access to health data by county health departments and the general public.

County health departments (CHDs) are on the front line of community health care and disease prevention and treatment. They are the public health leaders in their community. In the area of chronic disease prevention and health promotion, the CHDs fulfill many of the same activities as the central office, but on a local level. The CHDs assess and prioritize community needs in partnership with the local county commission; coordinate health promotion; and develop community-level partnerships with schools, community groups, and professional groups to fulfill the department’s mission.

In 1995, the department adopted policy and technical assistance guidelines that authorized the CHDs to initiate community-based planning strategies to develop and implement local health promotion programs to reduce behavioral risk factors. Planned Approach to Community Health (PATCH) training, a CDC assessment and planning tool, has been provided to counties by request. When surveyed in November 2003, 75 percent of the CHDs had participated in a community health assessment and improvement process; 50 percent had a leading role in that process. Mobilizing for Action through Planning and Partnerships (MAPP), a CDC-developed community-wide strategic planning tool, has been adopted as a planning process. MAPP emphasizes community strategic planning, involving the entire health system, which is based on resources and assets. MAPP training is available online at http://www.doh.state.fl.us/planning_eval/CHAI/Training/schedule-LM.htm.

The Community Health Assessment Resource Tool Set or CHARTS provides a basis for county assessment and planning. The CHARTS provides a mechanism for county health departments, consumers, and professionals to generate specific reports of interest, using county or state-level data. The types of data that are available include: birth, death, fetal death; leading causes of deaths by county; communicable disease deaths by county and by zip code; population projections; crime and domestic violence; hospitalizations; personal health behaviors that contribute to morbidity and mortality; air and beach water quality reports; and injuries, both intentional and unintentional. This interactive tool is located at http://www.floridacharts.com/charts/mapp_report.aspx.

Figure 3: The Florida Public Health System



FISCAL AND PROGRAMMATIC SUMMARY 1980–2004

In the early 1990s, the department's primary funding to promote healthy behaviors was the Preventive Health and Health Services Block Grant from the CDC.

Recognizing the devastating impact of chronic diseases on Floridians, the department began seeking additional funding for prevention efforts. Through persistence and several successful applications, the department receives a total of \$4,795,000 (in fiscal year 2003–2004, not including breast and cervical cancer screening) from the CDC dedicated to chronic disease prevention and healthy lifestyles. The state contribution to programs in the Healthy Communities, Healthy People initiative is \$4,361,109 designated for Youth Tobacco, Closing the Gap, and the Chronic Disease Health Promotion and Education programs. Appendix A summarizes the Healthy Communities, Healthy People funding history and program development.

MEASURING EFFECTIVENESS OF CHRONIC DISEASE PREVENTION AND HEALTH

Promotion Activities

Department of Health priorities are driven by health-related data and the priorities of the Florida Legislature and federal funding sources. The department measures program effectiveness through several indicators: process or short-term indicators that include the achievements of programs, intermediate indicators that include behavior change, and mortality as a long-term indicator. Through this methodology, the department monitors the effectiveness of individual programs and the collective effort of all programs.

The Department of Health has modeled intermediate and long-term chronic disease health outcomes after the national Healthy People outcomes. Healthy People, the prevention agenda for the nation, is a compilation of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. It enables diverse groups, including states, communities, and professional organizations, to focus and combine their efforts. The effort has two overarching goals: to increase the quality and length of healthy life and to eliminate health disparities. Health outcomes are established in 10-year increments with the current outcomes projected for 2010. Healthy People 2010 features 467 science-based objectives and 10 leading health indicators, which are a smaller set of objectives chosen to track progress toward meeting Healthy People 2010 goals. Of the 10 leading health indicators, three are directly related to healthy lifestyles and chronic disease prevention: physical activity, overweight and obesity, and tobacco use.

Programs in Florida's Healthy Communities, Healthy People initiative have adapted a number of the objectives within the focus areas of Healthy People 2010 as benchmarks for health. These will be discussed more fully in the "Measures of Success" section of this report. Each program also develops a program-specific work plan and a disease-specific strategic state plan. Work plans—generally annual plans—are required by funding agencies to layout the activities the program will undertake to achieve federally established goals. Work plans are typically a combination of capacity building, partnership, and intervention objectives. Strategic plans, which federal-funding agencies also require, are developed with the assistance and support of state and community partners and establish a common vision and goals for all parties. Strategic plans identify goal-related strategies, annual activities, and measures of success. Due to the collaborative development process, strategic plans often include objectives beyond the scope of funding requirements.

Each of the programs in the Healthy Communities, Healthy People initiative undertakes monitoring and evaluation efforts to the extent that funding will allow. Monitoring activities common to all federally funded programs include:

- Annual state-level monitoring of related health risk behaviors through the Behavioral Risk Factor Surveillance System (BRFSS).
- Annual state-level monitoring of related chronic disease morbidity and mortality.
- Assessment of disparities in screening and mortality using vital statistics and BRFSS data.
- Regular publication of disease-specific burden reports, special interest reports, and progress reports.

■ **County health department quality improvement reviews (discussed below).** These reviews rely heavily on county mortality and behavior data.

■ **Expenditure monitoring.** Federally funded programs require approval from the CDC for the intended use of funds to ensure appropriateness. An annual financial summary report that documents expenditure of funds is submitted to the CDC. In addition, programs monitor expenditures on a monthly basis through surplus and deficit reports.

■ **Regular submission of progress and achievement reports to the CDC.** Continued funding and increases in funding (when available) are contingent upon successful performance and are used as an indicator of success.

■ **Process evaluation of specific activities and interventions to gain insight, improve the program, and assess effects are conducted as the budget allows.**

The Quality Improvement (QI) Peer Review provides a systematic method of assessment and assurance of CHD efforts related to chronic disease. Chronic disease health-status indicators, prevention resources, and local capacity are assessed. The process provides an interactive opportunity to identify areas of excellence and areas in need of improvement, share best practices, and offer technical assistance. The QI review is a data-driven process that improves healthcare services delivered by CHDs and community providers, and encourages mobilizing partnerships to solve community health problems. The chronic disease health-status indicators currently reviewed in the CHD QI review process are:

■ **Coronary heart disease age-adjusted death rate**

■ **Diabetes age-adjusted death rate**

■ **Smoking-attributable mortality rate**

In all of its evaluation and monitoring efforts, the Healthy Communities, Healthy People initiative uses a continuous improvement model. The CDC work plans, strategic plans, and internal planning documents are revised on a regular basis to reflect new information, evaluation findings, and changing trends.

Related Documents

Healthy People 2010 at: <http://www.healthypeople.gov/>

Florida Chronic Disease Healthy People 2010 Report at: <http://www.doh.state.fl.us/family/arthritis/indexReport.html>

Florida Chronic Disease Report 2002-2003 at: <http://www.doh.state.fl.us/family/chronicdisease/02chronicdiseaserpt.pdf>

MEASURES OF SUCCESS

In measuring the success of programs in the department's Healthy Communities, Healthy People initiative, two primary

areas are reviewed: changes in the prevalence of behavioral risk factors and trends in mortality of leading chronic diseases. For each area, three data characteristics are examined:

- 1. The direction of the data trend. Specifically, are unhealthy behaviors and mortality decreasing?**
- 2. A percentage-point change. Mortality data is a census of all deaths in the state and so is an exact number. Behavior data, on the other hand, is an estimate derived from the BRFSS.**
- 3. Progress toward the Healthy People 2010 target. The CDC's Progress Quotient methodology was adopted in this report to monitor the state's progress toward attaining Healthy People 2010 objectives. The progress quotient is a relative measure of change over time. It measures the percent of targeted change that has been achieved. The progress quotient is calculated using the formula:**

$$\frac{\text{Current status} - \text{Baseline} \times 100}{\text{Target} - \text{Baseline}}$$

While the progress quotient is not a perfect measure, it does provide a look across measures that are quite different and have different target dates. It does not consider the variability in the estimate or the length of time between baseline and target. The progress quotient is a positive number when the indicator is moving toward the target, negative when it is moving in the "wrong" direction, and greater than 100 percent when the target has been exceeded.

Behavioral Health Indicators—A State Level Assessment

The programs in the Healthy Communities, Healthy People initiative monitor and track the three leading health indicators: physical inactivity, overweight and obesity, and tobacco use. Data are estimated through the Behavioral Risk Factor Surveillance System (BRFSS). This statewide telephone surveillance data collected throughout the year is funded by the CDC and cooperative agreements. The survey collects data from randomly selected, non-institutionalized Florida adults age 18 and older. Information from the survey is used for health planning, program evaluation, and monitoring health objectives within the department. Many programming decisions are based on this behavior data. The BRFSS was implemented in each county in 2002 providing a wealth of information, which allows funding to be directed to areas most in need. Behavioral data are available at the state and county levels through CHARTS.

The prevalence of youth tobacco use was estimated from the Florida Youth Tobacco Survey (FYTS). The FYTS is a survey of Florida public middle school (grades 6–8) and high school (grades 9–12) students in classrooms and schools that were randomly selected using a two-stage cluster design. The FYTS, conducted by the Florida Department of Health in cooperation with the Florida Department of Education, was administered in 1998–2004. The prevalence of youth behaviors was estimated from the Youth Risk Behavior Survey (YRBS), a cooperative project between the Departments of Health and Education. The YRBS is a survey of Florida high school students implemented in conjunction with the FYTS in odd years.

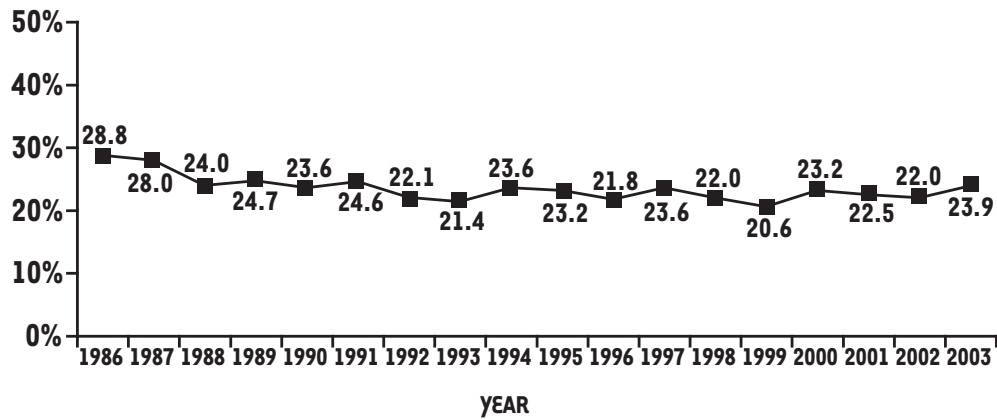
Tobacco Use

Tobacco use is the leading preventable cause of premature death. Use of tobacco increases the risk of cancer (lung, oral, esophageal, laryngeal), cardiovascular disease (coronary heart disease, stroke), and chronic lower respiratory disease (emphysema, chronic bronchitis, chronic airway obstruction). Cigarette smoking causes an estimated 87 percent of all lung cancer deaths, 22 percent of all coronary heart disease deaths, and 12 percent of all stroke deaths.

Among Florida adults, current cigarette use declined between 1986 and 1993 from 28.8 percent to 21.4 percent (see Figure 4). Since 1993, however, smoking among adults has remained relatively stable. In 2003, 23.9 percent of all adults currently smoked cigarettes: 24.8 percent of non-Hispanic Whites, 19.3 percent of non-Hispanic Blacks, and 21.2 percent of Hispanic adults. Another 31.2 percent of non-Hispanic Whites, 13.3 percent of non-Hispanic Blacks, and 20.3 percent of Hispanic adults were former smokers and 44.0 percent, 67.4 percent, and 58.5 percent, respectively, never smoked cigarettes.

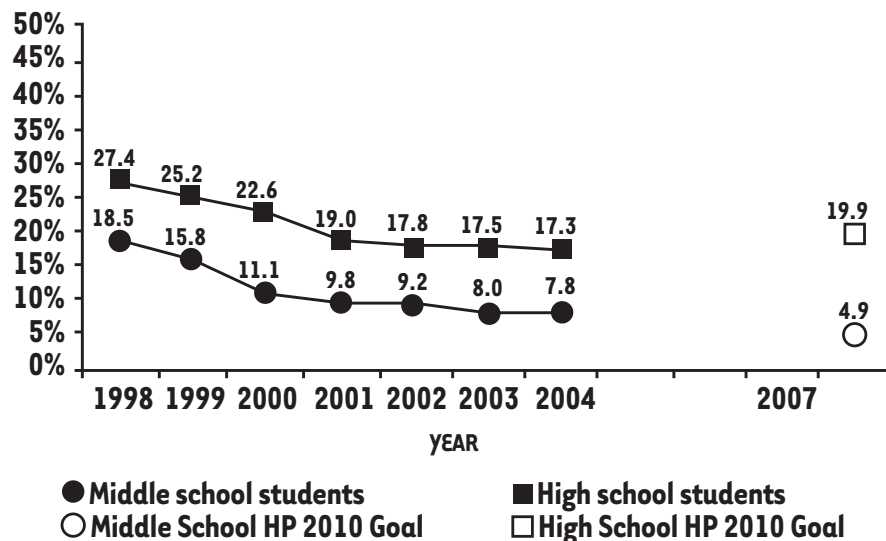
County-level smoking prevalence for adults is available for 2002 from the county BRFS. The prevalence of current smoking ranged from a low of 16.4 percent in Leon County to high of 35.5 percent in Glades County.

Figure 4: Percent of Florida adults who are current cigarette smokers, by year, Florida BRFS, 1986-2003



In 1998, the department began surveillance of youth tobacco use with the administration of the Florida Youth Tobacco Survey. At that time, 18.5 percent of middle school students and 27.4 percent of high school students had smoked cigarettes on one or more of the previous 30 days. In 2004, the prevalence of current cigarette use had dropped to 7.8 percent among middle school students and 17.3 percent among high school students. While this represents a 36.9 percent decrease among high school students and a 57.8 percent decrease among middle school students since 1998, rates have stabilized among high school students since 2002. (See Figure 5) Among middle school students, current smoking prevalence in 2004 was 9.9 percent among non-Hispanic Whites, 4.3 percent among non-Hispanic Blacks, and 7.3 percent among Hispanic youth. Among high school students, those rates were 22.2 percent, 5.5 percent, and 17.1 percent, respectively.

Figure 5: Percent of middle and high school students who are current smokers (smoked cigarettes on one or more of the previous 30 days), FYTS, 1998-2004



The department monitors four tobacco-related Healthy People 2010 objectives related to adult and youth tobacco use. Summary Table 1 at the end of this section lists the objectives and the progress for each.

Physical Activity

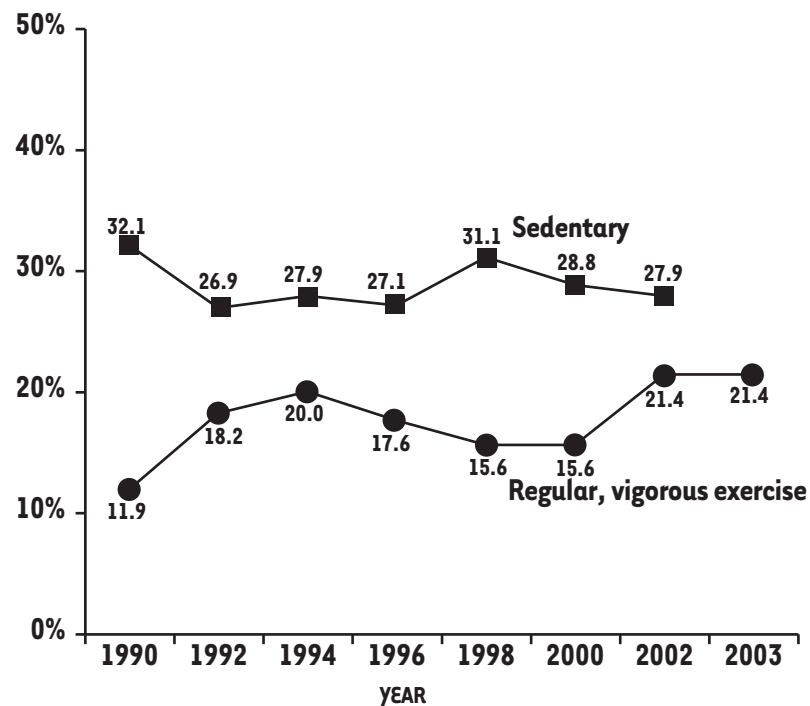
Regular physical activity improves health by reducing the risk of dying prior to reaching average life expectancy, dying from heart disease, developing diabetes, developing high blood pressure, and developing colon cancer. Regular physical activity also reduces feelings of depression and anxiety; aids in weight control; helps maintain healthy bones, muscles, and joints; and aids older adults in becoming stronger, thus preventing injuries.

Nationwide, more than 60 percent of adults do not achieve the recommended amount of regular physical activity—a cumulative 30 minutes of moderate activity per day on most days of the week. In fact, 25 percent of all adults are not active at all.

In Florida in 2003, more than one out of four adults did no physical activity and about one out of five did the recommended amount of vigorous physical activity (at least 20 minutes of activity that makes one sweat and breathe hard on at least three days of the week). (See Figure 6.) In

2003, 41.2 percent of adults did the recommended amount of moderate physical activity (at least 30 minutes of activity that does not make one sweat and breathe hard on at least five days of the week). Inactivity increases with age and is more common among women than men, and among those with lower incomes and less education than among those with higher incomes or education.

Figure 6: Percent of Florida adults who are sedentary and percent who participate in regular, vigorous exercise, by year, Florida BRFSS, 1990–2003



The National Association for Sport and Physical Education recommends a minimum of 225 minutes weekly of physical education (PE) instructional time for middle and high school students. This is equivalent to five 45-minute classes per week. Less than half of all Florida middle and high school students went to PE five days per week. Further, only 21.1 percent of high school students spent more than 40 minutes per PE class actually exercising or playing sports. In fact, 39.9 percent of middle school students and 54.4 percent of high school students did not go to PE at all during the week. More girls than boys did not go to PE during the week and in high school, as grade level increased, more students had no days of PE.

About 60 percent of high school students participate in sufficient vigorous physical activity—20 minutes of activity that makes them sweat and breathe hard on three or more days of the week. Vigorous activity includes, for example, playing basketball or football, mowing the yard, or running. About 22 percent of high school students participated in sufficient moderate physical activity—at least 30 minutes of activity that does not make them sweat and breathe hard on at least five days of the week.

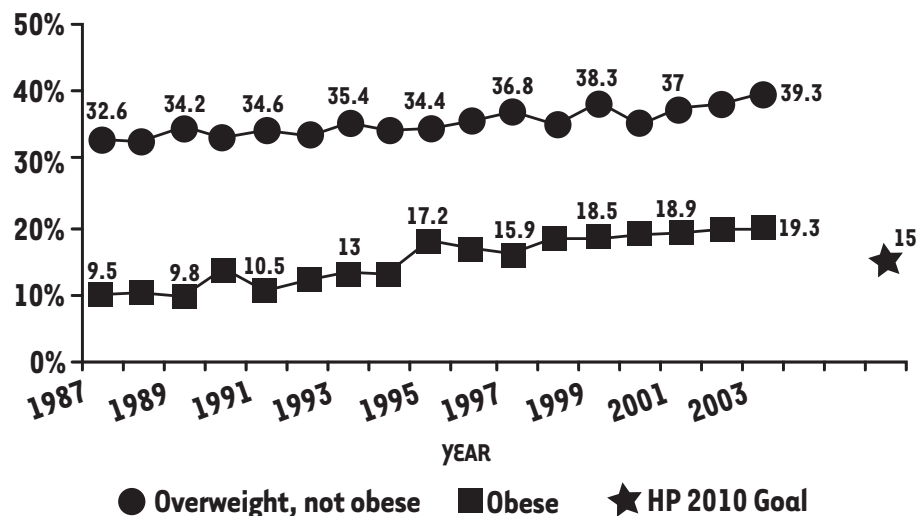
Overweight and Obesity

Overweight and obesity are functions of nutrition and physical activity or calories taken in and calories expended. When caloric intake exceeds caloric expenditure, overweight or obesity may result. For surveillance purposes, overweight and obesity are determined by body mass index (BMI), which is a calculation based on body weight relative to height. An adult with a BMI of 25 to 29.9 is considered overweight and an adult with a BMI of 30 or greater is considered obese.

Overweight and obese individuals are at increased risk for a plethora of physical ailments including high blood pressure; high blood cholesterol; type 2 diabetes; coronary heart disease; congestive heart failure; stroke; gallstones; osteoarthritis; obstructive sleep apnea and respiratory problems; some types of cancer (such as endometrial, breast, prostate, and colon); complications of pregnancy; and psychological disorders (such as depression, eating disorders, distorted body image, and low self-esteem). Analysis of the national 2001 BRFSS data found that adults with BMIs greater than 40 were more likely to be diagnosed for diabetes, high blood pressure, high cholesterol, asthma, and arthritis, and to report fair or poor health compared to adults with normal weight.

In Florida, the prevalence of obesity more than doubled between 1987 and 2003, increasing from 9.5 percent in 1987 to 19.9 percent in 2003. The prevalence of overweight (including obesity) increased by 39 percent between 1987 and 2003, from 42.1 percent to 58.6 percent. (See Figure 7)

Figure 7: Percent of Florida adults who are overweight (not including obese) and percent who are obese, by year, Florida BRFSS, 1987–2003



The prevalence of obesity varies by race/ethnicity and gender. Throughout the 1990s and into the twenty-first century, the prevalence of obesity was higher among non-Hispanic Blacks compared to non-Hispanic Whites and Hispanics. In 2003, 46.3 percent of males who were overweight compared to 31.4 percent of females, and 21.0 percent of males who were obese compared with 18.8 percent of females.

A logistic regression analysis of 1990–2000 BRFSS data shows that, accounting for all variables in the model, those who were obese were more likely to be non-Hispanic Black, had incomes less than \$15,000 per year, had a high school education or less, tended to be older, and were less likely to participate in regular, vigorous physical activity.

Status Summary 1 below provides Florida’s Healthy Communities, Healthy People 2010 behavioral objectives and the current progress toward achieving these objectives.

Status Summary 1: Leading Behavioral Health Indicators

OBJECTIVE	FLORIDA BASELINE (2000 UNLESS INDICATED)	STATUS (2003 UNLESS INDICATED)	PERCENTAGE POINT CHANGE	PROGRESS QUOTIENT	HOW DOES FLORIDA COMPARE TO THE NATION?
By 2007, reduce the percentage of adults in Florida who report using cigarettes to 20%. (BRFSS, CDC, Florida)	23.20% (21.8–24.5)	23.90% (22.0–25.8)	-.7%**	-21.9%	More adults smoke
By 2007, reduce the percentage of Florida middle school students who are current smokers to 4.9%. (Baseline 1998; Florida Youth Tobacco Survey)	18.50% (17.1, 19.9)	7.8 % (7.1–8.5) 2004	10.7%	78.7%	Not available
By 2007, reduce the percentage of Florida high school students who are current smokers to 19.9%. (Baseline 1998; Florida Youth Tobacco Survey)	27.40% (25.8–29.0)	17.3% (15.8–18.7) 2004	10.1%	134.7%	Fewer youth smoke
Reduce to 25.2% the proportion of adults who engage in no leisure-time physical activity.	28.8% (27.4–30.1)	27.9% (26.0–29.8)	.9%**	25.00%	Not available
Increase to 50% the proportion of adults who engage in moderate activity for at least 30 minutes five or more days per week. (2003 baseline)	33.20%	41.20% (39.0–43.4) 2003	8.0%	47.62%	Fewer in Florida meet this guideline
Increase to 35% the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on 5 or more of the previous seven days. (Grades 9–12 baseline in 2001, YRBS)	22% (20.5–23.5)	22.3% (20.6–24)	3%**	2.31%**	Not a significant difference
Increase the proportion of adolescents who engage in vigorous physical activity for at least 20 minutes on 3 or more of the previous seven days to 85%. (Grades 9–12 baseline in 2001, YRBS)	58.8% (56.9–60.7)	60.8% (58.9–62.7)	2.0%**	7.63%	Not a significant difference
Increase the proportion of adults who are at a healthy weight to 60% (neither overweight nor obese).	46.1% (44.5–47.6)	41.4% (39.2–43.6)	-4.7%	-33.81%	Not a significant difference
Reduce the proportion of adults who are obese to 15%.	18.7% (17.5–19.8)	19.9% (18.1–21.6)	-1.2%**	-32.43%	Lower (better) than 42 other states.
Reduce the proportion of adolescents (Grades 9–12) who are at risk for overweight to 13%. (2001 baseline–YRBS)	14.3% (13.3, 15.3)	14% (12.7, 15.3)	.3%**	23.1%	Not a significant difference
Reduce the proportion of adolescents (Grades 9–12) who are overweight to 7%. (2001 baseline –YRBS)	10.4% 99.6, 11.2)	12.4% (10.9, 13.9)	-2.0%	-58.8%	Not a significant difference

*Progress quotient = $\frac{\text{current estimate} - \text{baseline}}{2010 \text{ target} - \text{baseline}} \times 100$

**not a significant change

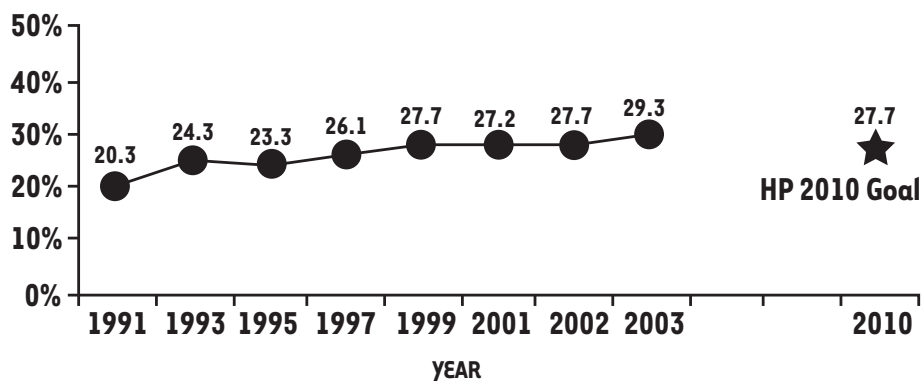
CHRONIC DISEASE RISK AND SCREENING INDICATORS—A STATE-LEVEL ASSESSMENT

Among chronic diseases, there are many risk indicators that act as intermediate markers of health status, or early indicators of future poor health. Screening and early detection enables adults to take action to change behavior or seek medical treatment to prevent further complications. For cardiovascular disease, two markers that are easily identified through screening are hypertension or high blood pressure and high cholesterol. Among the various types of cancer, early diagnosis often indicates a greater likelihood of a successful outcome. For adults with diabetes, lower extremity amputation is a marker that the diabetes has progressed to a dangerous state. These intermediate markers can often be affected through behavioral change—either by changing unhealthy habits, taking appropriate medication, or seeking early treatment. Monitoring these markers is a more helpful and an immediate indicator of health status than monitoring mortality.

Blood Pressure and Blood Cholesterol

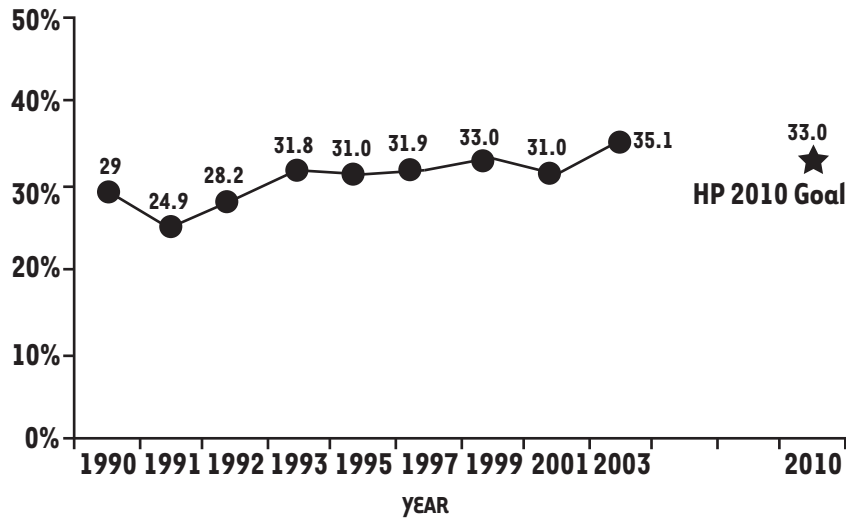
Hypertension or high blood pressure contributes substantially to the risks of coronary heart disease and stroke. In many cases, the cause of high blood pressure is unknown. However, some people can prevent or control high blood pressure by changing to healthier habits: such as eating healthy foods including fruits, vegetables, and low-fat dairy products; cutting down on salt and sodium in the diet; losing excess weight and staying at a healthy weight; being physically active; and limiting alcohol intake. Since the 1970s, the prevalence of high blood pressure has decreased among adults in the United States (U.S.). In Florida in the 1990s and into the twenty-first century, more than 20 percent of adults screened for high blood pressure reported being told by a doctor that they have high blood pressure. The prevalence of screened adults in Florida, who have physician-diagnosed hypertension increased, significantly between 1991 and 2003, from 20.3 percent to 29.3 percent, and is higher than the 2003 national prevalence of 24.8 percent. In 1999, the last time that the prevalence of screening rates for high blood pressure was determined, more than 94 percent of adults had been screened within the previous two years. In 1992, non-Hispanic Blacks were 84 percent more likely to have physician-diagnosed hypertension than their non-Hispanic White counterparts; men and women were equally likely; and obese adults were three times more likely than non-obese adults to have hypertension. Physician-diagnosed hypertension is also associated with increasing age.

Figure 8: Percent of Florida adults who have been told by a physician that they have high blood pressure among those who have been screened in the past two years, Florida BRFSS, 1991–2003



As the level of serum cholesterol increases, the risk of coronary heart disease increases. High blood cholesterol is thought to account for approximately 30 percent of coronary heart disease and up to 20 percent of strokes. The most important modifiable risk factor for high serum cholesterol is dietary fat intake. Among Florida adults who have had their cholesterol tested, from 1990 to 2003, about 30 percent were told it was high. Between 1991 and 2003, the prevalence of those with elevated serum cholesterol increased from 29 percent to 35.1 percent, an increase of 21 percent. Women were more likely to have elevated serum cholesterol than men. Having high serum cholesterol did not vary by race/ethnicity or income level, but did increase with increasing age.

Figure 9: Percent of Florida adults who have been told they have high cholesterol among those who have had their cholesterol tested, Florida BRFSS, 1990–2003



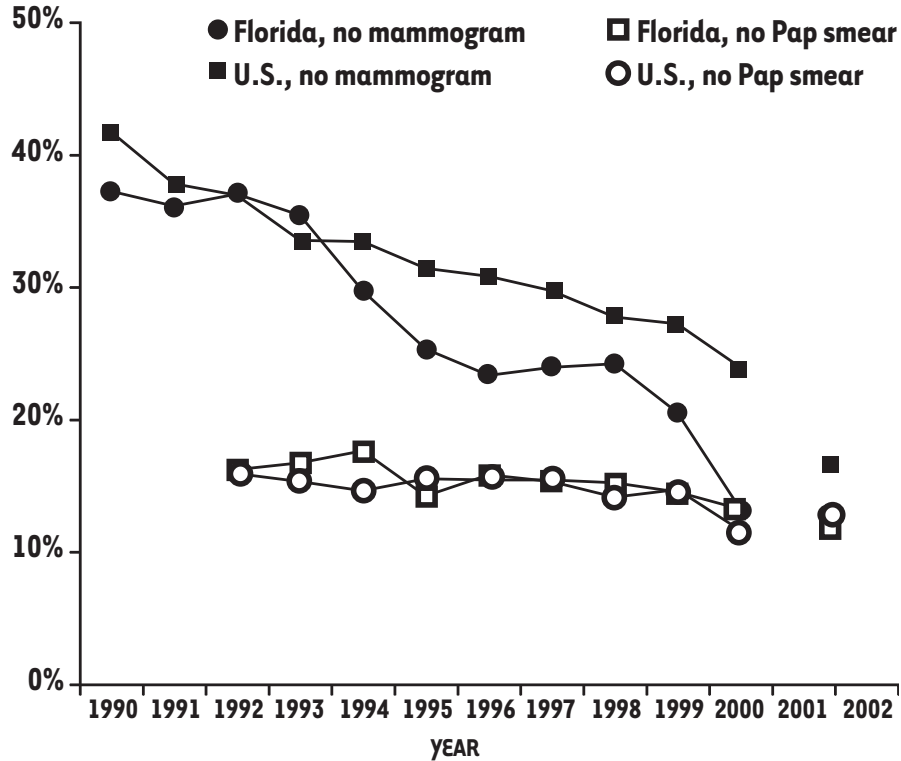
Cancer Screening

Use of preventive services and measures can substantially influence the impact of cancer. The American Cancer Society (ACS) recommends that women have a mammogram annually beginning at age 40 and have a pap smear annually beginning at age 18, and that men and women have a sigmoidoscopy every five years and a fecal occult blood test (FOBT) annually beginning at age 50.

Among women age 18 and older in the U.S. and in Florida in 2002, greater than 90 percent have had a pap smear and the distribution is uniform across race/ethnic groups: White, Black, and Hispanic. The prevalence of ever having a mammogram is significantly lower among Hispanic women compared to White and Black women in the U.S.

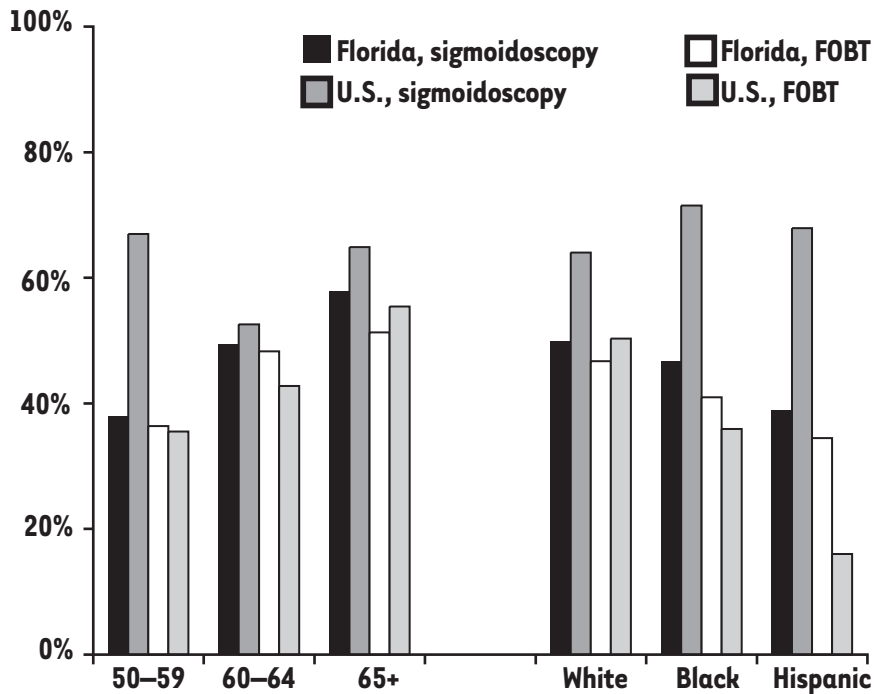
Among Florida women age 40 and older in 1990, 37.2 percent did not have a mammogram within the past two years. In 2002, this percent had declined by 65 percent to 12.8 percent. During the last half of the 1990s and into the twenty-first century, the prevalence of women age 40 and older who did not have a mammogram in the past two years was below the prevalence observed for the U.S. About 15 percent of women aged 18 years and older did not have a pap smear in the past three years, and this percentage did not change significantly through the years (see Figure 10). County-level BRFSS data are available on the percent of women over 40 years old who have not had a mammogram in the past two years and the percent of women who have not had a pap smear in past three years.

Figure 10: Percent of Florida and US women age 40 years and older who have not had a mammogram in the past two years and women age 18 years and older who have not had a pap smear in the past three years, by year, BRFSS, 1990–2002



Compared to mammography and pap smears, the use of sigmoidoscopy and FOBT is much lower. Figure 11 shows the prevalence of sigmoidoscopy and FOBT test use by age group. Florida has much higher use of sigmoidoscopy than does the U.S. In Florida, approximately 60 percent of adults age 50 and older have had a sigmoidoscopy. Approximately 50 percent of adults age 50 and older have had a FOBT. The prevalence of ever having a FOBT is significantly lower among Blacks and Hispanics age 50 and older than compared to Whites.

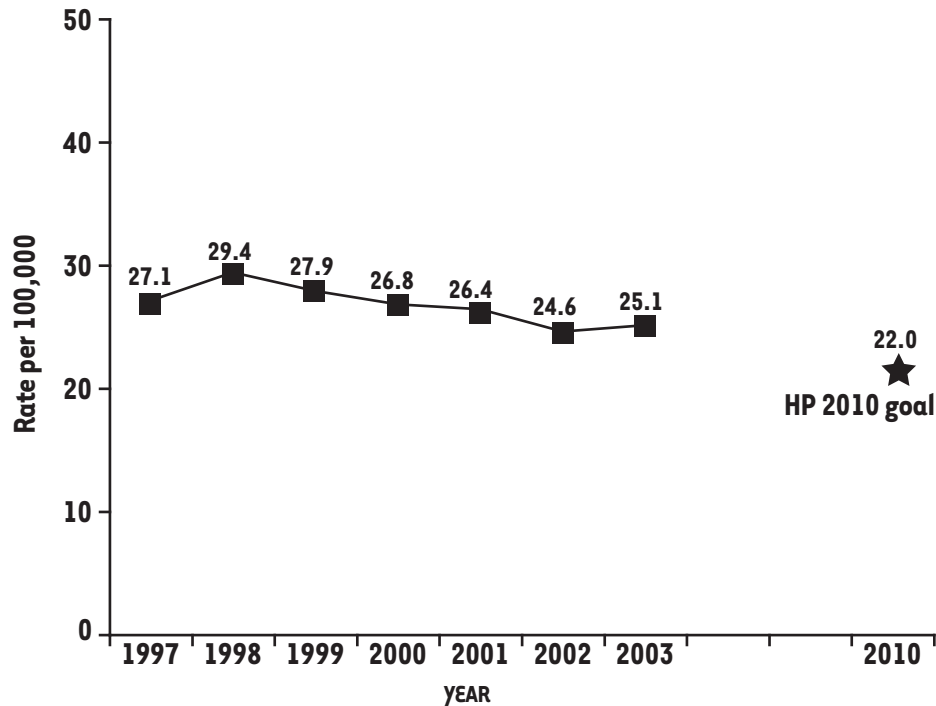
Figure 11: Percent of Florida and U.S. adults age 50 years and older who have ever had a sigmoidoscopy and percent who have ever had a FOBT, by age and race/ethnicity, BRFSS 2002



Diabetes Lower Extremity Amputations

More than half of the lower extremity amputations in the U.S. occur in people with diabetes who represent a much smaller proportion of the population. Documented risk factors for lower extremity amputations include lower extremity ischemia, peripheral neuropathy, elevated glycated hemoglobin levels, history of foot ulcers, and retinopathy. A lower extremity amputation among diabetes patients is a sign of macro and microvascular disease brought on by poor disease management. Rates of lower extremity amputation are an indicator of the quality of self-managed care and quality of medical care. As seen in Figure 12, the rate of non-traumatic lower extremity amputations attributable to diabetes has decreased by 7 percent since 1997.

Figure 12: Age-adjusted rate per 100,000 population of non-traumatic, lower extremity amputation attributable to diabetes, AHCA hospital discharge dataset, 1997–2003



Status Summary 2: Risk and Screening Health Status Indicators

OBJECTIVE	FLORIDA BASELINE	STATUS (2003 UNLESS INDICATED)	PERCENTAGE POINT CHANGE	PROGRESS QUOTIENT	HOW DOES FLORIDA COMPARE TO THE NATION?
Stop the increase in the proportion of adults with high blood pressure and maintain the 1999 level of 27.6%. (Baseline 2001 BRFSS)	26.9% (25.3-28.4)	29.3% (27.4-31.2)	-2.4%**	Not a significant change	Higher (worse) than the national median
Stop the increase in the proportion of adults with high total blood cholesterol levels and maintain the 1999 level of 33%. (Baseline 2001 BRFSS)	31.0% (29.2-32.7)	35.1% (33.0-37.3)	-4.1%	-205%	Not significantly different from national median
Reduce the age-adjusted rate of lower extremity amputation in persons with diabetes by 18% to 22.0 per 100,000 population. (Baseline: 2000 26.8. Source: Florida AHCA Hospital discharge data)	26.8/100,000 pop	25.1/100,000 pop	1.7	35.4%	Comparison data not available.

*Progress quotient = $\frac{\text{current estimate} - \text{baseline}}{2010 \text{ target} - \text{baseline}} \times 100$

**not a significant change

CHRONIC DISEASE MORTALITY INDICATORS—A STATE-LEVEL ASSESSMENT

Mortality data is collected and analyzed by the Florida Department of Health, Bureau of Vital Statistics. Mortality is based on an actual count of the number of deaths attributed to a specific cause as noted on the death certificate. Age-adjusted death rates are calculated using the year 2000 standard million population (U.S. population) so that the rates are comparable over time. Age adjusting minimizes the effects of age so that data can be compared across demographically different regions—like across states.

Mortality data is easily accessible through the department's online CHARTS system. Data about the causes of death, age-adjusted death rates, and trends are available at both the state and county level. The CHARTS includes historical data.

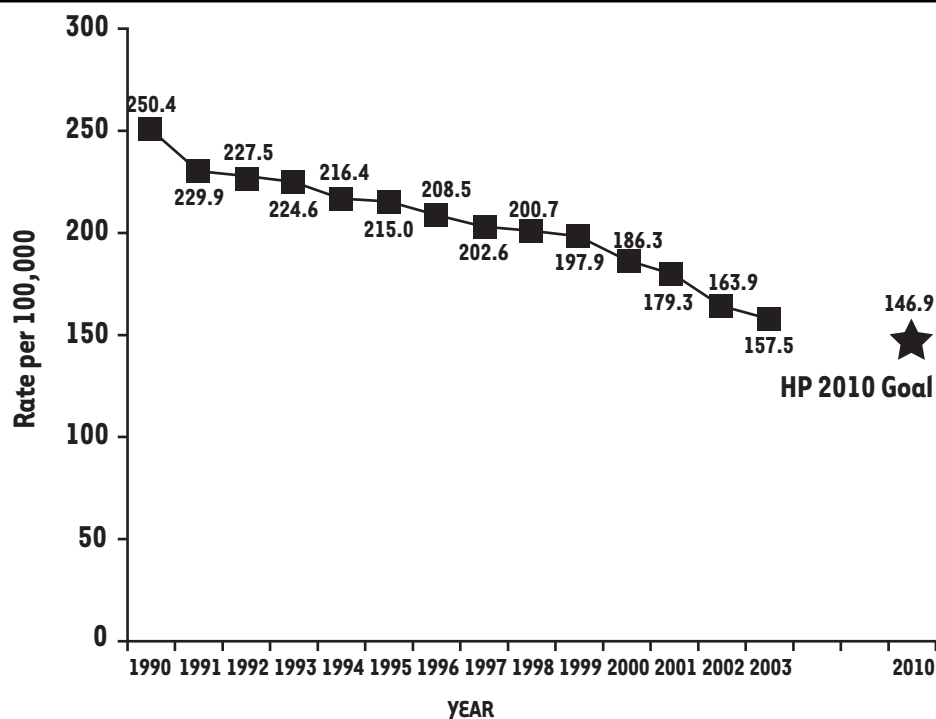
Cardiovascular Disease

Cardiovascular disease remains the leading cause of death in both Florida and the nation. Cardiovascular disease refers to numerous and varied diseases of the heart and blood vessels and includes coronary heart disease and stroke, plus hypertension and rheumatic heart disease. Coronary heart disease results from decreased circulation to the heart muscle, most frequently caused by narrowing of the coronary arteries by deposits of plaque along the walls of the artery. Stroke or cerebrovascular disease affects the arteries of the central nervous system and results from a clogged or ruptured artery. The loss of blood flow to the brain causes tissue death in the affected area and often results in neurological deficits or death. Both coronary heart disease and stroke have causes that stem from modifiable risk factors such as tobacco use, poor nutrition, physical activity, overweight and obesity, and high blood pressure and high cholesterol. Reducing these risks in the population would have great impact on the morbidity and mortality due to cardiovascular disease.

Throughout the 1990s and into the twenty-first century, Florida's age-adjusted cardiovascular disease mortality rates have been lower than national rates. In Florida, rates have declined over the past decade. Approximately 60 percent of all cardiovascular disease deaths are due to coronary heart disease. Another 15 percent of cardiovascular disease deaths are due to stroke.

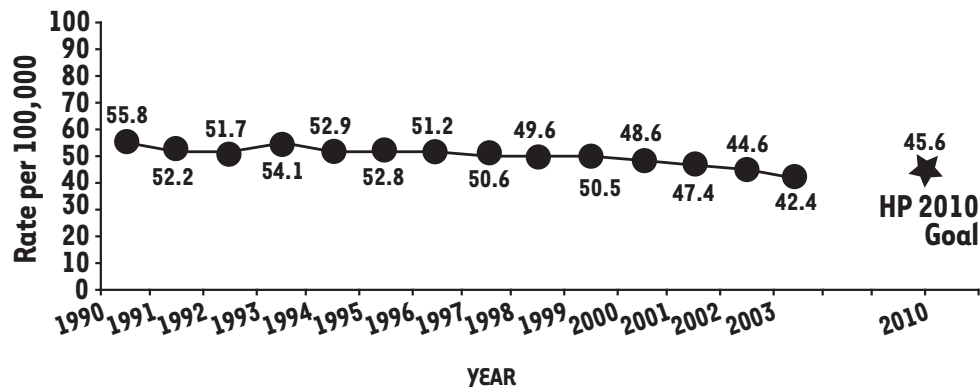
Age-adjusted coronary heart disease death rates have declined in the past ten years, among both men and women. However, rates are substantially higher among men than among women. Among men, coronary heart disease mortality rates dropped by 27 percent, from 315.0 deaths per 100,000 population to 230.9 deaths per 100,000 population. Death rates declined among women by 26 percent, from 185.4 deaths per 100,000 population to 137.0 deaths per 100,000 population. Death rates have remained relatively stable among Hispanic and non-Hispanic Blacks since 1990, but have decreased among non-Hispanic Whites.

Figure 13: Florida age-adjusted mortality rates for coronary heart disease, 1990-2003, Florida Vital Statistics



Age-adjusted stroke death rates among men, women, and all race/ethnicity categories, remained stable during the 1990s, and have been decreasing since 2001. In 2001, the Florida age-adjusted death rate for stroke (47.4) was lower than the national rate (57.9). Men and women had virtually identical stroke death rates. Rates were highest among non-Hispanic Blacks (about 95 deaths per 100,000 population), followed by non-Hispanic Whites (about 50 deaths per 100,000 population) and Hispanics (about 35 deaths per 100,000 population).

Figure 14: Florida age adjusted mortality rates for stroke, 1994-2003, Florida Vital Statistics



Cancer

Cancer is the second leading cause of death in Florida.

Cancer is the second leading cause of death in the United States and in Florida. More than one million new cases are diagnosed and over half a million people die in the U.S. as a result of cancer each year. In Florida in 2001, there were more than 92,000 new cases of cancer reported. The leading causes of cancer death and leading sites of cancer incidence in men and women were lung, breast, colorectal, and prostate. Age-adjusted cancer mortality rates have slowly decreased in Florida—about 13 percent in Florida between 1994 and 2003. Mortality rates in Florida were similar to those observed for the U.S. as a whole. The four most important risk factors for cancer are tobacco use, lack of physical activity, exposure to ultraviolet light, and poor nutrition.

Age-adjusted mortality rates for lung cancer are about three times higher than for breast, prostate, and colorectal cancer, and have been slightly above the rates for the U.S. for a number of years during the 1990s and into the twenty-first century, especially early in the nineties. Florida mortality rates for breast and colorectal cancer in Florida were slightly below rates for the U.S. for most years during the 1990s. Florida mortality rates for prostate cancer were very similar to rates for the U.S. in the 1990s.

Age-adjusted lung cancer mortality rates varied greatly by sex and race/ethnicity. Age-adjusted mortality rates among men were about twice the rates observed for women throughout the 1990s and into the twenty-first century. This gap narrowed during the decade due to a 17 percent decline in age-adjusted lung cancer mortality rates among men. Hispanics had the lowest mortality rates followed by non-Hispanic Blacks, with non-Hispanic Whites having the highest rates. Rates did not change for non-Hispanic Whites and Hispanics, but did decrease by 20 percent among non-Hispanic Blacks.

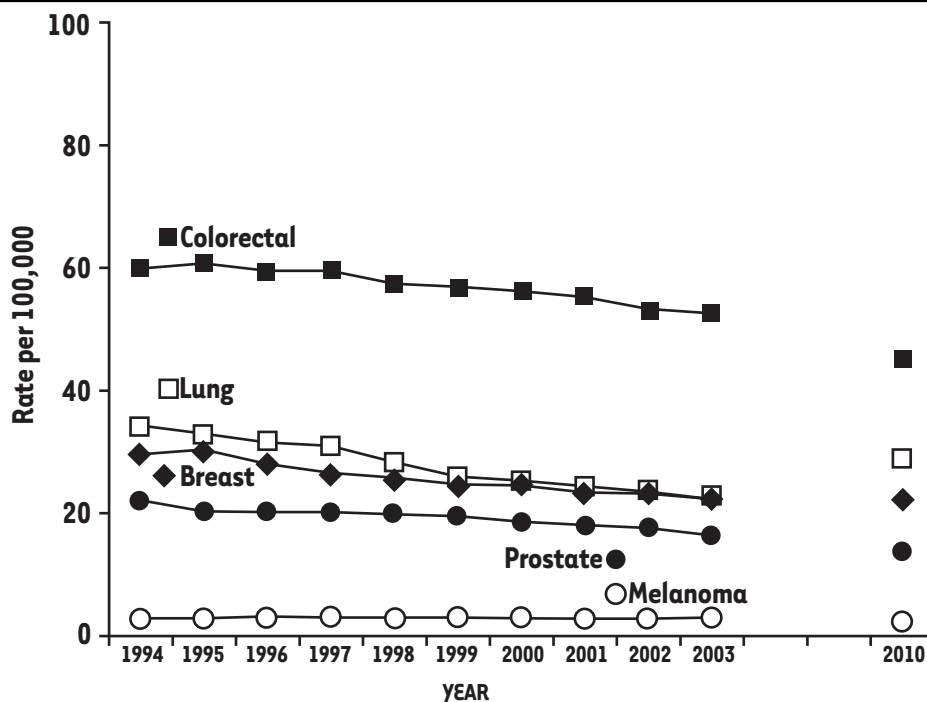
Breast cancer is predominantly a disease among women. Overall, breast cancer mortality rates have decreased by 38 percent between 1990 and 2002. Rates were typically higher among non-Hispanic Black women, followed by non-Hispanic White women. Hispanic women had the lowest age-adjusted mortality rates. In Florida, Black and Hispanic women have significantly lower prevalence of ever having a mammogram compared to their White counterparts.

Age-adjusted colorectal cancer mortality rates were stable from 1990-1994 and then began to decline slowly. Colorectal cancer death rates were consistently about 40 percent higher among men compared to women. Hispanics had the lowest mortality rates compared to non-Hispanic Whites and non-Hispanic Blacks.

Mortality rates among non-Hispanic Black men were 70 percent to 80 percent higher than rates among non-Hispanic White men and Hispanic men. Rates among non-Hispanic White men, non-Hispanic Black men, and Hispanic men dropped 32 percent, 19 percent and 9 percent, respectively, during the nineties.

Melanoma is currently the fastest growing cancer in the U.S. It represents 5 percent of all types of skin cancer and 71 percent of all skin cancer deaths. It occurs in all age groups, including children, but is most common in young adults. The age-adjusted death rate due to melanoma has remained relatively stable over the past 10 years at just under three deaths per 100,000 population. When found and treated at a superficial stage, the survival rate is very high, but becomes lower as the melanoma progresses. The risks for melanoma include ultraviolet exposure (especially severe sunburn) and an excess of moles. Reducing sun exposure, including using an SPF 30 sunscreen, is recommended to reduce an individual's risk for melanoma. Reducing sun exposure by applying sunscreen lotion with an SPF 15 factor or higher, seeking shade, and wearing a hat and sunglasses are recommended to reduce an individual's risk for skin cancer.

Figure 15: Age-adjusted mortality rates for lung, colorectal, skin, prostate (men), and breast (women) cancer, 1994–2003, Florida Vital Statistics



Diabetes

Diabetes is the sixth leading cause of death among Floridians.

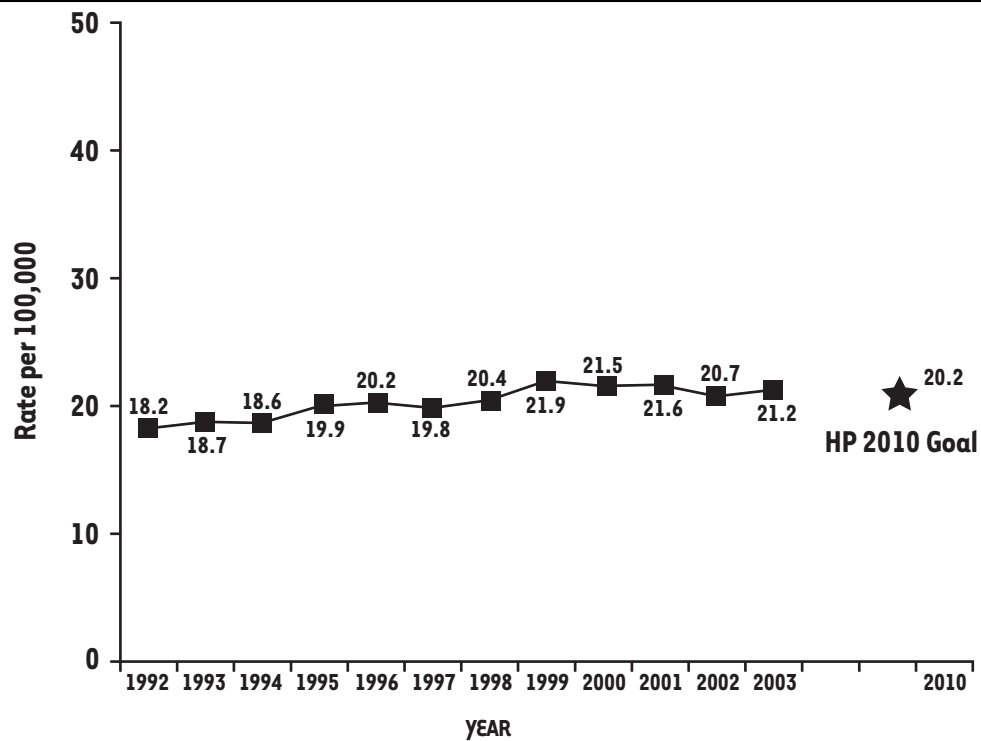
Diabetes mellitus, commonly called diabetes, is a group of diseases in which the tissues that utilize glucose—muscle, fat, and liver—are unable to use or obtain adequate amounts of insulin. Type 1 diabetes was previously called insulin-dependent diabetes mellitus or juvenile-onset diabetes. This form of diabetes typically affects children and young adults who need several insulin injections a day or an insulin pump to survive. Type 1 diabetes accounts for 5 percent to 10 percent of all diagnosed cases of diabetes. Type 2 diabetes was previously called non-insulin-dependent diabetes mellitus or adult-onset diabetes. Type 2 diabetes accounts for about 90 percent to 95 percent of all diagnosed cases of diabetes. Type 2 diabetes is associated with older ages, obesity, family history of diabetes, prior history of gestational diabetes, impaired glucose tolerance, physical inactivity, and race/ethnicity. African-Americans, Hispanic/Latino Americans, American Indians, and some Asian Americans and Pacific Islanders are at particularly high risk for type 2 diabetes. Type 2 diabetes is increasingly being diagnosed in children and adolescents, especially among those who are overweight.

The prevalence of diabetes has been increasing since the 1950s. Over one million adults in Florida have been diagnosed with diabetes and more than 9,000 people in Florida die each year from diabetes or complication of diabetes. In addition to those diagnosed, it is estimated that 300,000 to 400,000 others have the disease but have not been diagnosed. Between 1980 and 2000, the age-adjusted (to the 1940 standard million) diabetes mortality rate increased from 8.2 deaths per 100,000 population to 13.3 deaths per 100,000 population. The increase in mortality rates for diabetes is due, in part, to the increase in diabetes diagnoses, increased awareness of diabetes as an underlying cause of death, and changes in physician death certificate completion practices.

In Florida in 2003, diabetes was the sixth leading cause of death. People tend to die of complications of diabetes rather than diabetes itself and, therefore, diabetes is under-reported as an underlying or contributing cause of death. In Florida, the age-adjusted mortality rate with diabetes as the underlying cause of death for those age 35 and older has increased from 26.2 deaths per 100,000 population in 1979 to 47.0 deaths per 100,000 population in 2002, a 79 percent increase. There are also significant disabilities that result from diabetes including lower extremity amputation, kidney disease, and blindness. Many of these complications can be prevented or delayed if diabetes is controlled by utilizing disease self-management practices. People who can control their diabetes by maintaining normal or close to normal blood sugar levels lower their risk of complications and gain, on average, five extra years of life, five more years of eyesight, six years free from kidney disease, and six years free from amputations and nerve damage.

Overall, age-adjusted diabetes deaths among all age groups increased between 1992 and 2003, from 18.2 deaths per 100,000 population to 21.2 deaths per 100,000 population. Diabetes mortality rates were substantially higher among men compared to women and among non-Hispanic Blacks compared to Hispanics and non-Hispanic Whites. Mortality rates were 25 percent to 45 percent higher among men compared to women. Diabetes mortality rates among Non-Hispanic Blacks were nearly three times as high as for non-Hispanic Whites and more than twice as high as mortality rates among Hispanics.

Figure 16: Age-adjusted death rates for diabetes, 1992–2003, Florida Vital Statistics



Status Summary 3: Mortality Health Status Indicators

OBJECTIVE	FLORIDA BASELINE (2000 UNLESS INDICATED)	STATUS (2003 UNLESS INDICATED)	PERCENTAGE POINT CHANGE	PROGRESS QUOTIENT	HOW DOES FLORIDA COMPARE TO THE NATION?
By 2010, reduce coronary heart disease (CHD) deaths to 166 per 100,000 population.	179.2	157.5	21.7	164.39%	Lower (better) rate in 2002
By 2010, reduce stroke deaths to 46.6 per 100,000 population.	48	42.4	5.6	400.00%	Lower (better) rate in 2002
By 2010, reduce the overall cancer death rate to 172.09 per 100,000 population.	188.99	175.4	13.59	80.41%	Lower (better) rate in 2002
By 2010, reduce the colorectal cancer death 15.52 per 100,000 population.	18.5	16.3	2.2	73.33%	Lower (better) rate in 2002
By 2010, reduce the prostate cancer death to 15.9 per 100,000 population.	25.2	22.2	3	32.26%	Lower (better) rate in 2002
By 2010, reduce the melanoma cancer death to 2.49 per 100,000 population.	2.8	2.9	.1	-33.33%	Higher (worse) rate in 2002
Stop the increase in the age-adjusted underlying diabetes death rate and reduce to the 1999 rate of 20.2. (Baseline: 2000 age-adjusted death rate 22.3 per 100,000.)	22.3	21.2	1.1	52.4%	Lower (better) 2002

*Progress quotient = $\frac{\text{current estimate} - \text{baseline} \times 100}{2010 \text{ target} - \text{baseline}}$

**not a significant change

PROGRAMS IN THE HEALTHY COMMUNITIES, HEALTHY PEOPLE INITIATIVE

There are nine programs that collectively comprise Healthy Communities, Healthy People. The department's Healthy Communities,

Healthy People programs are designed to reduce the leading causes of death by addressing the major behavioral risk factors associated with the causes of death. The programs focus on assessing behaviors, changing modifiable risk behaviors, promoting early detection, and facilitating policy and environmental change that supports healthy behaviors at both the state and community levels. Program activities enhance the skills, knowledge, motivation, and opportunities for individuals, organizations, healthcare providers, small businesses, health insurers, and communities to develop and maintain healthy lifestyles. Programs build plans and activities around four types of prevention interventions :

- 1. Health promotion activities are directed to the population in general to educate consumers about risk factors and protective measures. It includes educating people about risk factors and lifestyle changes to reduce risk.**
- 2. Primary prevention addresses major behavioral risk factors before chronic diseases develop and assists people who have risk factors for chronic disease to prevent or postpone the onset of disease. Examples include smoking cessation, controlling high blood pressure, and promotion of physical activity and healthy nutrition to prevent the onset of cardiovascular disease.**
- 3. Secondary prevention includes the detection and treatment of existing disease to prevent complications. Secondary prevention includes screening for cancer, diabetes, high cholesterol, or high blood pressure to detect conditions at an earlier more treatable stage. Secondary prevention for cardiovascular disease once diagnosed includes promoting physical activity, healthful nutrition, and control of hypertension to prevent recurring cardiovascular events.**
- 4. Tertiary prevention aims to prevent disability in people who have symptomatic disease to prevent the progression of a disease and its complications, or to provide rehabilitation.**

The programs also indirectly address development of mental, emotional, and social competencies in children, adolescents, and adults. Recent research provides mental health links, especially depression and alcoholism, to chronic conditions including overweight and obesity, diabetes, and heart disease. The literature also documents the benefits of physical activity to emotional and mental health and academic achievement.

Table 1 provides a list of programs in the Healthy Communities, Healthy People initiative and depicts the synergy with which these programs interact to address behavioral and mortality indicators.

Table 1: Synergy of Programs Included in the Healthy Communities, Healthy People Initiative

INDICATOR	BEHAVIOR				MORTALITY		
	PHYSICAL ACTIVITY	OVER-WEIGHT /OBESITY	TOBACCO USE	EARLY DETECTION	HEART DISEASE & STROKE	CANCER	DIABETES
PROGRAM							
Heart Disease and Stroke Prevention	X			X	X		
Chronic Disease Health Promotion and Education	X	X	X	X	X	X	X
Diabetes Prevention and Control	X			X	X		X
Obesity Prevention	X	X		X	X	X	X
Arthritis Prevention and Control	X	X		X			
Comprehensive Cancer Control		X	X	X		X	
Breast and Cervical Cancer				X		X	
Tobacco Prevention and Control			X		X		
Closing the Gap				X	X	X	X
Coordinated School Health	X	X	X	X	X	X	X

Subsequent sections provide a description, brief history, goals, activities, and key accomplishments of each of the programs in the Healthy Communities, Healthy People initiative.

Heart Disease and Stroke

The Heart Disease and Stroke Prevention Program

FUNDING	Centers for Disease Control and Prevention five-year Basic Implementation grant. Florida is one of only 12 states in the nation to receive this level of funding through a competitive process for approximately \$1,200,000.
HISTORY	First funded in July 2002
GOAL	To prevent and reduce the burden of cardiovascular disease in Florida.
PRIORITY POPULATION	All residents of Florida benefit from the program. However, the priority populations are women, and African-Americans and Hispanic minorities.
RELATED LEADING HEALTH INDICATOR	Physical activity, overweight/obesity, tobacco use
RELATED MORTALITY INDICATOR	Heart disease and stroke deaths

The Heart Disease and Stroke Prevention Program (HDSP) focuses on secondary prevention interventions. It creates systems changes that encourage use of effective strategies for the prevention and improvement of the quality of heart disease and stroke care through initiatives such as control of high blood pressure and high cholesterol, and effective emergency response to heart attacks and strokes. Program activities are implemented at the community level through the Chronic Disease Health Promotion and Education Program and at the state level.

The program work plan includes both capacity building and intervention objectives. Of eight proposed objectives to be completed by 2007, the four capacity-building objectives and one intervention objective have been completed. Objectives completed thus far include the establishment and support of the Chronic Disease Health Promotion and Education Program described below, completion of a state strategic plan, development of a cardiovascular Internet site, and publishing a state-burden report. Work will continue throughout the project period to implement planned state strategies.

Intervention objectives focus on reducing the risk factors for, and deaths due to, cardiovascular disease. They include:

- **Increasing the percentage of people taking action to control high blood pressure. (The original objective to increase physical activity in the state was redefined in accordance with the CDC reprioritization efforts.)**
- **By December 31, 2005, increase the number of adults aware of the signs and symptoms of both heart attack and stroke by 10 percent more than the 2003 BRFSS baseline. Priority populations include women and disparate populations.**
- **Through June 30, 2007, monitor and work to improve the quality of CVD care by:**
 - 1) Increasing the proportion of heart failure and acute myocardial infarction patients who receive appropriate hospital discharge instructions as measured by Florida Medical Quality Assurance, Inc (FMQAI) and American Heart Association (AHA) indicators.
 - 2) Increasing the number of EMS responders trained as trainers for cardiopulmonary resuscitation (CPR) and Automated External Defibrillators (AED) instruction.
 - 3) Increasing number of hospitals that adopt an electronic patient management system such as the AHA-endorsed "Get with the Guidelines" program.

Program Successes

The Heart Disease and Stroke Prevention Program has successfully implemented the following activities:

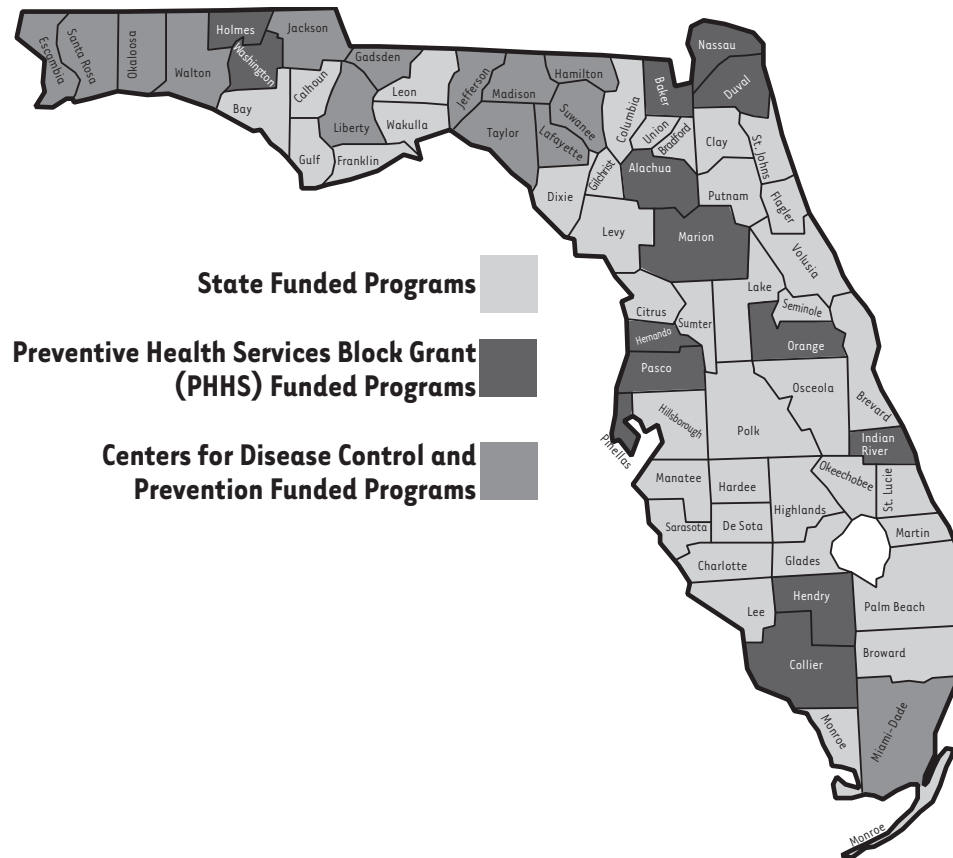
- **Created the Cardiovascular Health Council, which led to the development of a state strategic plan.**
- **Created the Heart Disease and Stroke Prevention Internet site that provides public and professional access to state and national heart disease and stroke information, including primary and secondary prevention information, culturally appropriate educational resources, links, data, and statistics. From January 26 to June 30, 2004, the web site had 10,776 unique visitors.**
- **Implemented multiple media campaigns that included radio, television, billboards, fact sheets, and a beauty shop mailing about hypertension, the signs and symptoms of heart attack, and the importance of calling 911. The hypertension radio campaign consisted of 6,236, 60-second spots and 1,329, 30-second spots, reaching 4,280,906 adults age 35 and older.**
- **Established a working partnership with the Rural EMS Network to enhance training and placement of automated external defibrillators in rural counties.**

Chronic Disease Health Promotion and Education (CDHPE) Program

FUNDING SOURCE	Heart Disease and Stroke Prevention Grant (19 percent of CDHPE funding) from the CDC, Preventive Health and Health Services (PHHS) Block Grant (44 percent of CDHPE funding) from the CDC, and Department of Health general revenue discretionary funds (37 percent of CDHPE funding) for a total of \$2,700,000 in 2003–2004.
HISTORY	Fully expanded in 2003–2004. Evolved from community programs implemented since 1986.
GOAL	To reduce deaths due to cardiovascular disease.
PRIORITY SETTINGS	Communities, schools, worksites, churches
LEADING HEALTH INDICATORS	Physical activity, overweight/obesity, tobacco use
LEADING MORTALITY INDICATORS	Heart disease and stroke, cancer, diabetes

The CDHPE Program is the community-based component of the Heart Disease and Stroke Prevention Program. The CDHPE Program provides funding to all 67 Florida county health departments to develop and implement cardiovascular prevention programs addressing at least five Healthy People 2010 objectives. These single-county and multi-county programs mobilize community resources and partnerships to implement policy and environmental changes.

Figure 17: Chronic Disease Health Promotion and Education Program Funding, by County



Each CDHPE program develops an annual work plan around the five risk factors for cardiovascular disease: physical inactivity; overweight and poor nutrition; lack of awareness of the signs and symptoms of heart attack and stroke and the need to call 9-1-1; diabetes; and tobacco use by adults and youth. Thirty-three Healthy People 2010 objectives form the basis for community driven interventions. Examples include “to increase the proportion of adults who take action to control high blood pressure” and “to reduce the proportion of adults who engage in no leisure time physical activity.” Local impact objectives, which mirror or lead to the Healthy People 2010 objectives, are developed based on community data and resources. Work-plan interventions focus on the implementation of policy and environmental changes

and education that support those changes. Interventions are set in schools, faith-based organizations, businesses, communities, and worksites. When available, interventions are based upon best practices provided by national resources that include the Community Guide to Preventive Services and the Clinical Preventive Services.

The program has five process objectives completed, but ongoing to maintain the program's effectiveness, and one outcome objective for 2003-2006.

Process objectives include:

- **To distribute funding from state and federal funding sources to county health departments, contingent upon the availability of funding and successful program performance.**
- **Assure that each CDHPE project has a full-time coordinator.**
- **Provide technical assistance to each CDHPE project.**
- **Monitor each CDHPE project work plan, budget, and activities to assure appropriate use of funds, and focus on the five-targeted Healthy People 2010 objectives.**
- **Assure that each CDHPE project conducts a process evaluation and produces a report that documents best practices and areas in need of improvement.**

Currently, 35 projects are funded. Projects cover between one and six counties. Funding ranges from \$58,000 to \$126,000 per project annually. Project staff have phone and e-mail access to consultants in each of the risk-factor areas, are provided annual orientation and training conferences that are evaluated, and meet quarterly through conference calls to discuss best practices and training. Monitoring includes: work-plan guidance by a team of three technical experts to assure measurability and achievability, and assist in identifying indicators; a project liaison who facilitates monthly monitoring calls; and quarterly and year-end progress reports to review work-plan achievement, expenditures, and progress toward completion of policy and environmental interventions. The program has contracted for three years with an external evaluator through a competitive bidding process to develop performance criteria, assist project staff in the development of an evaluation plan, coordinate tools to track intervention indicators, provide technical assistance and evaluation guidance, and provide a summative evaluation at the end of three years.

As a process outcome objective, the CDHPE program will implement 50 percent of the policy and environmental changes proposed by community projects. Completion of policy and environmental changes are reported quarterly. By the end of the first project year, CDHPE programs had completed 187 of 306, or 62 percent, of the proposed policy and environmental interventions. A 62 percent completion rate is well beyond expectations for this newly formed program.

Program Successes

Indian River The CDHPE partnered with the school food service program, school board, and school health advisory committee to provide healthier vending machine options for students.

Hernando County The Worksite Wellness Challenge is a competition in which participants track their physical activity, daily pedometer steps, daily intake of fruits and vegetables, and water consumption for a period of 12 weeks. Participants organized themselves into teams and worked feverishly to challenge other worksite teams in their mutual quests for better health. There were 22 teams consisting of 214 individuals participating in the challenge. One team leader decreased sodium and fat intake, while increasing her intake of fruits and vegetable to meet the challenge. After one year, this team leader has maintained a 32-pound weight lost and has stabilized blood pressure without medication.

Challenge results:

- **125,414,143 steps were recorded**
- **88 percent of participants increased physical activity**
- **85 percent of participants increased fruits and vegetable intake**
- **84 percent of participants increased daily water consumption**
- **66 percent of participants reported that they will continue with these lifestyle habits**

Pinellas The Pinellas County Strong Heart program initiated the Healthy Kids menu. The program dietician analyzed child menu items in local restaurants and suggested changes that would be healthier. As of June 2003, 22 restaurants are Healthy Kids Heroes, some with multiple sites in the county.

Participating restaurants receive Healthy Kids menu stickers and window decals. They also earn a listing on the Healthy Kids Heroes web site. The program has received national media attention.

Closing the Gap Cardiovascular Projects

FUNDING SOURCE 2000 legislative appropriation of \$5 million for 2000–2001, of which \$1,006,941 was used to fund six cardiovascular, 19-month projects through a competitive process.

In 2003–2004, seven projects were funded for a total of \$734,129 for 12 months.

HISTORY Initial implementation December 2000. Projects may or may not be refunded for subsequent cycles.

PRIORITY POPULATION Racial and ethnic minorities

GOAL To improve cardiovascular disease–related health outcomes of racial and ethnic populations through community–based and neighborhood–based projects.

RELATED LEADING HEALTH INDICATORS . . Physical activity, overweight/obesity

RELATED FLORIDA MORTALITY INDICATOR. Cardiovascular disease

This is a community–based grant program driven by community needs and resources, which provide prevention, intervention, and education services, including screenings. Project objectives and activities are based on an array of Healthy People 2010 objectives in the focus areas of heart disease and stroke, physical activity, and nutrition and overweight. Projects aim to reduce disparities through the development and implementation of policy and environmental interventions at the community level.

The Closing the Gap cardiovascular health project activities include screenings for hypertension and high blood cholesterol with referral to community providers for treatment, increasing physical activity to prevent hypertension and high blood cholesterol, increasing healthy weight and healthful nutrition among community members, and increasing community knowledge of the signs and symptoms of heart attack and stroke and the need to call 9–1–1.

Model Project: Sarasota Memorial Health Care System—“Newtown Wellness Program”

The Newtown Wellness Program provides services and direct activities to address the cardiovascular disease health disparities of the African American residents of "Newtown." The project goals for fiscal year 2003–04 are to:

- 1. Increase the proportion of adults age 20 and older who are aware of the early warning symptoms and signs of a heart attack and the importance of calling 911.**
- 2. Increase the proportion of people who are at a healthy weight.**
- 3. Increase the proportion of adults who engage regularly (preferably daily) in moderate physical activity.**

Project Successes

- **6,154 people participated in at least one aspect of the Newtown Wellness Initiative during the past year.**
- **A policy agreement between the Newtown Wellness Program and Sarasota Memorial North County Health Center was developed to accept referrals for treatment.**
- **306 adults were screened for lipids and 263 adults for blood pressure and weight.**
- **78 women attended the “Women's Heart Advantage Program,” which promoted health screenings, physical activity, and nutrition.**
- **18 women were trained as community lay–health educators.**
- **18 weight management classes that included nutrition education and cooking demonstrations were conducted.**
- **10 nutrition and food safety classes at the local high school and four different exercise classes for the community were conducted.**
- **A Community Walking Club with 254 members was supported and integrated the 10,000 Step-a-Day Program. Three of the**

members have logged more than a million steps; seven have logged more than two million steps; and 14 have walked more than one million steps in 10 months.

Related Documents

Overview of Reducing Racial and Ethnic Health Disparities: Closing the Gap Program—Cardiovascular Disease at: <http://www.doh.state.fl.us/Family/heart/rehd.html>

Diabetes

Diabetes Prevention and Control Program (DPCP)

FUNDING SOURCE The CDC competitive award is currently at the highest level of funding for state diabetes programs along with 26 other states. Funding for fiscal year 2003–2004 is \$650,000.

HISTORY Funded as a core capacity state in September 1996.

PRIORITY POPULATION Disparate groups, persons with diabetes.

PROGRAM GOAL To reduce the burden of diabetes and the health-related complications of Floridians with diabetes by improving the access to, and quality of, diabetes care.

RELATED LEADING HEALTH INDICATORS . . Physical activity, overweight/obesity

RELATED FLORIDA MORTALITY INDICATOR. Cardiovascular disease

Public health is the accepted convener in Florida to organize, implement, and evaluate strategies that improve the health outcomes for all people living with diabetes. The DPCP coordinates with county health departments, health maintenance organizations, managed care organizations, hospitals, and a wide array of medical providers. The DPCP works for changes in legislation, policy, protocols, and administrative procedures that improve the quality of, and access to, diabetes care within health systems. The DPCP focuses heavily on reducing health disparities among minority groups.

The following is a list of the objectives and progress toward achievement, as of 2003 (all baseline information comes from the 2000–2001 Florida Behavioral Risk Factor Survey):

Key Program Activities

- Facilitate the activities of the Diabetes Advisory Council and the Implementation Workgroup.
- Support the National Diabetes Education Program and the CDC initiatives including Small Steps, Big Rewards, Be Smart About Your Heart, and Control Your Diabetes For Life.
- Provide professional education regarding the Florida Diabetes Medical Practice Guidelines and other topics through a statewide teleconference series.
- Promote diabetes self-management education among professionals and consumers.
- Facilitate the “Diabetes Hispanic Initiative” to establish a statewide Diabetes Hispanic Coalition.
- Participate in initiatives to promote prevention of type 2 diabetes.
- Disseminate public education and awareness materials including the Diabetes Patient Health and Care Diaries (developed to outline the critical parameters of the Florida Diabetes Medical Practice Guidelines) and complementary Patient Flow Sheets (developed to outline care and treatment that individuals with diabetes should receive).

Program Successes

- A statewide Diabetes Health System Assessment Congress was held in 2003 to understand the strengths and weaknesses of the diabetes healthcare system. The results of the congress will be used to develop and implement a statewide Performance Improvement Plan and to guide strategic planning efforts.

- Guidelines for the care of Florida's estimated 31,093 Florida PK-12 public school students with diabetes were developed in partnership with the School Health Program.
- A directory of diabetes services and resources, by county, was compiled for all of Florida's 67 counties.
- A series of audio teleconferences for medial and other professionals were presented at county health departments, community health centers, and private practices. Eight conferences were held (as of June 2004) with each teleconference attended by an average of 200 professionals. Continuing education credits were made available.
- A Diabetes Hispanic Initiative was established to mobilize the Hispanic community, ensure the availability of culturally appropriate educational materials, and promote prevention and care for Hispanic persons with diabetes.
- In 1998, Florida was one of five states chosen to participate in the original Medicare Managed Care Quality Improvement Project in collaboration with the Centers for Medicare and Medicaid Services.
- Since its inception, the program has promoted the use of hemoglobin A1C tests as a tool to monitor long-term blood glucose levels and, hence, reduce diabetes-related complications. From 1994-1996 to 2000-2001, the percent of those with diabetes who had their A1C checked at least once increased from 13.2 percent to 67.7 percent. In addition, only about 7 percent of those with diabetes in 2000-2001 indicated that they had never heard of hemoglobin A1C.

In addition to mortality indicators, the Diabetes Prevention and Control Program established the objectives listed in Table 2 to monitor clinical services for persons with diabetes. These activities reflect not only the effectiveness of professional education and adherence to the Florida Diabetes Medical Practice Guidelines, but also reflect patient self-management education and awareness of necessary medical care. These objectives were proposed and monitored in response to the CDC cooperative agreement requirements. Table 2 shows progress toward achievement of these clinical measures as of 2003: All baseline information comes from the 2000-2001 Florida Behavioral Risk Factor Survey.

Table 2: Diabetes Prevention and Control Program Indicators 2003–2004

OBJECTIVE	2003 POINT ESTIMATE (95% CONFIDENCE INTERVAL)	PERCENT CHANGE FROM BASELINE	PROGRESS QUOTIENT*
Increase the percent of people with diabetes who had a dilated eye examination during the past year from 77.6% to 81.2%.	**75.6% (71.5% to 79.4%)	2% decrease	-55.56%
Increase the percent of people from all race/ethnic groups other than non-Hispanic White who had a dilated eye exam in the past year from 78.1% to 84.3%.	**74.9% (66.2% to 81.8%)	4% decrease	-51.61%
Increase the percent of people 65 years of age and older with diabetes who received influenza immunization in the past year from 60.9% to 78%.	**64.8% (58.7%, 70.4).	6% increase	22.81%
Increase the percent of persons aged 65 and older of race/ethnic groups other than non-Hispanic White with diabetes who received an influenza immunization in the past year from 55.7% to 71.3%.	**47.0% (33.8, 60.6)	15% decrease	-55.77%
Increase the percent of people with diabetes aged 65 and older who have ever received a pneumococcal immunization from 61.6% to 75%.	**65.1% (59.0, 70.8)	6% increase	12.32%
Increase the percent of those in race/ethnic groups other than non-Hispanic White with diabetes aged 65 and older who have ever received a pneumococcal immunization from 49.1% to 72.7%.	64.8% (58.7, 70.4)	32% increase	66.53%
Increase the percent of people with diabetes who had their A1C checked at least two times in the past year from 69.4% to 74.0%.	**68.9% (64.0, 73.4)	less than 1% decrease	-10.87%
Increase the percent of people with diabetes of race/ethnicity other than non-Hispanic White who had their A1C checked at least four times in the past year from 62.7% to 71.4%.	**65.6% (55.1, 74.7)	5% increase	33.33%
Increase the percent of people with diabetes who receive a foot examination by a healthcare professional in the past year from 64.1% to 71.7%.	**70.7% (66.5, 74.5)	10% increase	86.84%
Increase the percent of people with diabetes of race/ethnicity other than non-Hispanic White who receive a foot examination by a healthcare professional in the past year from 54.5% to 61.0%.	73.6% (65.3, 80.5)	35% increase	293.85%
Increase the percent of people with diabetes who engage in any leisure time physical activity from 60.8% to 74.2%.	**64.8% (58.7, 70.4)	7% increase	29.85%

*Progress quotient = $\frac{\text{current estimate} - \text{baseline}}{2010 \text{ target} - \text{baseline}} \times 100$

**not a significant change

Closing the Gap Diabetes Projects

FUNDING SOURCE	General revenue, specific appropriation. In 2003–2004, seven diabetes projects were funded for a total of \$716,00.0
PROGRAM DATES.	1999 to present
GOAL	To decrease racial and ethnic disparities in morbidity and mortality rates related to diabetes.
PRIORITY POPULATION	African-Americans and Hispanics with diabetes
LEADING HEALTH INDICATOR ADDRESSED.	Physical inactivity, overweight and obesity
LEADING CAUSE OF DEATH ADDRESSED . . .	Cardiovascular and diabetes deaths

Model Project

Baker County Health Department's project, "Working Toward Wellness in Baker County for a Healthier Tomorrow," strives to reduce the percentage of African-American adult church members who do not engage in physical activity, increase the percent of African-Americans who receive formal diabetes education, and decrease the mean body mass index (BMI) of African-American adults at selected local churches. Since first being funded in 2000, the project developed the first and only diabetes self-management training program in the county, established a community fitness trail, established faith-based weight management and exercise programs in three African-American churches in the county, and conducted health screenings. These programs have resulted in increased community awareness and interest in health issues; community mobilization and empowerment; increased community resources for health information; support; and healthier behavior such as increase physical activity, weight management, healthy eating, and diabetes self-management. The project has also mobilized the African-American community to form a program planning committee to plan events and activities. This project has been funded since 2000 and was awarded \$111,813 in 2003–2004.

Although this project reaches many more in the community, the most direct impact is measured by the diabetes self-management classes offered through the local churches. These classes have been ongoing monthly since 2002, and class size ranges from eight to 20 participants per class. An analysis of the evaluation data collected from March to October 2002 show that there was a significant decrease in the overall mean A1C levels from 7.99 percent to 7.16 percent ($p=0.016$), and the overall mean total cholesterol levels from 189.4 to 171.2 ($p=0.001$). The impact was greatest for those participants with initial measures that exceeded recommended levels (7 percent for A1C and 200 for total cholesterol). The data indicate that among this group (those above recommended levels), the mean A1C decreased from 9.42 percent to 7.96 percent ($p=0.015$), and the mean total cholesterol decreased from 241.3 to 204.3 ($p=0.006$).

Program Accomplishments

- The program received American Diabetes Association (ADA) recognition for using the ADA diabetes education program and can now file for reimbursement from private insurers. This is a prestigious recognition and supplements the project's sustainability efforts.
- Project runs a large-scale fitness contest with area churches. This innovative approach makes fitness and learning about nutrition and healthy lifestyle choices a fun process.
- The project has shared the best practices and lessons learned with county health directors, chronic disease health promotion and education coordinators, and nationally, at diabetes partnership meetings.
- Participants have documented weight loss and have seen reductions in blood glucose levels.

Related Documents

The Diabetes Advisory Council Strategic Objectives for 2001–2004 at: <http://www.doh.state.fl.us/family/dcp/DAC/strategic.html>

Cancer

Comprehensive Cancer Control (CCC) Program

FUNDING Capacity-building competitive grant from the CDC began at \$187,331 in 2001 and was increased to \$300,000 for 2004, a 62 percent increase.

GOAL To reduce the burden of cancer in Florida on individuals, families, and communities by improving communication, coordination, and collaboration among public and private organizations at local, regional, and state levels.

PRIORITY POPULATION Adults

RELATED HEALTH INDICATORS Tobacco use, physical activity, overweight/obesity

RELATED MORTALITY INDICATOR Cancer

The program implements cancer prevention and education programming with a focus on colorectal, lung, ovarian, prostate, and skin cancer through a collaborative effort with public and private partners throughout Florida. This is accomplished through on-going efforts with the existing Governor-appointed Cancer Control and Research Advisory Council (C-CRAB), Cancer Information Services, American Cancer Society, Regional Collaborative, and cancer survivors.

Staff collaborate with the CDC on various media projects promoting healthy lifestyles and cancer reduction, and provide the administration and management of “Closing the Gap – Reducing Racial and Ethnic Health Disparities”-funded providers. Other responsibilities include working toward developing guidelines and policies as it pertains to county health department activities.

Program Activities

- **Assess and address the cancer burden by coordinating the revision of the comprehensive cancer control plan, collaborating on the integration of regional cancer plans into the state plan, implementing department activities identified in the plan, and ensuring that all key objectives in the plan are implemented by a key stakeholder to ensure accountability and full integration of the plan.**
- **Conduct systematic evaluation of the comprehensive cancer control planning process and the program through identifying resources and staff for evaluation; defining planning evaluation questions; assessing the planning process; and identifying emerging challenges, solutions, and outcomes of the planning process.**
- **Build and sustain partnerships among new and existing state-level coalitions, such as the Cancer Control Research and Advisory Council (C-CRAB), Cancer Information Services (CIS), American Cancer Society, and the Regional Collaborative, to ensure broad-based representation and a comprehensive cancer focus are maintained or augmented.**
- **Implement public and professional educational campaigns to create awareness and leadership development around comprehensive cancer prevention and control issues, as well as coordinate with the Centers for Disease Control and Prevention (CDC) regarding education and training issues.**

Key Accomplishments

- **Over the past year, the Comprehensive Cancer Control Program has successfully worked in collaboration with cancer partners in the creation and distribution of the Florida Cancer Plan 2003-2006.**
- **Programmatic funding was increased 62 percent for comprehensive cancer initiatives.**
- **Statewide cancer stakeholders were mobilized to create the Florida Cancer Plan Council and to promote implementation of the Florida Cancer Plan 2003-2006 by coordinating the efforts of Florida’s cancer control partners, providing technical assistance wherever possible, encouraging achievement of the plan’s prioritized goals, and providing support to the Regional Collaborative.**

Related Documents

Florida 2003–2006 Cancer Plan at: <http://www.doh.state.fl.us/family/cancer/plan/plan20032006.pdf>

2002 Florida Annual Cancer Report at: http://www.doh.state.fl.us/disease_ctrl/epi/cancer/1999AR.pdf

Prostate Cancer Incidence and Mortality Rates for Florida by Race and Age 1990–1997 at: http://www.doh.state.fl.us/disease_ctrl/epi/cancer/prostate.pdf

Florida Cancer Data System at: <http://fcds.med.miami.edu/>

Closing the Gap Cancer Projects

FUNDING \$548,168 in general revenue appropriation funds six projects in 2003–2004—three for comprehensive cancer and three for breast and cervical cancer.

GOAL Decrease racial and ethnic disparities in morbidity and mortality rates relating to cancer.

PRIORITY POPULATION African-American and Hispanic adults

RELATED HEALTH INDICATORS Tobacco use, physical activity, overweight/obesity

RELATED MORTALITY INDICATOR Cancer

Model project: GrOW (Growing Older Well) Comprehensive Cancer Program, addresses prostate, colorectal, and lung cancer; and the dangers of second-hand smoke among African-Americans, Asians, Hispanics, and Pacific Islanders in Pinellas County. The program provides health education and awareness for adults and youth, and screening and referral services. The program is also developing a resource directory.

Accomplishments

In just one quarter (July–September 2004) GrOW provided:

- **Education and health screening events for 3,133 individuals about colon and prostate cancer.**
- **Colorectal screenings at 10 community events; prostate-antigen testing at six community events; and screening, education and colorectal test kits, and prostate cancer screenings at 11 faith-based events.**
- **146 fecal occult blood-testing kits were distributed.**
- **44 men received prostate-antigen testing.**
- **1,747 men and women received information about healthy living and healthy eating at education and screening sessions.**

Breast and Cervical Cancer Early Detection Program

SOURCE OF FUNDING Federal: Breast and Cervical Cancer Mortality Act of 1990, Public Law 101-354. The CDC currently funds this program at \$4,302,634 for July 1, 2004 – June 30, 2005. Medicaid provides treatment valued at approximately \$6 million (this \$6 million includes both federal and state matching funds).

HISTORY Established in 1994

GOAL Reduce the burden of breast and cervical cancer through early diagnosis.

PRIORITY POPULATION Women with incomes at or below 200 percent of the federal poverty line, who are uninsured or underinsured, and are between the ages of 50 and 64.

RELATED MORTALITY INDICATOR Cancer

The Florida Breast and Cervical Cancer Program is primarily a clinical program that promotes screening and early detection as the means to reduce deaths due to breast and cervical cancer. Screening tests can detect cancer early when it is most treatable. In fact, research indicates that regular mammography and clinical breast exams can reduce breast cancer mortality by 30 percent among women age 50 and older. Mortality due to cervical cancer is preventable, if caught early. Detecting any cancer at an early stage is the key to improved survival and decreased mortality rates.

The Breast and Cervical Cancer Program collaborates with the Cancer Prevention and Control Program when possible and provides expert guidance through participation on the Internal Cancer Workgroup and the Florida Cancer Plan Council. Recent studies have provided evidence that physical activity may lower the lifetime risk of developing breast cancer and have linked excess weight to an increased risk of breast cancer. A very large study of nurses in the U.S. found that gaining 10 or more pounds after age 18 increased the risk of both developing and dying from postmenopausal breast cancer. Before menopause, it appears that

being somewhat overweight decreases a woman's risk of getting breast cancer. After menopause, however, being overweight increases the disease risk by about 20 to 60 percent.

Services Provided

- Breast and cervical cancer screening exams (mammograms, PAP smears and clinical breast exams).
- Diagnostic exams are provided as necessary (grant pays for only a limited number).
- Effective July 1, 2001, treatment is paid for eligible women by Medicaid as funding allows
- Case management is provided to all clients.
- Outreach, public education, professional education, and data collection are provided.
- Data is collected and utilized to assess the program's effectiveness and quality.
- Evaluation of program's effectiveness and quality is ongoing based on collected data, as well as surveys.

Statistics

- Between March 1994 and June 2003, more than 25,000 women received mammograms and over 22,000 women received PAP smears through this program.
- Between March 1994 and June 2003, 442 women screened through this program have been diagnosed with breast cancer, 23 with invasive cervical cancer, and 241 with pre-cancerous lesions (CIN I, CIN II or CIN III) or precancerous conditions.

Tobacco

Tobacco Prevention

FUNDING	Tobacco Prevention Program: CDC Basic Implementation grant for \$750,000 awarded through a competitive application.
TOBACCO PREVENTION EDUCATION	State tobacco settlement funds currently funded for \$1 million.
FLORIDA CLEAN INDOOR AIR Act	\$90,000 general revenue appropriation
HISTORY	Began directing federal funding for tobacco prevention in 1989. Adult prevention and control program funded by the CDC in 1992 as a capacity-building program. In 1998, the Florida Legislature created Florida's youth tobacco program from tobacco settlement funds beginning at \$59 million and reduced in 2003 to \$1 million per year.
GOAL	The Florida Tobacco Prevention Program is organized and developed around the following goals: Preventing initiation of tobacco use, reducing tobacco use, protecting from exposure to environmental tobacco smoke, and reducing tobacco use among distinct populations.
PRIORITY POPULATION	All residents, adults and youth, smokers and non-smokers
RELATED HEALTH INDICATORS	Tobacco use
RELATED MORTALITY INDICATOR	Cancer deaths

Florida's Tobacco Program Includes the Following Components

Florida Clean Indoor Air Act Program In 1988, the Department of Health was given enforcement responsibilities for Chapter 386, Florida Statutes, the Florida Clean Indoor Air Act (FCIAA). The act regulates smoking in public places. Activities include educating the public about secondhand smoke. Enforcement activities are complaint driven.

CDC Tobacco Prevention Program Adult Tobacco Prevention and Control Program goals are to continue and improve existing tobacco prevention and control activities at the state, regional, and local level. The main priorities are to 1) sustain a comprehensive, public health focus for statewide tobacco prevention and control; 2) promote cessation among adults through the QuitLine; and, 3) eliminate exposure to secondhand smoke.

Youth Tobacco Prevention Program Originally established as a pilot initiative, Florida's youth tobacco program was created by the Florida Legislature in 1998 from tobacco settlement funds. The Division of Health Awareness and Tobacco (DHAT), now the Division of Health Access and Tobacco, was established to administer the Florida Youth Tobacco Prevention Program's Students Working Against Tobacco (SWAT), and to promote the Department of Health's strategic objectives relative to youth tobacco use in Florida. The DHAT initially established six functional components around which the execution of the program is organized: marketing and communications, education and training, community partnerships, youth development, diversity initiatives, and evaluation and research.

Key Activities

- **Maintain and promote the QuitLine.** The QuitLine is a toll-free telephone, tobacco-use cessation hotline. Any teen or adult living in Florida can use QuitLine. QuitLine services include: counseling sessions; self help materials; counseling and materials in English, Spanish, and Haitian-Creole; language translation services; pharmacotherapy assistance; and telecommunication device for the deaf (TDD) service. Media campaigns to promote the QuitLine and to educate the public about secondhand smoke are planned.
- **Facilitate and support the activities of the Internal Tobacco Workgroup, five regional coalitions, and SWAT chapters in each county to support youth cessation and non-initiation; and provide technical assistance as needed.** SWAT, which at one time grew to an estimated 70,000 members, will remain a centerpiece of program best practices.
- **Administer the Youth Tobacco Survey annually to assess youth tobacco use and exposure to secondhand smoke.**
- **Distribute local grants to reduce disparities.**
- **Promote and enforce the Florida Clean Indoor Air Act (FCIAA).**
- **Implemented the CDC's Adult Tobacco Survey (ATS) in the spring of 2003 and repeated in 2004.**
- **Promote and enforce smoke-free workplaces.** In November 2002, Constitutional Amendment 6, which prohibits workplace smoking, passed with support from 71 percent of the voters.
- **Provide professional and public education about secondhand smoke, the FCIAA, and spit tobacco.**
- **Educate decision makers about youth empowerment, tobacco prevention, and the youth program's successes.**
- **Implemented previous key activities of the SWAT Program including tobacco prevention curricula in schools, a youth counter-marketing program, internal and external evaluation, and statewide youth empowerment initiatives.**

Key Accomplishments

- **Between 1998 and 2004, there was a 56.8 percent decrease in middle school smoking and a 36.8 percent decrease in high school smoking.**
- **Built and maintained a SWAT membership, which peaked at approximately 70,000 in 2000-2001. Developed SWAT clubs in 203 middle schools, 206 high schools, and 85 community facilities across Florida.**
- **Successfully fostered the adoption of tobacco product-placement ordinances in 46 cities and/or counties across Florida.**
- **The Florida Quitline received more than 2,000 calls during fiscal year 2003-2004. An evaluation of services found that 61 percent of the clients contacted for follow-up within a three-month period had stopped smoking for one or more days; and 16 percent, or 159 people had quit smoking.**
- **Successful anti-tobacco teen summits were held.**
- **Successful statewide youth empowerment activities were conducted.**
- **Previous key accomplishments of the SWAT program include recognition of the SWAT program as a national model, youth focused advertising campaign, Tobacco Prevention Coordinators, and Tobacco Free Partnerships in each of the 67 counties, and online reporting system for county work plans.**

Related Documents

Florida Youth Tobacco Survey Results for 2004 at: http://www.doh.state.fl.us/disease_ctrl/epi/FYTS/2004_FYTS.htm

Students Working Against Tobacco at: www.gen-swat.com

Behavioral Risk Factor Surveillance Survey Data at: <http://apps.nccd.cdc.gov/brfss/display.asp?cat=TU&yr=2003&qkey=4396&state=FL>

Tobacco Use Cessation Quitline at: www.cancer.org

Florida Clean Indoor Air Act at: <http://www.doh.state.fl.us/Environment/facility/fciaa/index.html>

Florida's Comprehensive Plan for Action 2001–2003 at: <http://www.doh.state.fl.us/family/tobacco/CSP.html>

Quit-for-Life Line Progress Report, 2003 at: <http://www.doh.state.fl.us/family/tobacco/cessation/cessation.html>

Florida Youth Tobacco Survey 2004 Reports (FYTS) at: http://www.doh.state.fl.us/disease_ctrl/epi/FYTS/2004FYTS_Report1_CigaretteUse.pdf

The Florida Clean Indoor Air Act, F.S. 386, Part II at: http://www.flsenate.gov/Statutes/index.cfm?App_mode=Display_Statute&URL=Ch0386/part02.htm&StatuteYear=2003&Title=->2003->Chapter%20386->Part%20II

Obesity

Obesity Prevention Program

FUNDING	CDC capacity-building grant for approximately \$400,000 awarded through a competitive application.
HISTORY	First funded in 2001
GOAL	To prevent overweight and obesity through the promotion of physical activity, healthy nutrition, breastfeeding, and appropriate portion size, and reduction of television viewing time.
PRIORITY POPULATION	Adults
RELATED HEALTH INDICATORS	Overweight and obesity
RELATED MORTALITY INDICATOR	Cardiovascular deaths, some types of cancer

Program Components

The Obesity Prevention Program includes the 5-A-Day Program to promote fruit and vegetable consumption and the Physical Activity Program. The department's employee wellness program, Health In-Site, is also administratively within the Obesity Prevention Program.

Key Activities

- Build and sustain the Florida Partnership for Promoting Physical Activity and Healthful Nutrition (FPPPAHN) by increasing the number of statewide members. The partnership guides the Obesity Prevention Program in the strategic planning process. The FPPPAHN mission is to reverse the epidemic of overweight and obesity in Florida through collaborative efforts and unified leadership of many individuals and organizations, effective education, and advocacy on the political front.
- Promote increased physical activity among adults and youth.
- Promote increased fruit and vegetable consumption among adults and youth.
- Promote breastfeeding among new mothers.
- Promote decreased television-viewing time, decreased video game usage time, and decreased leisure time among youth.
- Increase employee wellness activities.
- Increase the knowledge and skills of medical professionals regarding the diagnosis and treatment of overweight and obesity in children and adults.

- Increase public awareness about the obesity epidemic in Florida including prevention strategies and behaviors that promote healthy weight.
- Promote and disseminate patient and family health-education materials.

Program Successes

- Facilitated the Governor’s Task Force on the Obesity Epidemic in Florida, which provided recommendations for obesity prevention activities in worksites, schools, healthcare, families, and communities.
- Participate in the Florida Interagency Food and Nutrition Council, which planned and implemented the 5 A Day the Florida Way campaign in 2003 and the Snack Smart Move More campaign in 2004.
- Worked with FPPPHAN to complete a five-year state strategic plan to reduce the burden of overweight and obesity.
- Developed a speakers’ bureau of medical professionals to teach other professionals about the clinical guidelines for treating overweight and obesity among adults.
- Developed and implemented the Youth Physical Activity and Nutrition Survey—a statewide assessment of middle school youth physical activity and nutrition behaviors.
- Created 5-A-Day toolkits.
- Completed formative research in a five-county north Florida area, which led to the implementation of a middle school pedometer project. More than 2,000 students participated in the nine-week program.

In addition to monitoring weight and physical activity trends, the program monitors fruit and vegetable consumption as an indicator of healthy nutrition. Fruit and vegetable consumption is related to healthy weight and the prevention of some types of cancer. The program’s Healthy People 2010 nutrition objective is provided in Table 3.

Table 3: Obesity and Overweight Program Nutrition Objective

OBJECTIVE	FLORIDA BASELINE (2000 UNLESS INDICATED)	2010 TARGET (UNLESS OTHERWISE NOTED)	STATUS IN 2002	PROGRESS QUOTIENT	HOW DOES FLORIDA COMPARE TO THE NATION?
By 2010, increase the proportion of adults who consume five or more servings of fruit and vegetables each day to 35%. (Florida BRFSS)	23.2%	35%	27.4%	35.6%	Floridians consume more fruit

Related Documents

The Florida Obesity Report at: <http://www.doh.state.fl.us/Family/obesity/documents/documents.html>

Florida Governor’s Task Force Recommendations at: <http://www.doh.state.fl.us/Family/obesity/documents/documents.html>

FPPPAHN Strategic Plan at: <http://www.doh.state.fl.us/Family/obesity/documents/documents.html>

Youth Physical Activity and Nutrition Survey (YPANS) Report at: <http://www.doh.state.fl.us/Family/obesity/documents/documents.html>

Florida Youth Risk Behavior Survey (YRBS) Report at: <http://www.doh.state.fl.us/Family/obesity/documents/documents.html>

Arthritis

Arthritis Prevention and Education Program

FUNDING SOURCE	CDC
PROGRAM DATES.	1999 to present
PRIORITY POPULATION	Individuals diagnosed with arthritis and those who have symptoms of arthritis.
PROGRAM GOAL	Reduce the occurrence, impairment, activity limitation, and restriction in social participation due to arthritis and other rheumatic conditions.
LEADING HEALTH INDICATOR ADDRESSED.	Physical activity (mobility in persons with arthritis can be improved by increasing their physical activity)

Arthritis is the leading cause of disability in the nation.

The prevention strategies implemented by the Arthritis Prevention and Control Program are secondary (for example, emphasizing early diagnosis and appropriate management) and tertiary (for example, increasing self-management activities to ameliorate pain from, and limitations to, activity) in nature. The program promotes physical activity specifically for people with arthritis as a means to increase and improve mobility and hence prevent disability, in addition to professional education and public education.

Activity limitation occurs frequently among people with arthritis and reduces quality of life, limits independence, and compromises health. People with arthritis consistently report a higher average number of days that activities are limited due to poor physical or mental health compared to their non-arthritic counterparts. Physical activity limitations may further compromise health status and increase the risk of developing or exacerbating other physical activity-related diseases and conditions such as obesity, diabetes, heart disease, and some types of cancer. As with other chronic diseases, weight control and physical activity are important elements in preventing and managing arthritis.

Among those people with physician-diagnosed arthritis, 36.7 percent report being limited in their usual activities. For those with less than a high school education, a higher percentage report being limited in their activities than those with at least a high school education. For those at the lowest end of the income range, a higher percentage report being limited in their activities than any other income range.

Key Activities

- **Promote and support self-management education for people with arthritis through the Arthritis Self-Help Course (ASHC) and Spanish Arthritis Self-Management Program (SASMP).** These courses address nutrition, depression, physical activity, pain management, and medication, as well as other topics relevant to living with arthritis. There is evidence that ASHC participants experience decreased pain, decreased physician visits, and increased efficacy.
- **Increase public and professional knowledge about lupus.**
- **Promote awareness of the benefits of physical activity for persons with arthritis.**
- **Lead the statewide arthritis partnership.**

Program Successes

- **Between June 2002 and August 2004, six county health departments conducted ASHCs.** Approximately 56 courses were completed with 576 participants. A total of 86 lay leaders were trained to teach the ASHC course.
- **Nine SASMP courses were taught in Sarasota County between June 2002 and June 2004, with approximately 78 participants.** There were 14 lay leaders trained to teach the SASMP course.
- **Eight “Unlocking the Mystery of Lupus” seminars were conducted across Florida with approximately 475 patients, professionals, family members, and friends attending.** Six additional educational and awareness seminars, targeting nurses, will be conducted prior to July 2005.
- **The “Physical Activity: The Arthritis Pain Reliever” campaign was implemented during May 2004 in five Florida counties – Leon, Gadsden, Sarasota, Lee, and Charlotte.** Radio and print ads were used. The target audience for this campaign was Caucasian and African-American adults, ages 45 to 64, with arthritis and no more than a high school education, and whose incomes were less than \$35,000 a year. Over 6,700 brochures were placed throughout these communities. More than 150 radio spots aired which reached audiences outside the five target counties providing the added bonus of even more coverage.

■ The Florida Arthritis Partnership continuously implements Florida's arthritis strategic plan activities either through the efforts of the Department of Health; the Arthritis Foundation, Florida Chapter; the Lupus Foundation; the Lupus Support Network, the Tai Chi for Arthritis Association; or workgroups consisting of everyday citizens interested in reducing the burden of arthritis in Florida.

Related Documents

2005–2008 Strategic Action Plan at: <http://www.doh.state.fl.us/family/arthritis/indexPlan.html>
2001–2004 Strategic/Action Plan at: <http://www.doh.state.fl.us/family/arthritis/indexPlan.html>
State of Arthritis in Florida Report at: <http://www.doh.state.fl.us/family/arthritis/indexReport.html>

School Health

Florida's Coordinated School Health Program (CSHP)

FUNDING: \$750,000 per year under a CDC cooperative agreement with the Department of Education; \$100,000 designated for Department of Health.

HISTORY Florida's Coordinated School Health Program is in its eleventh year and has received funding through 2009.

GOAL To improve the health and reduce the risky behaviors of school-aged youth.

PRIORITY POPULATION School-age children

RELATED HEALTH INDICATORS Overweight and obesity, physical inactivity, tobacco use, poor nutrition

RELATED MORTALITY INDICATOR Cardiovascular and some types of cancer deaths

Program Components

Florida's Coordinated School Health Program (CSHP) is a collaborative effort between the Florida Department of Education and Department of Health. The CSHP works with schools, school districts, county health departments, child advocates, and professional organizations to improve the health of Florida's children through trainings, information sharing, and coordination of services on a local, state, and national level. The CSHP consists of eight interactive components: health education, physical education, health services, nutrition services, staff health promotion, school environment, family and community involvement, and counseling and psychological services.

Program Activities

- Tobacco Prevention and Intervention funds were awarded to 12 school districts. Awards were a maximum of \$50,000.
- CSHP pilot projects provided funding to implement the CHSP model in 16 school districts.
- A general session of the Florida School Health Association Statewide Conference was sponsored and two sessions about the CSHP Pilot Project and CSHP initiatives were presented.
- The Promoting Prevention Together project and regional workshops were developed and a professional development curriculum was presented addressing HIV/AIDS, sexually transmitted diseases, pregnancy prevention, and human sexuality.
- The Physical Education Legislation Workshop provided leadership in implementing physical education legislation, 2004-255, Laws of Florida, passed during the 2004 Legislative Session.
- The statewide Florida Youth Risk Behavior Survey was used to identify risk behaviors associated with physical activity, nutrition, safety, and drug and tobacco use.

- An HIV/AIDS Prevention Summit will be held in February 2005 to address dealing with controversial issues in HIV/AIDS and sexuality education in the community.
- A Safe and Healthy Students Resource Center that will serve schools, parents, and other organizations was developed to provide educational materials related to health and safety of children.
- Partnerships with organizations on local, state, and national levels involved in promoting the health of school children were maintained.
- A statewide consortium comprised of professionals from the fields of medicine and education, along with child advocates and school health advisory committees, was developed.

Special Accomplishments

- **School Health Partners Project**—The CSHP offered funding to schools to establish a Healthy School Team to address physical and health education, staff wellness, family involvement, and healthy school nutrition. Fifty seven schools, in 20 districts, serving approximately 58,000 students are participating.

Coordinated School Health Program Web Site

<http://www.firn.edu/doe/commhome/comphome.htm>

SUMMARY

Changing individual behaviors and reducing mortality are daunting tasks. Behaviors are affected by a complex interaction between the environment, policy

and individual choice, and motivation. Best practices and proven strategies for changing behavior are still being developed. Likewise, mortality is affected by an individual's behavioral risks and genetics, as well as access and quality of medical care.

In spite of this, Florida has made incredible progress in reaching and progressing toward chronic disease, health improvement objectives. Of the 21 objectives proposed in the Healthy Communities, Healthy People initiative, the status of the objectives currently is:

Four objectives are between 0–25 percent of the projected targets.

Four objectives are between 25–50 percent of the projected targets.

Two objectives are between 50–75 percent of the projected targets.

Two objectives are between 75–100 percent of the projected targets.

Four objectives have exceeded the projected targets.

For five of these objectives, there has been negative progress.

To be successful in achieving all the proposed Healthy People 2010 objectives, it will take public health, health care, communities, and government working together to create an environment in which the healthy choice is the easy choice.

Challenges and Opportunities

While great strides have been made in chronic disease prevention programming in the past 12 years, there is still a lot of work to be done. Too many Floridians are dying of heart disease, cancer, and stroke, and too many Floridians are overweight or obese. To continue reducing death and disability due to chronic disease and risk behaviors, we must enhance our current efforts and work toward the following:

- **Implement the recommendations of the Governors Task Force on Overweight and Obesity.**
- **Identify a mechanism and necessary funding to collect behavioral data at the county level on a regular basis.**
- **Identify and focus resources on reducing risk factors for cardiovascular disease including high blood pressure, high cholesterol, tobacco use, and overweight.**
- **Continue to assess the needs of county health departments.**
- **Continue to seek funding to address asthma in Florida.**
- **Continue to promote increased physical activity among youth and adults through communities, schools, and worksites.**
- **Seek additional funding to address youth and adult obesity prevention activities.**
- **Seek additional funding to address cancer prevention and control including skin, prostate, and colorectal cancer.**
- **Continue and expand partnerships with healthcare providers and insurers.**
- **Continue and expand partnerships with employers.**
- **Continue to work with the faith community to promote healthy behaviors.**
- **Identify and disseminate best practice projects developed by programs in the Healthy Communities, Healthy People initiative. Support national efforts to identify best practices for behavioral change including the modification of policies and the environment.**
- **Develop and support policies at the state and local level that support healthy environments and healthy behaviors—limit smoking in public places, promote healthful nutrition, and support a physically active environment.**

APPENDIX A

PROGRAM DEVELOPMENT SUMMARY

Late 1970s One of the first, if not the first, chronic disease programs in Florida was the Hypertension Program, which began in the late 1970s with a budget of approximately \$150,000 in federal funds. There may have also been some federal categorical funding for health education/risk reduction and chronic disease prevention for the elderly.

1981 Congress authorized the Preventive Health and Health Services (PHHS) Block Grant to carry out programs previously authorized separately. Programs included in the block grant relevant to chronic disease prevention were hypertension and health education/risk reduction. To date, this federal funding for chronic disease prevention services continues at \$2.3 million. Although the amounts have fluctuated over the years, the PHHS Block Grant has provided a stable source of funding for chronic disease prevention – Healthy Communities, Healthy People programs. This funding has enabled Florida to demonstrate the capacity to develop and maintain programs, and were leveraged to obtain other funding.

1983 Ongoing programs included hypertension screening, insulin distribution, health-risk reduction, and cardiovascular health promotion that provided access to, and promoted use of, electrocardiogram (EKG) to investigate heart disease.

1985–1986 Executed first contract for patient and professional education with the National Kidney Foundation of Florida.

1986 The Florida Legislature incorporated all chronic disease statutes into one statute, Chapter 385, Florida Statutes, and mandated the development of Comprehensive Health Improvement Projects (CHIP) throughout the state. CHIP involved two elements: chronic disease prevention and control activities within the county health departments, and health promotion activities in the community. The chronic diseases addressed by CHIP were cardiovascular disease, hypertension, diabetes, chronic obstructive pulmonary disease, stroke, and cancer of the lung, breast, colon, and cervix. The program was funded by the PHHS Block Grant.

1986–1987 Executed the first contract with the University of Florida for end-stage renal disease vocational rehabilitation training and literature.

1986–1991 Implemented the Long Term Integrated Non-communicable Disease Activities (LINDA) Program, a five-year project for integrated hypertension and diabetes programs, funded with \$500,000 from the World Health Organization's Collaborative Centre for Non-Communicable Disease. Program activities included partnering with the American Heart Association and American Diabetes Association to provide training for medical professionals, partnering with University of South Florida to develop diabetes training modules, and implementing a special pilot project at the Pinellas County Health Department to provide fundoscopic eye exams to patients with diabetes.

1986–1993 Awarded approximately \$200,000 per year from the Centers for Disease Control and Prevention (CDC) to develop a state-based diabetes control program.

1988-1989 Funding reductions of \$500,000 for chronic disease programs in county public health units.

End-stage renal disease "hot line" included in the University of Florida contract.

1989-1990 Vocational rehabilitation activities and information "hot line" included in the continuing contract with the National Kidney Foundation of Florida. The Statewide Patient Services Committee was formally established in contract.

1990 Expanded CHIP by merging PHHS block grant funding for hypertension and CHIP with the CDC diabetes funding to create one integrated program. Approximately \$1.8 million was divided among 17 sites that served 21 counties. Programs continued to address cardiovascular disease, hypertension, diabetes, chronic obstructive pulmonary disease, stroke, and cancer of the lung, breast, colon, and cervix.

1991-1992 \$213,636 reduction in the kidney program funding. All program activities discontinued except for partial reimbursement for dialysis treatment.

1992 Health Care Reform Act directed the state to develop the Healthy Communities, Healthy People Program. No funding was attached. The statute directed the department to consolidate and use existing resources and programs to develop Healthy Communities, Healthy People Program.

New federal legislation mandated that the PHHS block grant be solely devoted to Healthy People 2000/2010, the nation's health objectives.

1992-1993 5 percent reduction in the kidney program funding.

1993-1998 Awarded five-year grant from the CDC for Initiatives to Mobilize for the Prevention and Control of Tobacco (IMPACT). This grant addressed youth and adult tobacco prevention and cessation.

The Tobacco-Free Florida Coalition (TFFC) was established.

1994 Awarded SmokeLess States funding of \$250,000 for four years from the Robert Wood Johnson Foundation.

Awarded \$50,000 from the Cancer Society and Lung Association to implement local initiatives and establish nine regional Advocacy Coordinators.

1994-1995 \$250,000 increase for the kidney program, re-instituted patient/family conferences, as well as replication of successful vocational rehabilitation in the Tampa Bay area entitled: Renal Employment Program.

1995 Florida filed suit against tobacco companies.

Policy and technical assistance guidelines for developing Healthy Communities, Healthy People initiatives were developed and included in the County Health Department Guidebook.

1995-1996 \$61,966 reduction in the kidney program funding.

1996 Existing chronic disease programs were reorganized into a bureau to improve coordination of chronic disease prevention efforts.

Awarded \$250,000 from the CDC to reduce the burden of diabetes in Florida.

Awarded \$50,000 from the CDC for one year to support the Southeastern Tobacco Prevention Network (SToP) Conference.

1996-1997 The kidney program budget doubled. The funds were used to increase the portion of total cost of dialysis were covered by reimbursement (16 percent to 32 percent of total cost). Each treatment cost approximately \$130.00.

1997 The tobacco settlement was reached on August 25.

\$250,000 to \$400,000 funding increase from the CDC for tobacco program.

Revised the CHIP program to the Community Intervention Program (CIP) program for increased accountability and reallocated funding based on a competitive bid process. A total of \$1,505,840 was allocated to 16 sites in 20 counties. The programs focused on one to three of the following chronic diseases: cancer (excluding breast, cervical, and prostate), diabetes, heart disease, hypertension, stroke, renal disease, and chronic obstructive lung disease. Funding was awarded for up to five years based on performance and availability of funds.

1998 Teen Tobacco Summit kicks off the Tobacco Pilot Program in March with \$65 million from the tobacco industry settlement agreement. The program's goal was to reduce youth tobacco use by working through county-level coordinators.

The CDC-funded tobacco program shifted focus to adults-only in view of youth-only focus for the Tobacco Pilot Program.

TFFC restructured as the Florida Leadership Council for Tobacco Control and the Tobacco-Free Florida Partners Network

The Diabetes Advisory Council was re-established with \$20,000 in general revenue funds.

One-time funding provided to five counties for a Northeast Florida Cardiovascular Health Assessment Project (\$90,000) from the PHHS block grant.

1999 The Leadership Council hosted the first Tobacco-Free Florida Partners Network Annual Educational Forum.

Florida hosted the Fifth National Conference on Tobacco and Health.

Awarded \$350,696 from the CDC to focus on reducing the burden of arthritis and other rheumatic conditions.

Awarded \$30,000 from the CDC to conduct a statewide chronic disease prevention conference.

Received state appropriation of \$1,000,000 to contract with the Diabetes Research Institute.

2000 The Chronic Disease (Adult) Tobacco Control Program developed and disseminated strategic plans reflecting new goals and program structure.

Statewide Opportunity Grants for Adult Tobacco Prevention and Control were awarded to nine projects covering 12 counties funded for short-term; total funding – \$264,120.

\$750,000 increase in the annual CDC funding for the Chronic Disease (Adult) Tobacco Control Program.

\$25,000 increase in kidney program funding for total of \$225,000. The funding provides for dialysis for individuals with no existing resources for the service. The kidney program contract was transferred to Bureau of Chronic Disease Prevention.

Legislation and appropriation of \$100,000 per year to implement a two-year Women and Heart Disease Task Force.

The CIP funding reduction of \$100,000 was due to a reduction in the PHHS Block Grant funding.

The Obesity Prevention Internal Workgroup was created. Using existing funds, the DOH and the Department of Education jointly hosted an obesity prevention summit entitled, "Get Healthy."

\$386,696 increase in the CDC funding awarded to the Arthritis Prevention and Education Program.

Six Closing the Gap projects covering an eight-county area received state funding for a 19-month period (December 1, 2000 – June 30, 2002) to reduce racial and ethnic health disparities in diabetes. Total funding for the 19-month projects is \$1.8 million. An additional two projects were funded for a seven-month period for \$300,000.

Six Closing the Gap projects, covering a six-county area, received \$956,941 in state funding for a 19-month period to reduce racial and ethnic health disparities in cardiovascular disease. An additional project was funded for \$127,988 for a seven-month project.

2001 The Third Annual Tobacco-Free Florida Partners Network Educational Forum was held with Stanley Rosenblatt, the lawyer that won the landmark judgment on behalf of six smokers against the tobacco industry, as the keynote speaker.

Tobacco cessation and prevention-related needs assessment survey conducted. The Department of Health Secretary e-mailed it to 5,000 DOH employees.

Chronic Disease (Adult) Tobacco Program partnered with National Spit Tobacco Education Program (NSTEP), minor league baseball, and dental health professionals for the spit tobacco education project.

The Florida Quit line was launched on December 7. Funding was obtained from a CDC grant.

Kidney program funding previously allocated to the department was transferred to Medicaid on June 30. In 1998, the Medicaid Program was given the authority to seek a waiver to allow Medicaid payment to free-standing dialysis clinics for outpatient dialysis treatments.

Funding for the Closing the Gap projects was reduced by 20 percent for the 19-month projects.

Awarded \$345,122 from the CDC through a competitive process to establish the Obesity Prevention Program, which focuses on reversing the increasing trend of obesity in Florida.

Awarded \$187,331 from the CDC through a competitive process to establish the Florida Comprehensive Cancer Control Program, focusing on coordinating efforts of the statewide partners and developing a state plan.

2002 Final evaluation of the CIP completed. Overall, the projects were successful in achieving their targeted objectives. In fact, one project received national recognition by the National Association of County and City Health Officials in 2002 as a “best practice”. Of the 60 objectives developed by the projects, 40 percent were achieved and 35 percent were partially successful. Only 25 percent were considered “unmet.” Often, the reasons for not achieving objectives included lack of reliable data for baseline or follow-up, or setting unrealistic, goals. Sixteen of the 17 projects indicated that some components of the program would be continued through the county health department or through collaboration with another community group.

Revised the CIP to the Community Cardiovascular Health Program and awarded four-year funding to 11 county health departments covering 12 counties to develop and implement community-based cardiovascular health programs focusing on the development and implementation of policy and environmental strategies, as well as education at the community, school, and individual levels.

The Arthritis Prevention and Education Program, in conjunction with the Lupus Foundation, Greater Florida Chapter and Southeast Florida Chapter, applied for and received \$10,000 to conduct regional lupus seminars in Florida.

The Youth Tobacco Program was funded at 39.1 million as part of the Prevention and Control program efforts.

The tobacco-related programs were consolidated. The Chronic Disease (Adult) Tobacco Program was moved from the Bureau of Chronic Disease Prevention in Division of Family Health Services to the Division of Health Awareness and Tobacco.

The Comprehensive Cancer Control funding cycle was changed, which extended the grant until 2007.

Awarded \$1 million for five years from the CDC for the implementation of the Heart Disease and Stroke Prevention Program. Approximately 50 percent of the funds were directed to four regional projects that cover 17 Florida counties.

The Department of Health Coordinated School Health Program was moved to the Bureau of Chronic Disease Prevention in the Division of Family Health Services. This program was previously housed in the Office of School Health, Division of Family Health Services.

Expanded the Community Cardiovascular Health Program county projects with \$1 million, general revenue appropriation and funding from the Heart Disease and Stroke Prevention Program to establish 35 Chronic Disease Health Promotion and Education programs. Most serve multiple counties so that all 67 counties in Florida have (limited) resources to address chronic disease prevention.

The CDC increased Heart Disease and Stroke Prevention Program funding to a total of \$1.2 million.

2003 The Arthritis Prevention and Education Program competed successfully to obtain an additional five years of funding through the CDC. The first year of funding, \$308,083 was awarded.

Youth Tobacco Prevention Program funding was reduced to \$1 million.

The Florida Obesity Prevention Program competed for and received continuation funding of \$400,000 from the CDC.

The department provided oversight for the Governor's Obesity Prevention Task Force.

The Diabetes Prevention and Control Program funding increased from \$265,000 to \$650,000 by the CDC. The funding is annual for a five-year period.

The Pinellas County Health Department was awarded an approximately \$900,000 Steps to a Healthier US grant. Grant initiatives will focus on reducing diabetes, obesity, and asthma in Pinellas County.

2004 The Hillsborough County Health Department was awarded an approximately \$1 million Steps to a Healthier US grant. Grant initiatives focus on reducing diabetes, obesity, and asthma in Hillsborough County.

Additional information is provided in the various sections of this report about specific programs in the Healthy Communities, Healthy People initiative.

