

The Georgia Cardiovascular Health Initiative

Georgia's Strategic Plan

For the Prevention of Cardiovascular and Related Chronic Diseases Using Policy and Environmental Strategies
2004-2014



*"To furnish the means of acquiring knowledge is the greatest benefit that can be conferred upon mankind."
— John Quincy Adams*

produced by
Georgia Department of Human Resources
Division of Public Health

in collaboration with
The American Heart Association - Southeast Affiliate
The Georgia Coalition for Physical Activity and Nutrition

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<http://health.state.ga.us>



The Georgia Department of Human Resources, Division of Public Health is pleased to present the Georgia Cardiovascular Health Initiative Strategic Plan. Funded through a grant from the Centers for Disease Control and Prevention, the Georgia Cardiovascular Health Initiative is committed to helping people make healthier choices, thereby reducing or preventing cardiovascular disease in our state. Cardiovascular disease, including heart disease and stroke, is the nation's leading cause of death and a major cause of disability, costing the Georgia economy nearly \$2 billion in hospital charges in 1999. As Georgians, we engage in unhealthy behaviors — smoking, eating high-fat foods, and leading sedentary lives — that place us at increased risk for having a heart attack, stroke, or other serious health problems.

Produced in collaboration with the American Heart Association – Southeast Affiliate and the Georgia Coalition for Physical Activity and Nutrition, this strategic plan establishes the foundation for addressing the cardiovascular health of our citizens. In addition to its focus on primary prevention, the plan also highlights the unique opportunity to address secondary prevention through the Stroke and Heart Attack Prevention Program (SHAPP). SHAPP, created in 1974, is a statewide education and treatment program for hypertension. This public health program provides the opportunity to prevent or reduce cardiovascular disease and stroke while improving the management and treatment of hypertension for thousands of Georgians.

Establishing a strategic plan is only the first step toward reducing cardiovascular disease throughout the state. Creating this plan required the expertise and dedication of many people; the successful implementation of this plan will require even more. It is imperative that we work with communities, schools, worksites, and healthcare systems to create an environment and enact policies that positively affect the health of Georgians.

We look forward to working with you to make the Georgia Cardiovascular Health Initiative Strategic Plan a reality.

Sincerely,

Kathleen E. Toomey, M.D., M.P.H., Director
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The American Heart Association Southeast Affiliate is pleased to collaborate with the Georgia Department of Human Resources (DHR), Division of Public Health on the Georgia Cardiovascular Health Initiative Strategic Plan.

This initiative, funded by a basic implementation grant awarded by the Centers for Disease Control and Prevention (CDC), sets the foundation for addressing the cardiovascular health of Georgians and will serve as a blueprint for eradicating cardiovascular disease throughout the state. This document contains cardiovascular disease prevalence data and acknowledges its impact on Georgians' health. The plan also presents a strategy to minimize the financial burden that places on our economy. Finally, the strategic plan provides health professionals, communities and other potential partners with information on how we can work together to prevent cardiovascular disease and its disabling effects.

This plan aims to create a public health paradigm shift by moving from a basic education and awareness mindset into one that incorporates environmental and policy strategies aimed at reducing cardiovascular disease.

Behavior change is often difficult to achieve, and it won't happen immediately. With support from public health officials, legislators, community advocates, and concerned citizens, we can — and we will — reduce the burden of cardiovascular disease in Georgia. Your personal commitment is essential to implementing this plan and ensuring our success as a state and as a nation.

Sincerely,

A handwritten signature in blue ink, appearing to read "C. J. W. B. Leggett".

C. J. W. B. Leggett, M.D.
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Executive Summary

- Cardiovascular disease (CVD) is the leading cause of death in Georgia and the United States.
- Risk factors for cardiovascular disease include tobacco use, physical inactivity, obesity, poor nutrition, and high blood pressure.
- The mission of the Cardiovascular Health Initiative is to support policy and environmental changes to promote physical activity, improve nutritional choices, increase access to medical care for the underserved, and develop strategies to assist in relieving the financial burden of health costs.
- The primary goal of the Cardiovascular Health Initiative is to reduce the burden of cardiovascular disease in Georgia. This will be achieved by making policy and environmental changes in worksites, healthcare systems, communities, and schools.
- Target populations include African Americans, Latinos, and those with low socio-economic status.
- The Cardiovascular Health Initiative Strategic plan was developed by a diverse group of people, allowing different perspectives on a common goal.
- Working together, we can reduce the burden of cardiovascular disease and improve the quality of life for all Georgians.

Contributors

This Georgia Cardiovascular Health Initiative State Strategic Plan is the cumulative effort of three committees within the Georgia Coalition for Physical Activity and Nutrition (G-PAN). The committees, comprised of 93 members representing 67 organizations, worked from October 1999 until April 2002 to develop the plan.

In addition to G-PAN's work in the areas of worksite, school, and community initiatives, a fourth group has formed to develop strategies and oversee the development and implementation of the healthcare segment of this plan.

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Introduction

"Cardiovascular disease is largely preventable," states *The Victoria Declaration on Heart Health*, (Declaration of the Advisory Board, International Heart Health Conference, Victoria, Canada, May 28, 1992). Cardiovascular disease is a phenomenon of modern western culture, having risen rapidly in the last half of the 20th century. To combat this malady, the Centers for Disease Control and Prevention have undertaken the initiative to fund state programs to decrease cardiovascular disease using strategies in policy and the environment. This state plan is part of Georgia's efforts to carry out this work. Three guiding documents lay the groundwork for further refinement of objectives and strategies to effectively decrease cardiovascular disease and related risk factors. The *Victoria Declaration* sets forth 64 recommendations for intervention. The *Catalonia Declaration: Investing in Heart Health* (Declaration of the Advisory Board of the Second International Heart Health Conference, Barcelona, Catalonia [Spain], June 1, 1995), identifies international partners working to curb the alarming rise in CVD. The *Singapore Declaration: Forging the Will for Heart Health in the New Millennium* (Declaration of the Advisory Board International Heart Health Conference [Singapore], September 2, 1998), proposes a framework for the development of scientific capacity to define and track the problem, and the

development of an infrastructure to address the problem.

The Cardiovascular Health grant initiative, now active in 28 states, lays the groundwork for much progress. The Victoria Declaration's recommendation #43 clearly embodies the essence of this grant objective: change policies and the environment in the areas of nutrition and physical activity across all segments of society to improve heart health. The broad focus areas are classified into the domains of: school, worksite, the community at large, and healthcare. This plan is laid out according to these domains.

The financial burden of cardiovascular disease is enormous. The cost of cardiovascular disease in Georgia increased by \$500 million between 1999 and 2001. Total hospital charges for 1999 were \$1.98 billion and \$2.51 billion in 2001.

Cardiovascular disease, including heart disease and stroke, was the number one killer of Georgians in 1999, accounting for 39% of all deaths. The cardiovascular death rate in Georgia was 14% higher than the national rate in 1999 (Figure 1).

Cardiovascular disease death rates differ by sex and race; blacks have higher rates than whites and men have higher rates than women (Figure 2). However, cardiovascular disease kills more women

than men in Georgia because women live to older ages when cardiovascular disease is more common.

Cardiovascular disease does not just affect people of old age. Of persons in Georgia who died from cardiovascular disease in 1999, 22% were younger than 65 years of age (Figure 3).

Partnerships and collaborative coalitions must be continued and strengthened in all domains throughout the community. With current state and federal budget shortfalls continuing into the foreseeable future, collaborators and partners are paramount. Internally and externally, we must collaborate to prevent duplication of services and competition. Those concerned with primary, secondary, or tertiary prevention and treatment of cardiovascular disease have more in common with programs focused on diabetes, obesity, child health, tobacco use, and care for the elderly than we have differences. We are all treating the same individual. Collaboration on data collection, training, media campaign, resource identification and program development and integration is logical and necessary. Communication is the key to success. Collaboration with internal and external partners is synergistic when done effectively.

The Georgia Coalition for Physical Activity and Nutrition (G-PAN) has a broader focus than cardiovascular disease

with emphasis on policy and environment. In the following plan, chapters 5 and 6, represent other programs and initiatives that may be of interest to the reader. These chapters include:

1. A list of organizations that participate in the social marketing campaign, *Take Charge of Your Health (TCOYH)*. The TCOYH campaign includes text and graphic messages that are included on materials used internally and externally in their companies and organizations.
2. A strategy to impact policy through grassroots efforts.
3. A list of programs and contact resources pertaining to many chronic diseases for all age groups, including a focus on racial and ethnic populations that are disproportionately affected by certain diseases and risk factors.

We hope the reader finds this information helpful, and, on behalf of G-PAN, invite all interested parties to join and participate in the G-PAN coalition. This state plan is intended to serve as a starting point for change through collaboration. It is a fluid document, with the ability to change and grow as new partners and opportunities are identified. Please take a moment to visit the G-PAN website at www.g-pan.org and inform us of your interest in learning more about becoming part of this movement. This is the

Figure 1. Cardiovascular disease death rates in Georgia and the United States, 1980–1999

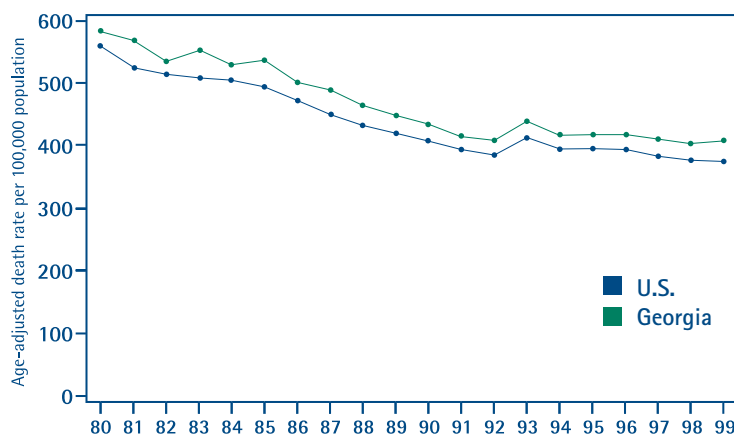


Figure 2. Cardiovascular disease death rates in Georgia by race and sex, 1999

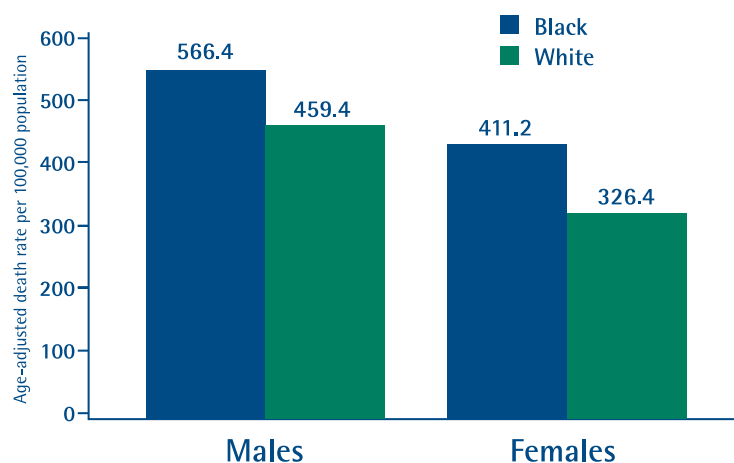
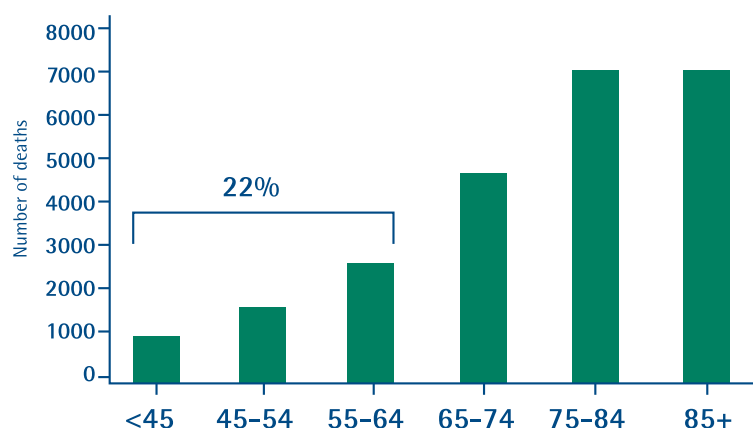


Figure 3. Cardiovascular disease deaths in Georgia by age group, 1999



“In nature, there are neither rewards nor punishments, there are only consequences.” — Robert Ingersoll

first edition of the state plan. Subsequent editions will reflect new partners and new opportunities in addition to reporting progress.

The Victoria Declaration's recommendation #6 implies that curbing marketing of unhealthy foods and behaviors to children and youth should be a priority. It appears that this has not occurred. In a market driven society, fast food restaurants would sell carrot sticks all day long, if we, the consumers, would buy them. Instead of seeing fast food restaurants as the scourge of "super size," why not engage them in a national effort to introduce children to healthier foods? For example, the "Healthy Meal" could offer carrot sticks with dips, and even a mini order of fries. A "Healthy Meal" could contain the most valued toys, and could even be sold at a lower price than the traditional fare. Additionally, a national policy to give equal television airtime to healthy lifestyle issues might be put in place (appealing to the ethics and integrity of the industry).

Our tobacco policy-change colleagues have taught us that media exists in four areas: advocacy, public relations, advertising, and social marketing. All four areas should be addressed. We need to advocate on a large scale, for livable, walkable communities. Public health needs to be promoted as an integral

part of a viable community in a public relations campaign that dispels the idea that it exists only to serve the needy. We need to advertise parks, trails, walking clubs, and recreation facilities. Social marketing messages should be designed by the target audience and be clear, unambiguous, and simple.

Education to develop advocacy skills for health professionals, as well as citizens, is needed to effectively work with local governments in land use planning. A tool-box to assist the public to initiate contact and work with regional planning commissions, departments of transportation, state, and local government is needed. There is momentum among state governors to support livable communities. Former Governor of Georgia, The Honorable Roy Barnes, reported the Chambers of Commerce are insistent that to continue healthy economic growth, barriers in the banking and lending institutions and barriers to "smart growth" must be overcome. (Remarks made at the Georgia Tech SMARTRAQ conference, October 2001). Bottom-up, grassroots movements to change are required and so are top-down approaches. Both contribute to forge the political will.

Promoting Better Health for Young People Through Physical Activity and Sports, A Report to the President from the Secretary of Health and Human

Services and the Secretary of Education, Fall 2000, suggests it is time to re-examine our values, place a higher priority on health and the importance of family. Today, the pentacle of success (and perceived happiness) is seen not just as financial security, but is measured in terms of faster cars, more exotic vacations, bigger houses, more possessions, a bigger bargain. Americans are so successful in this regard that we have lavished ourselves with amenities not dreamed possible even 50 years ago. We serve ourselves with entertainment through television, video games, computer communications; microwave ovens, and independent transportation, all of which have contributed to a sedentary lifestyle and poor food choices. Our system of government is driven by what society is willing to purchase, and so the challenge is to plant and grow the desire to purchase and invest in what is healthy for us as individuals, and for society, collectively. This includes re-thinking how the disenfranchised (the poor, the immigrant, ethnically disadvantaged) are valued and invested in. Ethnic and racial minorities, and the economically disadvantaged must be considered as a part of the fabric of change, not as an "add-on".

Familiar examples of policy and environmental changes include: the addition of fluoride to drinking water to prevent tooth decay, addition of iodine

to salt to combat widespread cases of goiter, regulations controlling purchase and use of tobacco products in public places, such as airplanes and restaurants. Changes in policies and environments to support the common good can be seen throughout history. Personal hygiene, including bathing, oral hygiene, hand washing and use of antiseptics in medical practice are examples that have saved thousands, if not millions of lives.

In 1900, the average life expectancy was age 40. In 2003, we have almost doubled that to 77 years. This increased longevity is accompanied by an increase in chronic diseases, cardiovascular disease (heart attack and stroke) being the most devastating. The three major risk factors for cardiovascular disease are: sedentary lifestyle (lack of regular physical activity), poor nutrition choices, and tobacco use. These risk factors are termed causes of "preventable death" or "premature death." We choose to avoid physical activity, not eat wholesome foods, and use tobacco. It follows logically, then, that we may choose to walk regularly (exercise daily), eat "5-A-Day" (fruits and vegetables), and not indulge in the use of tobacco products. The health of the nation depends on our personal choices.

Some initiatives worthy of inclusion and focus to assist in forging the political will and changing the landscape of the nation include:

- Gain a better understanding of the market forces at work in the current healthcare system.
- Promote public health as an essential stakeholder in community development and planning.
- Develop policy strategies to stabilize the healthcare system and increase access to care for the under and uninsured.
- Support a national mandate requiring employers to provide for health screening including blood pressure, blood glucose, and cholesterol as part of any basic benefits package.
- Teach health professionals and citizens the benefit of working constructively with local county commissions and city councils to develop "smart growth." Develop strategies that are specific and focused on the decision maker to implement policies that support healthier communities in all settings.
- Work with the Georgia Recreation and Parks Association to underscore the significance of health and the need for maximizing opportunities provided by the GRPA to engage in physical activity in the community. Georgia has several pilot sites for the Hearts 'N' Parks project sponsored by the National Heart, Lung, and Blood Institute (NHLBI), the National Parks and Recreation Association, and the American Dietetic Association.
- Align with and support the National Governor's Association initiative "Principles for Better Land Use Policy" to promote livable communities.
- Support the intent of the newly mandated School Councils to involve business industry to invest in the schools, and to focus on academic excellence.
- Ensure that health and fitness are recognized as an essential component of academic excellence.
- Collaborate internally and externally to create statewide media campaigns that employ the four media segments: advocacy, public relations, advertising, and social marketing.

Worksite

Create policy and environmental changes that focus on healthy lifestyles and prevention of chronic diseases.

Worksite

Worksite health promotion programs are designed to identify and reduce health risks and assist employees in developing and maintaining good health habits. Not only does the employer benefit from reduced healthcare costs, a good worksite health promotion program can attract new employees and retain current ones.

There has been very little, if any, data gathered regarding worksite health promotion in Georgia. In 2002, the first Georgia Worksite Health Promotion Policies and Practices Survey was conducted. Adapted from the 1999 National Worksite Health Promotion Survey, it consisted of 69 questions relating to worksite policies, environments, and programs affecting the physical activity, nutrition, and smoking practices of Georgia workers. Topics addressed include: screenings, health-related education or behavior change programs, disease management programs, worksite opportunities for physical activity, healthy eating opportunities at the worksite, smoking policies, and funding of worksite health promotion programs.

The 2002 survey was conducted on worksites with 15 or more employees. Public sector employers and both public and private schools were excluded from the sample. A stratified random sample of worksites was drawn based on the number of employees and industry type. Telephone interviews were conducted with the human resources or employee health directors at the selected worksites. A total of 1,085 interviews were completed and the data were weighted so that each stratum represented its true proportion in the worksite population. According to the 2000 Census data, 95 percent of Georgia companies employ fewer than 100 people.

Efforts are currently underway by the Cardiovascular Health Initiative to evaluate Georgia businesses who have successfully implemented worksite health promotion activities. Several businesses have agreed to allow in-depth analysis of the economic impact of worksite health promotion. The data collected will be used to develop new programs and modify existing ones.



“A wise person should realize that their health is their most valuable possession.” — Hippocrates

HEALTHY PEOPLE 2010 OBJECTIVES RELATED TO WORKSITE

- 1-1 Increase the proportion of persons with health insurance.
- 7-5 Increase the proportion of worksites that offer a comprehensive employee health promotion program to their employees.
- 7-6 Increase the proportion of employees who participate in employer-sponsored health promotion activities.
- 19-16 Increase the proportion of worksites that offer nutrition or weight management classes or counseling.
- 20-9 Increase the proportion of worksites employing 50 or more persons that provide programs to prevent or reduce employee stress.
- 22-13 Increase the proportion of worksites offering employer-sponsored physical activity and fitness program.

Assess, analyze, develop, implement, and evaluate worksite wellness initiatives in all 19 public health districts. Provide services to 500 worksites by 2007.

STRATEGY

Strategy 1.1: Inform worksite decision makers about the benefits of worksite wellness.

Strategy 1.2: Develop resources to promote worksite wellness by 2003.

Strategy 1.2.1: Develop a Power Point presentation to be used by committee members, other interested coalition members, and partners to highlight successful worksite wellness initiatives in Georgia and to demonstrate the effectiveness of worksite wellness programs.

Strategy 1.2.2: Train public health staff and external partners to deliver the Power Point presentation and engage worksite decision makers in wellness assessment.

Strategy 1.2.3: Provide Power Point presentation for business and professional groups (such as Chambers of Commerce, Society of Human Resource Managers, service/community organizations, business trade shows/training events) to promote worksite wellness as a means to decrease healthcare costs, decrease employee turnover, and improve job satisfaction.

Strategy 1.3: Promote worksite wellness by way of local television appearances by public health officials and designated spokespersons.

Strategy 1.4: Promote cardiovascular health through articles to be placed in company and subscriber member newsletters.

Strategy 1.5: Develop a web-based resource guide for worksite wellness as a part of the G-PAN website.

Strategy 1.6: Encourage insurance providers to include health promotion/disease prevention as a covered service.

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DECISION MAKERS

CVHI

TARGET GROUP/RECIPIENT POPULATION

Employers, insurance providers

Conduct, analyze, and report Georgia Worksite Health Promotion Policies and Practices of 2002.

CONVENER

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TARGET GROUP/RECIPIENT POPULATION

Worksite administrators

STRATEGY

Strategy 2.1: Develop survey.

Strategy 2.2: Identify a random selection of worksites representative of all Georgia worksites.

Strategy 2.3: Conduct the survey by using a phone survey system of identified sites.

Strategy 2.4: Analyze the findings of the survey to identify patterns of worksite wellness indicators.

Strategy 2.5: Report and publish the findings distributing to internal and external partners.

Strategy 2.6: Repeat the survey in 2007 to determine changes from the baseline data.

Increase the proportion of employees who participate in employer-sponsored health promotion activities. A 20% increase over baseline will occur in half of the worksite locations for whom the Georgia Worksite Wellness Tool is conducted. Locations to include: public health districts, public health clinics, hospital staff, school staff, all strata and size of worksite operations (factories, offices, universities).

STRATEGY

Strategy 3.1: Implement the Georgia Worksite Wellness Assessment Tool at worksites.

Strategy 3.1.1: Train public health staff, occupational health nurses, and partners in use of the Georgia Worksite Wellness Assessment Tool.

Strategy 3.1.2: Provide expert consultation, technical assistance, and resources to the CDPI District Coordinators, and individual worksites on the recommendation of the CVHI Director.

Strategy 3.1.2.1: Work with college student interns to conduct worksite assessments.

Strategy 3.2: Conduct follow-up assessment to determine environmental, policy, and behavior changes.

Strategy 3.3: Support public health districts through mini-grant opportunities, training, and technical assistance to engage worksites in policy and environmental changes.

Strategy 3.4: Increase awareness of heart disease and stroke.

Strategy 3.4.1: Pair Cooperative Extension Service, American Heart Association, other supervised educators, and other partners to provide education to worksites.

Strategy 3.4.1.1: Train worksites to respond to heart attacks.

Strategy 3.4.1.2: Encourage business to place automated external defibrillator programs at worksite.

CONVENERS

Chronic Disease Prevention Initiative (CDPI) Worksite Wellness Coordinator; Cardiovascular Health Initiative (CVHI); Health Navigators, Inc.; CDPI District Coordinators (Northwest Health District, North Georgia Health District, North Health District, Cobb/Douglas Health District, Fulton Health District, Clayton Health District, LaGrange Health District, South Central Health District, North Central Health District, West Central Health District, South Health District, Southwest Georgia Health District, East Health District, Southeast Health District, Coastal Health District, Northeast Health District); Kaiser Permanente

KEY PARTNERS

Georgia Coalition for Physical Activity and Nutrition (G-PAN); National Association for Health and Fitness; Occupational Health Nurses Association; America Heart Association – Southeast Affiliate; Georgia Cooperative Extension Service; Wellness Professionals of Atlanta (WPA); Kids' Health, Inc.; Division of Aging Services; Diabetes Prevention and Control Program; Asthma Program

DECISION MAKERS

Worksite administrators

TARGET GROUP/RECIPIENT POPULATION

Employees, employers, and insurance providers

WORKSITE OBJECTIVE 3 (continued)

Strategy 3.4.1.3: Include procedure for dialing 911 as part of staff training and orientation.

Strategy 3.5: Link Georgia Coalition for Physical Activity and Nutrition (G-PAN) partners, including the Cooperative Extension Service, to interested worksites to facilitate the provision of physical activity programs, classes in weight and stress management, cardiopulmonary resuscitation (CPR) and other health related education opportunities.

Strategy 3.5.1: Inform Occupational Health Nurses about partnering with G-PAN to promote wellness activities at the worksite.

Strategy 3.6: Develop a Retired Associate Wellness Committee at worksites employing more than 500 employees to help decrease healthcare costs of retired employees.

Strategy 3.7: Utilize Kids' Health to encourage participation in worksite wellness activities by the school faculty and staff following the health appraisals administered by Kids' Health staff.

Strategy 3.8: Promote insurance provider sponsorship of worksite health promotion activities.



Place policies, mission statements, and incentives that support individual wellness for staff in 20% of worksites participating in health promotion activities related to cardiovascular health by 2006.

STRATEGY

Strategy 4.1: Attain, develop, and have available policies, mission statements, and incentive prototypes for worksites and insurance providers.

Strategy 4.1: Provide assessment, consultation, and evaluation support to company policy makers through the CDPI District Coordinators, state level staff, and worksite experts through arrangement with the CVHI Director.

Strategy 4.2: Collaborate with Kids' Health to provide assessment, consultation, and evaluation support to company policy makers through the CDPI District Coordinators.

Strategy 4.3: Track progress and report.

CONVENER

Cardiovascular Health Initiative (CVHI); Health Navigators, Inc.; Chronic Disease Prevention Initiative (CDPI) District Coordinators (Northwest Health District, North Health District, Cobb/Douglas Health District, LaGrange Health District, West Central Health District, South Health District, Southwest Georgia Health District, East Health District, Southeast Health District, Coastal Health District, Northeast Health District)

KEY PARTNERS

Diabetes Prevention and Control Program; Occupational Health Nurses; Kids' Health, Inc.; American Heart Association - Southeast Affiliate; GPAN-Worksite Committee; Wellness Professionals of Atlanta (WPA); worksite wellness associations (America Association for Active Lifestyles and Fitness, American College of Sports Medicine, Association for Worksite Health Promotion, Health Enhancement Research Organization, National Wellness Institute, Society for Prospective Medicine, Washington Business Group on Health, Wellness Council of America, and Wellness Council of America)

DECISION MAKERS

Worksite administrators

TARGET GROUP/RECIPIENT POPULATION

Employees, employers, insurance

Promote park usage at worksites that are within walking distance. Park promotion will be included in 100% of interventions undertaken by the Cardiovascular Health Initiative (CVHI), the Chronic Disease Prevention Initiative (CDPI), and Health Navigators, Inc.

CONVENERS

Georgia Recreation and Parks Association; Kaiser Permanente; CDPI District Coordinators (Northwest Georgia Health District, North Health District, Cobb/Douglas Health District, Fulton Health District, Clayton County Health District, LaGrange Health District, West Central Health District, South Health District, South Central Health District, Southwest Georgia Health District, East Health District, Southeast Health District, Coastal Health District, Northeast Health District); Health Navigators, Inc.

KEY PARTNERS

Diabetes Prevention and Control Program, Asthma Program, public health staff, insurance providers, worksite decision makers, worksite employees, CVHI

DECISION MAKERS

Worksite administrators

TARGET GROUP/RECIPIENT POPULATION

Employees

STRATEGY

Strategy 5.1: Identify parks and recreation sites and distribute to Conveners by 2005.

Strategy 5.2: Pair Kaiser Permanente with Recreation and Parks Association to promote park usage at nearby parks and recreation facilities.

Strategy 5.2.1: With Kaiser, create an evaluation tool that documents park usage for application at other provider groups.

Strategy 5.3: Identify other worksites and provider groups to participate in this initiative.

Strategy 5.4: Identify activities appropriate for use by worksites to be implemented at recreation and parks facilities, such as 20% Boost and Take Charge Challenge.

Strategy 5.5: Collaborate with designated Hearts N' Parks sites to provide health promotion opportunities.

Healthcare

Promote a healthcare system that is equitable, responsible, affordable, competent, and that provides quality medical care for all Georgia residents with a shift from a focus on disease management to prevention.

Healthcare

The healthcare system in America is facing a crisis. Costs are spiraling out of control with an annual average national increase of nearly 20 percent. Employers and insurers have responded by increasing deductible amounts for treatment, decreasing benefits, and passing more of the premium cost on to the employee. While this provides a temporary fix, it also creates additional problems. The real solution is to focus on early detection and prevention of costly chronic diseases. Tommy Thompson, Secretary of Health and Human Services, recently declared his support of this approach. By making people aware of their individual risk factors for cardiovascular disease, we can help them make positive lifestyle changes. Such changes can prevent or significantly delay health problems as well as improve quality of life.

There are models in Georgia that prove this approach works. Fieldale Farms, headquartered in Baldwin, Georgia, is a poultry industry leader which has maintained its annual healthcare cost per employee at \$2,550 per year since 1992. (The current national average exceeds \$5,000 per year and the annual cost in Georgia was \$5,024 in 2001.) This company of 4,200 employees has achieved this success in part by targeting employees most at risk for cardiovascular disease. Annual screenings for blood pressure, blood glucose, and high cholesterol can determine which employees need focused attention and follow-up. Follow-up includes education regarding nutrition and physical activity as well as medical intervention for high blood pressure, diabetes, and heart disease where needed. Annual stress tests are provided free of charge to participants who are at high risk or who have a history of cardiac problems. In addition to maintaining low healthcare costs, plant productivity remains high. Health screenings account for less than 2 percent of the total company healthcare costs.

Robert Brubaker, CEO for the King and Prince Seafood Company in Brunswick, Georgia, says, "Our most valuable asset is our employees." The company employs approximately 450 people and provides an on-site clinic where they can be screened for risk factors associated with cardiovascular and other chronic diseases. Employees have access to the clinic during the working day and do not have to clock out when they have an appointment. The rate of hypertension control for this plant exceeds the national average. Negative birth outcomes dropped from 32 percent to 8 percent by the end of the clinic's second year in operation. Productivity is high and turnover is low. After the clinic had been open for only two years, healthcare costs had dropped so significantly that the employee contribution was suspended for one month.

If the healthcare system were to adopt the philosophy that an ounce of prevention is worth a pound of cure, significant progress could be made in reducing costs and improving the health of Americans. A national mandate requiring that employee benefits packages include screenings for blood pressure, blood glucose, and elevated cholesterol would provide people with valuable information about their health which could lead to a reduction in healthcare costs. The resulting savings would allow companies to expand screening for cancers and other chronic diseases while maintaining or even lowering healthcare costs – a solution which benefits everyone.

*“He who has health has hope, and he who has hope has everything.”
— Arabian proverb*

HEALTHY PEOPLE 2010 OBJECTIVES RELATED TO HEALTHCARE

Access to Healthcare

- 1-1 Increase the proportion of persons with health insurance.
- 1-2 Increase the proportion of insured persons with coverage for clinical prevention services.
- 1-3 Increase the proportion of persons appropriately counseled about health behaviors.
- 1-4 Increase the proportion of persons who have a specific source of ongoing care.
- 1-5 Increase the proportion of persons with a usual primary care provider.
- 1-7 Increase the proportion of schools of medicine, schools of nursing, and other health professional training schools whose basic curriculum for health care providers includes the core competencies in health promotion and disease prevention.
- 1-11 Increase the proportion of persons who have access to rapidly responding pre-hospital emergency medical services.

Cardiovascular Disease and Stroke and Heart Attack Prevention Program (SHAPP)

- 12-1 Reduce coronary heart disease deaths.
- 12-2 Increase the proportion of adults aged 20 years and older who are aware of the early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911.
- 12-4 Increase the proportion of adults aged 20 years and older who call 911 and administer cardiopulmonary resuscitation (CPR) when they witness an out-of-hospital cardiac arrest.
- 12-5 Increase the proportion of eligible persons with witnessed out-of-hospital cardiac arrest who receive their first therapeutic electrical shock within six minutes after collapse recognition.
- 12-7 Reduce stroke deaths.
- 12-8 Increase the proportion of adults who are aware of the early warning symptoms and signs of a stroke.
- 12-9 Reduce the proportion of adults with high blood pressure.
- 12-10 Increase the proportion of adults with high blood pressure whose blood pressure is under control.
- 12-11 Increase the proportion of adults with high blood pressure who are taking actions (for example, losing weight, increasing physical activity, or reducing sodium intake) to help control their blood pressure.
- 12-12 Increase the proportion of adults who have had their blood pressure measured within the preceding two years and can state whether their blood pressure was normal or high.
- 12-13 Reduce the mean total blood cholesterol levels among adults.
- 12-14 Reduce the proportion of adults with high total blood cholesterol levels.
- 12-15 Increase the proportion of adults who have had their blood cholesterol checked within the preceding five years.
- 12-16 Increase the proportion of persons with coronary heart disease who have their LDL cholesterol level treated to a goal of less than or equal to 100 mg/dl.
- 19-1 Increase the proportion of adults who are at a healthy weight.

“It is bad enough that a man should be ignorant, for this cuts him off from the commerce of other men’s minds. It is perhaps worse that a man should be poor, for this condemns him to a life of stint and scheming, in which there is no time for dreams and no respite from weariness. But what surely is worse is that a man should be unwell, for this prevents his doing anything about either his poverty or his ignorance.” — George Herbert Tinley Kimble

Diabetes

- 5-1 Increase the proportion of persons with diabetes who receive formal-diabetes education.
- 5-2 Prevent diabetes (target 2.4 new cases per 1,000 population/year).
- 5-3 Reduce the overall rate of diabetes that is clinically diagnosed.
- 5-4 Increase the proportion of adults with diabetes whose conditions have been diagnosed.
- 5-5 Reduce the diabetes death rate (target 45 deaths per 100,000 populations).
- 5-6 Reduce diabetes-related deaths among persons with the diabetes.
- 5-7 Reduce deaths from cardiovascular disease in persons with diabetes.
- 5-12 Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement at least once a year.
- 5-13 Increase the proportion of adults with diabetes who have an annual dilated eye examination.
- 5-14 Increase the proportion of adults with diabetes who have at least one annual foot examination.
- 5-15 Increase the proportion of persons with diabetes who have at least an annual dental examination.
- 5-16 Increase the proportion of adults with diabetes who take aspirin at least 15 times per month.
- 5-17 Increase the proportion of adults with diabetes who perform self-blood-glucose monitoring at least once daily.
- 23-17 Increase the proportion of persons with diabetes who obtain an annual urinary microalbumin measurement.

Osteoporosis

- 1-3 Increase the proportion of persons appropriately counseled about health behaviors.
- 2-9 Reduce the proportion of adults with osteoporosis.
- 2-10 Reduce the proportion of adults who are hospitalized for vertebral fractures associated with osteoporosis.
- 19-11 Increase the proportion of persons aged two years and older that meet dietary recommendations for calcium.
- 22-4 Increase the proportion of adults who perform physical activities that enhance and maintain muscular strength and endurance.

“We need to move from a health care system that treats disease to one that avoids disease.”
— Tommy Thompson, Secretary of Health and Human Services

HEALTHY PEOPLE 2010 OBJECTIVES RELATED TO HEALTHCARE (cont.)

Tobacco

- 27-1 Reduce tobacco use by adults.
- 27-2 Reduce tobacco use by adolescents.
- 27-3 Reduce the initiation of tobacco use among children and adolescents.
- 27-4 Increase the average age of first use of tobacco products by adolescents and young adults.
- 27-5 Increase smoking cessation attempts by adult smokers.
- 27-6 Increase smoking cessation during pregnancy.
- 27-7 Increase tobacco use cessation by adolescent smokers.
- 27-8 Increase insurance coverage of evidence-based treatment for nicotine dependency.
- 27-9 Reduce the proportion of children who are regularly exposed to tobacco smoke at home.
- 27-10 Reduce the proportion of non-smokers exposed to environmental tobacco smoke.
- 27-11 Increase smoke-free and tobacco-free environments in schools, including all school facilities, property vehicles, and school events.
- 27-12 Increase the proportion of worksites with formal smoking policies that prohibit smoking or limit it to separately ventilated areas.
- 27-13 Establish laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in public places and worksites.
- 27-14 Reduce the illegal sales rate to minors through enforcement of laws prohibiting the sale of tobacco products to minors.
- 27-16 Eliminate tobacco advertising and promotions that influence adolescents and young adults.
- 27-19 Eliminate laws that preempt stronger tobacco control laws.
- 27-21 Increase the State tax on tobacco products.

Physical Activity

- 22-1 Reduce the proportion of adults who engage in no leisure-time physical activity.
- 22-2 Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.
- 22-3 Increase the proportion of adults who engage in vigorous physical activity that promotes the development and maintenance of cardio-respiratory fitness three or more days per week for 20 or more minutes per occasion.
- 22-4 Increase the proportion of adults who perform physical activities that enhance and maintain muscular strength and endurance.
- 22-5 Increase the proportion of adults who perform physical activities that enhance and maintain flexibility.
- 22-6 Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on five or more of the previous seven days.
- 22-7 Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardio-respiratory fitness three or more days per week for 20 or more minutes per occasion.
- 22-8 Increase the proportion of the public and private schools that require daily physical education for all students.
- 22-9 Increase the proportion of adolescents who participate in daily school physical education.
- 22-10 Increase the proportion of adolescents who spend at least 50% of school physical education class time being physically active.
- 22-11 Increase the proportion of adolescents who view television two or fewer hours on a school day.
- 22-14 Increase the proportion of trips made by walking.
- 22-15 Increase the proportion of trips made by bicycling.

*“People don’t decide their future; they decide their habits.
It’s their habits that decide their future.” — Unknown*

Arthritis

- 2-2 Reduce the proportion of adults with chronic joint symptoms who experience a limitation in activity due to arthritis.
- 2-3 Reduce the proportion of all adults with chronic joint symptoms who have difficulty in performing two or more personal care activities, thereby preserving independence.
- 2-4 Increase the proportion of adults aged 18 years and older with arthritis who seek help in coping if they experience personal and emotional problems.
- 2-5 Increase the employment rate among adults with arthritis in the working-aged population.
- 2-7 Increase the proportion of adults who have seen a health care provider for their chronic joint symptoms.
- 2-8 Increase the proportion of persons with arthritis who have had effective, evidence-based arthritis education as an integral part of the management of their condition.
- 23-17 Increase the mean number of days without severe pain among adults who have chronic joint symptoms.

Cancer

- 3-3 Reduce the breast cancer death rate.
- 3-4 Reduce the death rate from cancer of the uterine cervix.
- 3-7 Reduce the prostate cancer death rate.
- 3-11 Increase the proportion of women who receive a Pap test.
- 3-13 Increase the proportion of women aged 40 years and older who have received a mammogram within the preceding two years.
- 19-5 Increase the proportion of persons aged 2 years and older who consume at least two daily servings of fruit.
- 19-6 Increase the proportion of persons aged 2 years and older who consume at least three daily servings of vegetables, with at least one third being dark green or orange vegetables.
- 19-8 Increase the proportion of persons aged 2 years and older who consume less than 10% of calories from saturated fat.
- 19-9 Increase the proportion of persons aged 2 years and older who consume no more than 30% of calories from total fat.

Health Data

- 23-4 Increase the proportion of population-based Healthy People 2010 objectives for which national data are available for all population groups identified for the objective.
- 23-5 (Developmental) Increase the proportion of Leading Health Indicators, Health Status Indicators, and Priority Data Needs for which data – especially for select populations – are available at the tribal, state, and local levels.
- 23-6 Increase the proportion of Healthy People 2010 objectives that are tracked regularly at the national level.
- 23-7 Increase the proportion of Healthy People 2010 objectives for which national data are released within one year of the end of data collection.
- 23-9 (Developmental) Increase the proportion of schools for public health workers that integrate into their curricula specific content to develop competency in the essential public health services.
- 23-15 (Developmental) Increase the proportion of federal, tribal, state, and local jurisdictions that review and evaluate the extent to which their statutes, ordinances, and bylaws assure the delivery of essential public health services.
- 23-17 (Developmental) Increase the proportion of federal, tribal, state, and local public health agencies that conduct or collaborate on population-based prevention research.

Develop a collaborative network to oversee the implementation of the Healthcare segment of the State Plan by 2004.

CONVENERS

Cardiovascular Health Initiative (CVHI); Health Navigators, LLC.; American Heart Association; American Stroke Association

KEY PARTNERS

Georgia Medical Care Foundation; Stroke and Heart Attack Prevention Program (SHAPP); Diabetes Prevention and Control Program; Asthma Program; Center for Health Services Research at Georgia State University; Kaiser Permanente; Fulton County Racial and Ethnic Approaches to Community Health (REACH); Atlanta Community Access Coalition; Georgia Academy of Family Practice; Georgia Hospital Association; Southeast Cluster Health Disparities Collaborative; Medical Association of Georgia; hospitals hosting continuing medical education meetings for practitioners; Association of Black Cardiologists; Georgia General Assembly; Emergency Medical Services; Georgia Association for Primary Health Care; Department of Community Health; CVHI; Emory University School of Medicine; Piedmont Hospital; St. Joseph's Hospital

DECISION MAKERS

Oversight group led by CVHI and medical partners/contractors

TARGET GROUP/RECIPIENT POPULATION

Conveners and key partners listed above

STRATEGY

Strategy 1.1: Convene the collaborative network to determine methods of oversight and communications.

Strategy 1.1.1: Identify key conveners for all objectives including evaluators, public health experts, and medical practitioners.

Strategy 1.1.2: Establish time lines.

Strategy 1.1.3: Set meeting schedule and agreed upon methods of communication.

Increase the control rate of hypertensive patients participating in the Stroke and Heart Attack Prevention Program (SHAPP) by 10% in 2006.

STRATEGY

Strategy 2.1: Determine best-practices methods in the SHAPP program and make recommendations.

Strategy 2.1.1: Conduct a CDC-funded best practices study in 2004.

Strategy 2.1.1.1: Analyze and report findings.

Strategy 2.1.1.2: Develop protocol based on best practices.

Strategy 2.1.1.2.1: Publish and distribute to other cardiovascular programs.

Strategy 2.1.2: Refine data collection instrument for SHAPP being developed by Epidemiology Branch.

Strategy 2.1.2.1: Establish baseline data collected by SHAPP in 2004.

Strategy 2.1.2.2: Repeat SHAPP data collection using tool in 2007.

Strategy 2.2: Educate the public and medical practitioners on importance of treatment and control of hypertension.

Strategy 2.3: Promote screening for hypertension in worksites, schools, healthcare settings, faith communities, and other settings as identified; provide network for follow-up and treatment.

Strategy 2.3.1: Develop an evaluation tool to identify the number of people screened at all settings.

Strategy 2.4: Work with community groups to advocate for a national mandate requiring provider organizations to include screening for hypertension as a part of all basic benefits packages.

CONVENERS

Stroke and Heart Attack Prevention Program (SHAPP); American Heart Association; American Stroke Association; Georgia Medical Care Foundation; Cardiovascular Health Initiative (CVHI); Emergency Medical Service (EMS) organizations

Key Partners

Fulton County Racial and Ethnic Approaches to Community Health (REACH); Atlanta Community Access Coalition; Georgia Academy of Family Practice; Georgia Hospital Association; Southeast Cluster Health Disparities Collaborative; Medical Association of Georgia; hospitals hosting Continuing Medical Education meetings for practitioners; Association of Black Cardiologists; Georgia General Assembly; EMS organizations; Georgia Association for Primary Health Care; Department of Community Health

DECISION MAKERS

CVHI, SHAPP, Epidemiology

TARGET GROUP/RECIPIENT POPULATION

SHAPP patients

HEALTHCARE OBJECTIVE 2 (continued)

Strategy 2.5: By 2004, identify baseline data sources, in addition to SHAPP tool, to define hypertensive rates.

Strategy 2.5.1: Potential sources for Medicaid and Medicare data include the Georgia Medicare Care Foundation.

Strategy 2.6: Create policies and practices that facilitate adults with high blood pressure to take action (by losing weight, increasing physical activity, or reducing sodium intake) to help control their blood pressure.



Strategy 2.6.1: Prescribe physical activity for adults with high blood pressure.

Strategy 2.6.2: Prescribe healthy weight achievement and maintenance plans.

Strategy 2.6.3: Incorporate healthy lifestyle practices for people with hypertension into community, worksite, and health care settings.

Strategy 2.7: Create policies and practices that facilitate low-cost, easy to access opportunities for adults to have their blood pressure checked.

Strategy 2.7.1: Prescribe blood pressure measurements based on American Heart Association recommendations.

Strategy 2.7.2: Provide opportunities for blood pressure measurements such as fire stations, health department clinics, faith community outreach, senior citizen centers, community centers.

Strategy 2.7.3: Educate adults so they can state whether their blood pressure was normal or high.

Decrease time lapse between 911 stroke or heart attack emergency call and delivery of patient to medical facility.

STRATEGY

Strategy 3.1: Collaborate with emergency medical service (EMS) organizations to assess and determine course of action.

Strategy 3.1.1: Develop or access database by 2004 to determine current response time to establish goals and objective to be achieved.

Strategy 3.1.2: Consult with EMS organizations to develop effective strategies.

Strategy 3.1.2.1: Identify barriers and opportunities for improving response time.

Strategy 3.1.2.2: Develop training for first responders.

Strategy 3.1.3.3: In collaboration with community partners, educate the public about the importance of placing the 911 call at the earliest sign of symptoms.

Strategy 3.2: Collaborate with partners to increase the proportion of adults aged 20 years and older who are aware of the early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911.

Strategy 3.3: Collaborate with partners to increase the proportion of people who call 911 and administer cardiopulmonary resuscitation (CPR) when they witness an out-of hospital cardiac arrest.

Strategy 3.4: Collaborate with partners to increase CPR knowledge.

Strategy 3.4.1: Collaborate with schools to include CPR into the 8th grade curriculum.

Strategy 3.4.2: Collaborate with worksites to include CPR into worksite health promotion programs.

CONVENERS

Cardiovascular Health Initiative (CVHI); American Heart Association; American Stroke Association; Georgia Medical Care Foundation; Stroke and Heart Attack Prevention Program (SHAPP), Emergency medical service (EMS) organizations; Health Navigators, Inc.

KEY PARTNERS

Epidemiology Branch; Georgia State University; Kaiser Permanente; Fulton County Racial and Ethnic Approaches to Community Health (REACH); Atlanta Community Access Coalition; Georgia Academy of Family Practice; Georgia Hospital Association; Southeast Cluster Health Disparities Collaborative; Medical Association of Georgia; hospitals hosting continuing medical education meetings for practitioners; Association of Black Cardiologists; Georgia General Assembly; EMS organizations; Georgia Association for Primary Health Care; Department of Community Health; nursing associations; CVHI

DECISION MAKERS

Oversight group led by CVHI and designees

TARGET GROUP/RECIPIENT POPULATION

Medical providers, EMS organizations, households with an emergency

Establish a monitoring and data collection system to determine level of care currently being provided to patients with cardiovascular disease or associated risk factors by 2004.

CONVENERS

Cardiovascular Health Initiative (CVHI); The Center for Health Services at Georgia State University; Epidemiology Branch; American Heart Association; American Stroke Association; Georgia Medical Care Foundation; Stroke and Heart Attack Prevention Program (SHAPP)

KEY PARTNERS

Kaiser Permanente; Fulton County Racial and Ethnic Approaches to Community Health (REACH); Atlanta Community Access Coalition; Southeast Cluster Health Disparities Collaborative; hospitals hosting continuing medical education meetings for practitioners; Association of Black Cardiologists

DECISION MAKERS

CVHI

TARGET GROUP/RECIPIENT POPULATION

Patients with cardiovascular disease or associated risk factors

STRATEGY

Strategy 4.1: Monitor secondary prevention services to determine level of care provided.

Strategy 4.1.1: Work with consultants to develop a survey to establish a baseline for the policies of health plans regarding primary and secondary prevention of cardiovascular disease and Health Plan Employer Data and Information Set (HEDIS) measures.

Strategy 4.1.1.1: For primary and secondary prevention, determine if reimbursement is being made for counseling regarding physical activity, nutrition, and tobacco use prevention. Also determine if a policy is in place for cardiovascular health treatment and care consistent with the American Heart Association's *Get With the Guidelines* program.

Strategy 4.1.1.2: Determine the compliance rate of health plans with cardiovascular disease HEDIS indicators.

Strategy 4.1.1.3: Analyze and report data.

Strategy 4.2: Support and utilize data from the Coverdell Stroke Registry.

Strategy 4.2.1: Support quality improvement opportunities identified by analysis of Registry data.

Educate health and medical care providers on best treatment practices in stroke and heart attack interventions, diabetes control, and asthma control based on current research. Provide 12 presentations to medical groups by July 2004 and 24 presentations between August 2004 and July 2005.

STRATEGY

Strategy 5.1: Implement research-based best practice guidelines, such as the American Heart Association and American Stroke Association's *Get With the Guidelines* program.

Strategy 5.1.1: Provide resources to medical care providers.

Strategy 5.1.1.1: Develop and present training events and information links for providers.

Strategy 5.1.1.1.1: Obtain appropriate continuing education units for all trainings.

Strategy 5.1.1.1.2: Determine effective methods of delivery and appropriate content for educating specific providers including those located in remote areas of the state. For example, implement alternate methods such as web-based interactive learning labs, distance trainings, and CDs.

Strategy 5.1.2: Promote researched evidence-based best practices.

Strategy 5.1.2.1: Include cardiopulmonary resuscitation (CPR) and Automated External Defibrillator (AED) use where appropriate.

Strategy 5.1.2.2: Increase awareness of healthcare providers and emergency response teams and emergency room personnel for the need to administer stroke intervention medications within the first three hours of symptoms by 2010.

Strategy 5.2: Follow-up with providers participating in educational initiatives to determine environmental, policy, and behavior/counseling changes.

Strategy 5.2.1: Follow-up will occur four to six months after training.

Strategy 5.2.2: To assure follow-up results, consider use of incentives.

CONVENERS

Cardiovascular Health Initiative (CVHI); Health Navigators, LLC.; American Heart Association; American Stroke Association

KEY PARTNERS

Georgia Medical Care Foundation; Stroke and Heart Attack Prevention Program (SHAPP); Diabetes Prevention and Control Program; Asthma Program; Emergency medical services (EMS) organizations; Kaiser Permanente; Fulton County Racial and Ethnic Approaches to Community Health (REACH); Atlanta Community Access Coalition; Georgia Academy of Family Practice; Southeast Cluster Health Disparities Collaborative; hospitals hosting Continuing Medical Education meetings for practitioners; Association of Black Cardiologists; insurance industry and health maintenance organizations; Department of Community Health; nursing associations

DECISION MAKERS

CVHI

TARGET GROUP/RECIPIENT POPULATION

Medical doctors, collaborative health disparities staff with the Health and Human Services Bureau of Primary Healthcare and the Georgia Association for Primary Health Care

Develop strategies to improve access to care for priority populations including low socioeconomic status (SES), African Americans and Latinos by 2006.

CONVENERS

Southeast Cluster Health Disparities Collaborative; American Heart Association; American Stroke Association; Georgia Medical Care Foundation; Stroke and Heart Attack Prevention Program (SHAPP); Health Navigators, Inc.

KEY PARTNERS

Emory University Rollins School of Public Health Interfaith Health Program Consultants; University of Georgia Heart Nutrition Program; Morehouse School of Medicine (MSM); Kaiser Permanente; Fulton County Racial and Ethnic Approaches to Community Health (REACH); Atlanta Community Access Coalition; Association of Black Cardiologists; Georgia Coalition for Physical Activity and Nutrition (G-PAN); Spring Creek Collaborative; insurance industry and health maintenance organizations; Department of Community Health; Hispanic Health Coalition; Epidemiology; Diabetes Prevention and Control Program; Asthma Program

DECISION MAKERS

Hospital governing boards, insurance industry, health maintenance organizations (HMOs) local health boards, medical care providers, and medical practitioners

TARGET GROUP/RECIPIENT POPULATION

African Americans, Latinos, and persons with low socioeconomic status

STRATEGY

Strategy 6.1: Identify population demographics, services, and barriers to healthcare services for priority populations.

Strategy 6.1.1: Develop an action plan to improve healthcare services for priority populations by 2004.

Strategy 6.1.2: Collaborate with the Georgia Medical Care Foundation, Southeast Cluster Health Disparities Collaborative, and insurance providers to promote prevention strategies for priority populations.

Strategy 6.1.2.1: Collaborate with partners to educate medical caregivers.

Strategy 6.1.2.2: Collaborate with partners to educate priority populations about risk factors, including hypertension, hyperlipidemia, diabetes, tobacco use, poor nutritional intake, and sedentary lifestyle.

By 2005, utilize population-based media strategies (focusing on radio) to increase awareness of sign and symptoms of stroke, heart attack, congestive heart failure, coronary artery disease, and cardiovascular disease risk factors among the providers and targeted priority populations (African Americans, Latinos, and persons with low socioeconomic status).

STRATEGY

Strategy 7.1: Develop a collaborative radio campaign.

Strategy 7.1.1: Include education on healthy blood pressure.

Strategy 7.1.2: Include education on the need for decrease time lapse between 911 stroke or heart attack emergency call and delivery of patient to medical facility.

Strategy 7.1.3: Design campaign to target priority populations using radio stations whose primary audience is African-American or Latino.

Strategy 7.1.3.1: Use spokespersons who are known in the African-American and Latino communities.

Strategy 7.1.4: Utilize company and member newsletters to promote heart health.

Strategy 7.1.5: Utilize professional journal articles to reach providers with best practice information and impart culturally sensitive information to care-givers.

Strategy 7.1.6: Track response of radio and print campaigns.

CONVENERS

Cardiovascular Health Initiative (CVHI); media consultant; Health Promotion Section media coordinator

KEY PARTNERS

American Heart Association; Georgia Medical Care Foundation; Stroke and Heart Attack Prevention Program (SHAPP); Tobacco Use Prevention Section; Cancer Control Section; Kaiser Permanente; Fulton County Racial and Ethnic Approaches to Community Health (REACH); Georgia News Network; Hispanic Health Coalition; Mundo Hispanic Newspaper; Health Navigators; CVHI-appointed spokespersons.

DECISION MAKERS

CHVI; Healthcare Oversight Collaborative Network convened in Objective 1

TARGET GROUP/RECIPIENT POPULATION

Priority populations, readers of trade and professional journals

Increase physician awareness and use of tools and educational interventions to prevent or intervene in unhealthy lifestyle practices for patients and family members across the life cycle.

CONVENERS

Obesity Action Network; Family Health Branch - Nutrition Section; Cardiovascular Health Initiative (CVHI); Epidemiology Branch

KEY PARTNERS

Children's Healthcare of Atlanta; American Academy of Pediatrics - Georgia Chapter; Nutrition Section; Kaiser Permanente-Obesity Project; Centers for Disease Control and Prevention; International Life Sciences Institute; Georgia Coalition for Physical Activity and Nutrition; Medical College of Georgia; Morehouse School of Medicine; University of Georgia; Department of Family and Children's Services; Women, Infants, and Children Program; Diabetes Prevention and Control Program; Asthma Program

DECISION MAKERS

Pediatricians and family practitioners

TARGET GROUP/RECIPIENT POPULATION

Family members and pediatric patients

STRATEGY

Strategy 8.1: Create policies and practices that facilitate interventions for overweight children and family members.

Strategy 8.1.1: Prescribe physical activity for patients.

Strategy 8.1.2: Prescribe diet for patients that is low in fat, high in fiber, and includes fruits and vegetables, such as the DASH diet.

Strategy 8.1.3: Incorporate healthy lifestyle practices in nutrition and physical activity as part of the classroom and practicum curriculum for medical students and allied health professionals.

Strategy 8.1.4: Inform all Georgia physicians regarding use and access to body mass index (BMI) charts.

Strategy 8.1.5: Determine prevalence of risk behaviors and health status in Georgia's middle and high school student population through scientific surveillance in partnership with the Department of Education.

Strategy 8.1.5.1: Obtain Youth Risk Behaviors Survey (YRBS) data.

Strategy 8.1.5.1.1: Analyze and report data.

Strategy 8.1.5.2: Conduct the School Health Education Profile survey in 2002 and 2004.

Strategy 8.1.5.2.1: Analyze and report data.

Community

Increase opportunities for physical activity and improved nutritional choices through changes in policies and the environment.

As America has moved steadily toward automation, the neighborhood of old has been swallowed up by fast moving cars and freeways. Our ability to exercise has been superceded by our desire to meet schedules on timetables that would have been impossible a few years ago. Our ability to choose healthy foods has been subjugated to our need to have instantly prepared foods at a low to moderate cost. These trends have contributed to our sedentary lifestyle and disregard of the idea that healthy foods sustain healthy bodies. Sedentary lifestyle and poor nutritional intake lead to overweight and hypertension that lead to heart disease, stroke, diabetes, cancer, and other chronic illnesses.

In 2001, a mini-grant program was established to support community-related projects. Since the program's inception, grants totaling \$768,285 have been distributed to 70 projects throughout the state. Administered by local public health departments, these grants are used to renovate, improve, enhance, and promote playgrounds, parks, walking trails, sidewalks, and community centers. Our vision is to have parks, schools, churches, and markets that are accessible, connected by sidewalks, and used by the community.

Partnerships with the Georgia Parks and Recreation Association, the Georgia Cooperative Extension Service, the American Heart Association, Pedestrians Educating Drivers on Safety (PEDS), restaurants, grocery stores, and the faith community will continue to support physical activity and proper nutrition.

Restaurants and grocery stores can offer and promote "Heart Healthy" food choices. The faith community can be a source of science-based information for improving health. The faith community and community centers can partner with public health, local hospitals, clinics, and other medical providers in the community to identify individuals at high risk and refer them for proper treatment and follow-up.

Currently, the infrastructure we have put in place to make our lives convenient seems to be controlling us. Isn't it a better idea for us to begin to exert some collective force to improve our surroundings in a way that would promote, not detract from, good health?

"The community which has neither poverty nor riches will always have the noblest principles."

—Plato



“He thought that, because the community represents millions of people therefore it must be millions of times more important than the individual, forgetting that the community is an abstraction from the many, and is not the many themselves.” — D. H. Lawrence

HEALTHY PEOPLE 2010 OBJECTIVES RELATED TO COMMUNITY

- | | |
|---|---|
| 6-12 Reduce the proportion of people with disabilities reporting environmental barriers to participation in community activities. | 19-18 Increase food security among U.S. households and in so doing reduce hunger. |
| 7-11 Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs for racial and ethnic minority populations. | 22-1 Reduce the proportion of adults who engage in no leisure-time physical activity. |
| 7-12 Increase the proportion of older adults who have participated during the preceding year in at least one organized health promotion activity. | 22-2 Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day. |
| 19-1 Increase the proportion of adults who are at a healthy weight. | 22-3 Increase the proportion of adults who engage in vigorous physical activity that promotes the development and maintenance of cardiorespiratory fitness three or more days per week for 20 or more minutes per occasion. |
| 19-2 Reduce the proportion of adults who are obese. | 22-4 Increase the proportion of adults who perform physical activities that enhance and maintain muscular strength and endurance. |
| 19-3 Reduce the proportion of children and adolescents who are overweight or obese. | 22-5 Increase the proportion of adults who perform physical activities that enhance and maintain flexibility. |
| 19-5 Increase the proportion of persons aged 2 years and older who consume at least two daily servings of fruit. | 22-6 Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on five or more of the previous seven days. |
| 19-6 Increase the proportion of persons aged 2 years and older who consume at least three daily servings of vegetables, with at least one-third being dark green or deep yellow vegetables. | 22-7 Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness three or more days per week for 20 or more minutes per occasion. |
| 19-7 Increase the proportion of persons aged 2 years and older who consume at least six daily servings of grain products, with at least three being whole grains. | 22-11 Increase the proportion of children and adolescents who view television two or fewer hours per day. |
| 19-8 Increase the proportion of persons aged 2 years and older who consume less than 10% of calories from saturated fat. | 22-14 Increase the proportion of trips made by walking. |
| 19-9 Increase the proportion of persons aged 2 years and older who consume no more than 30% of calories from fat. | 22-15 Increase the proportion of trips made by bicycling. |
| 19-10 Increase the proportion of persons aged 2 years and older who consume 2,400 mg or less of sodium daily. | |
| 19-11 Increase the proportion of persons aged 2 years and older who meet dietary recommendations for calcium. | |

Increase policies that support mixed-use community design, placement of parks, sidewalks, paths, and trails in towns and municipalities with a population of 5,000 or more. Establish baseline and indicator thresholds by 2004.

STRATEGY

Strategy 1.1: Create more walkable communities.

Strategy 1.1.1: Work with the Georgia Coalition for Physical Activity and Nutrition and the American Heart Association to provide training for public and private partners and citizens on how to effectively work with local officials on issues of land use planning, community connectivity, and green space.

Strategy 1.1.2: Work with UGA's Research Center at the Carl Vinson Institute of Government to assess, establish baseline measures, and evaluate policy implementation in areas of nutrition, physical activity and tobacco use.

Strategy 1.2: Develop partnerships with stakeholders and interested parties.

Strategy 1.3: Assess and evaluate strategies 1.1 and 1.2 to identify key components/tools that address the objective.

CONVENERS

Municipalities

KEY PARTNERS

Chambers of Commerce; Atlanta Regional Commission; Initiative on Smart Growth; Atlanta Regional Commission; SMARTRAQ; Pedestrians Educating Drivers on Safety (PEDS); Georgia PATH Foundation; Atlanta Journal & Constitution; American Heart Association; North Fayette Community Association; University of Georgia Carl Vinson Institute of Government; Association of County Commissioners of Georgia; Epidemiology Branch; Cardiovascular Health Initiative (CVHI); Asthma Program

DECISION MAKERS

County commissions; city councils

TARGET GROUP/RECIPIENT POPULATION

Communities

Increase public use of parks, trails, recreation centers, playgrounds, and sidewalks funded by Cardiovascular Health Initiative (CVHI) community project mini-grants by 20% through 2006.

CONVENERS

Georgia Recreation and Parks Association; CVHI; Chronic Disease Prevention Initiative (CDPI) District Coordinators(Northwest Health District, North Georgia Health District, North Health District, Cobb/Douglas Health District, Fulton Health District, Clayton Health District, DeKalb Health District, LaGrange Health District, South Central Health District, North Central Health District, South Health District, Southwest Georgia Health District, East Health District, Southeast Health District, Coastal Health District, Northeast Health District)

KEY PARTNERS

Division of Aging Services; Asthma Program; Area Agencies on Aging; Kaiser Permanente; Georgia Cooperative Extension Service; CVHI media consultant; Atlanta Regional Commission; Pedestrians Educating Drivers on Safety; PATH Association; Hearts N' Parks

DECISION MAKERS

Georgia Recreation and Parks Association; Kaiser Permanente; CVHI; funding sources; Division of Aging Services

TARGET GROUP/RECIPIENT POPULATION

Current and potential park users

STRATEGY

Strategy 2.1: Promote public parks, trails, programs, and services available through Georgia Recreation and Parks Association, the Cooperative Extension Service, and other targeted segments of the general and ethnic populations.

Strategy 2.1.1: Use print and/or broadcast media.

Strategy 2.1.2: Work with the Georgia Recreation and Park Association and others to compile and analyze data on usage of local parks; and changes in usage in parks participating in promotion and/or renovations.

Strategy 2.1.2.1: Establish base-line usage data prior to mini grant funding.

Strategy 2.1.2.2: Follow-up with usage post mini-grant funding.

Strategy 2.2: Consult with the Area Agencies of Aging (AAA) Services and the Recreation and Parks Association in promoting park and trail usage by older adults in vicinity of residence and park facilities used by this population group.

Strategy 2.3: Identify park and trail facilities near worksites where Kaiser Permanente is healthcare provider.

Strategy 2.3.1: Promote park and trail usage with Kaiser at worksites.

Strategy 2.4: Collaborate with the Hearts N' Parks project.

Strategy 2.5: Support park enhancements/improvements through the CVHI mini-grant program.

Strategy 2.6: Develop partnerships and links with other stakeholders.

Strategy 2.7: Identify champions and spokespersons.

Strategy 2.8: Identify funding sources for park improvements and enhancements.

Strategy 2.9: Work with Carl Vinson Institute of Government and others to establish a baseline and monitoring system.

Strategy 2.9.1: Data collected includes ordinances on zoning and land use codes in all local county and city governments in Georgia with a population of 5,000 or more.

Strategy 2.9.1.1: Codes surveyed pertain to sidewalks, bicycle lanes, greenways, and recreation facilities that are required in new and redeveloped residential area, new commercial developments, and mix-use communities.



Increase the consumption of fruits and vegetables a day by 10% as reported in the Behavioral Risk Factor Survey (BRFS) by 2005.

CONVENERS

Nutrition Section; 5-A-Day Georgia representative

KEY PARTNERS

Georgia Coalition for Physical Activity and Nutrition (G-PAN); Georgia Recreation and Parks Association (GRPA); Hearts N' Parks Project; Georgia Dietetic Association (GDA); the National Institute of Health (NIH); Chronic Disease Prevention Initiative (CDPI) District Coordinators (Northwest Health District, North Georgia Health District, North Health District, Cobb/Douglas Health District, Fulton Health District, Clayton County Health District, LaGrange Health District, South Central Health District, South Health District, Southwest Georgia Health District, East Health District, Southeast Health District, Coastal Health District, Northeast Health District); American Dietetic Association; Georgia Dietetic Association; National Heart, Lung, and Blood Institute; Kids' Health, Inc.; Cardiovascular Health Initiative (CVHI); the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System; Epidemiology Branch

DECISION MAKERS

Consumers; Hearts N' Parks participants; grocers; restaurants; worksites

TARGET GROUP/RECIPIENT POPULATION

General population

STRATEGY

Strategy 3.1: Implement the Hearts 'N' Parks nutrition education component in the five pilot sites located in Georgia through 2003 (Rome, Valdosta, Savannah, Waycross, Athens)

Strategy 3.1.1: Work with Parks and Recreation Departments to implement Hearts N' Parks in other areas of the state.

Strategy 3.1.2: Link district-level Georgia Recreation and Parks Association and Georgia Dietetic Association educators to provide accurate and culturally appropriate nutrition information to Hearts 'N' Parks participants as requested.

Strategy 3.1.3: Evaluate the Hearts 'N' Parks program in the pilot areas, using the information to offer guidance to other parks in the state.

Strategy 3.2: Promote consumption of fruits and vegetables through various media vehicles.

Strategy 3.2.1: Utilize the *Take Charge of Your Health* social marketing campaign message: Take 5-A-Day.

Strategy 3.2.2: Utilize print and broadcast promotion through health departments, newspapers, and professional and community newsletters for targeted segments of priority populations.

Strategy 3.3: Implement training and promotion initiatives with grocery stores, markets, and restaurants.

Strategy 3.3.1: Assist in designing policy change initiatives in grocery stores, restaurants, communities, and markets.

Strategy 3.3.2: Support local CDPI District Coordinators to work with Area Agency of Aging Wellness Coordinators, the Nutrition Section, and others through mini-grant opportunities to create and implement initiatives and policy changes in grocery stores, communities, and markets.

Strategy 3.3.3: Promote healthy food choices in restaurants.

Strategy 3.4: Promote fruit and vegetable consumption among teachers and students in participating Kids' Health schools.

Strategy 3.4.1: Assess the availability of fruits and vegetables in Kids' Health schools.

Strategy 3.5: Analyze fruit and vegetable consumption data through CDC's Behavioral Risk Factor Survey conducted in Georgia.

Strategy 3.5.1: Develop base line data in 2003.

Strategy 3.5.2: Assess data collected in 2005.

Strategy 3.5.3: Utilize the following questions pertaining to fruit and vegetable consumption

Strategy 3.5.3.1: How often do you drink fruit juices such as orange, grapefruit, or tomato?

Strategy 3.5.3.2: Not counting juice, how often do you eat fruit?

Strategy 3.5.3.3: Not counting carrots, potatoes, or salads, how many servings of vegetables do you usually eat?

Establish wellness/congregational care committees in 100 faith communities by 2005.

CONVENERS

Faith communities; Chronic Disease Prevention Initiative (CDPI) District Coordinators (Northwest Health District, North Health District, Cobb/Douglas Health District, Fulton Health District, Clayton Health District, DeKalb Health District, LaGrange Health District, South Central Health District, North Central Health District, South Health District, Southwest Georgia Health District, East Health District, Southeast Health District, Coastal Health District, Northeast Health District)

KEY PARTNERS

Georgia Coalition of Physical Activity and Nutrition (G-PAN); American Heart Association – Southeast Affiliate; faith-based associations; Emory University Rollins School of Public Health Interfaith Health Program Consultants; University of Georgia Heart Nutrition Program; Association of Black Cardiologists; Association of Parish Nurses; Tobacco Use Prevention Section; Cardiovascular Health Initiative (CVHI); Hispanic Health Coalition; Diabetes Prevention and Control Program; Asthma Program

DECISION MAKERS

Faith communities

TARGET GROUP/RECIPIENT POPULATION

African Americans, Latinos, people with low socioeconomic status

STRATEGY

Strategy 4.1: Provide media and resource packet developed by the Association of Black Cardiologists, outlining the benefits of promoting healthy lifestyles in churches.

Strategy 4.2: Work with consultants from Rollins School of Public Health, Emory University to develop a survey to determine existing healthcare programs and resources within the faith community.

Strategy 4.2.1: Determine essential indicators for surveillance.

Strategy 4.3: Provide training to leaders in the faith community about how environment and policies have a direct effect on health behaviors.

Strategy 4.3.1: Provide regional Interfaith Health Program Conferences to initiate collaboration of the faith and healthcare community in cooperation with Emory University Rollins School of Public Health, the American Heart Association – Southeast Affiliate, and the Association of Black Cardiologists.

Strategy 4.3.2: Provide incentives to faith communities that carry out policy or environmental changes that promote healthy behaviors in their congregations.

Strategy 4.4: Promote collaboration of faith communities in developing local faith-based nurse programs that would serve multiple congregations.

Strategy 4.5: Collect faith community policy and environmental changes to promote healthy behaviors through the monthly reporting system of the District CDPI Coordinators.

Strategy 4.6: Conduct workshops and provide training to leaders in the faith community on how to incorporate the American Heart Association's *Search Your Heart* program into their churches and communities. The *Search Your Heart* program is a free heart-health and stroke prevention initiative that helps faith-based organizations reach African Americans and Hispanics/Latinos.

School

Promote physical activity and improve nutrition in schools by creating policy and environmental changes that increase opportunities to participate in physical activity and make healthy food choices.

- Nearly half of young people ages 12 – 21 do not engage in physical activity on a regular basis.
- The percentage of young people who are overweight has more than doubled since 1970. Childhood obesity is recognized as a national epidemic.
- Type 2 diabetes is showing up in children. This type of diabetes was once almost entirely limited to adults.
- Only 2% of children eat from the food pyramid as recommended.
- 15% eat fruit as recommended.
- 30% drink milk as recommended.
- Children drink almost twice as much soft drinks as milk.

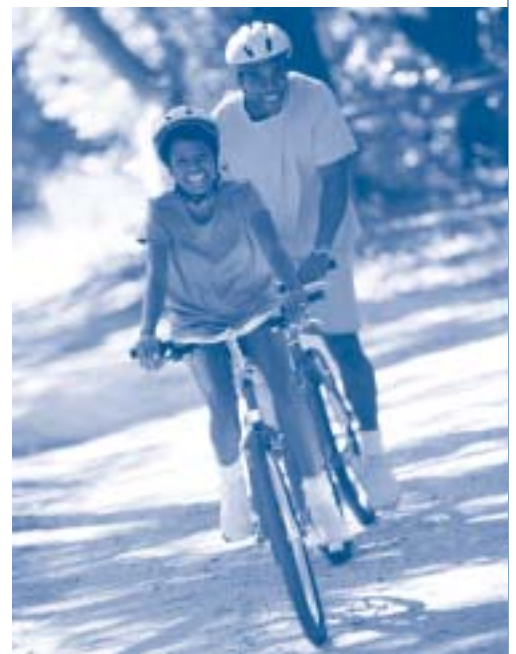
Healthy behavior is based not only on knowledge, but on facts, attitudes, and skills developed early in life. It is these formative years that offer schools a valuable opportunity to influence the development of health behaviors in children. The health of our children now and for a lifetime will not depend on spectacular medical breakthroughs, but rather on lifestyle choices they make. If we can provide our children with the knowledge and skills they need to make health lifestyle choices, we can dramatically reduce their risk of death and

disease for a lifetime. This ultimately will reduce their personal health care risk as well as reduce the spiraling costs of health care. Armed with this information, it is imperative that all of us take action to encourage our youth to adopt healthy lifestyles.

Legislation passed in the 2000 Georgia General Assembly removed physical education from the required curriculum in middle schools. During the 2001 Legislative Session, the Joint Study Committee on Physical Activities in Schools was created by Senate Resolution 252. The Committee was authorized to study issues related to physical activity in Georgia schools and to make recommendations on how to increase physical activity. The senators serving on the Committee were The Honorable Nadine Thomas, The Honorable Gloria Butler, and The Honorable Mike Beatty. The representatives were The Honorable Nikki Randal, The Honorable Renee Unterman, and The Honorable Sistie Hudson, who was appointed as the chairperson. The Advisory Committee was composed of representatives from the Georgia Dietetic Association; Georgia Association of Education Leaders; Georgia Association for Health, Physical Education, Recreation and Dance; Georgia Parent Teacher Association; Georgia Coalition for Physical Activity and Nutrition; Georgia Nurses

Association; Georgia Partnership for School Health; American Heart Association, Southeast Affiliate; Georgia Chapter of the American Academy of Pediatrics; Georgia Department of Human Resources, Division of Public Health; and the Georgia Department of Education. As a result of the testimony, eleven recommendations were made.

This section was developed with the Study Committee's Recommendations as a foundation for the objectives. Objective 1 and 2 of the plan address Recommendation #3; objective 3 addresses Recommendations # 4, 8, and 11; objective 4 addresses Recommendation #4.



“Everybody knows when little children play, they need a sunny day to grow straight and tall. Let the sun shine through.” — lyrics from “Windows of the World” by Burt Bacharach

HEALTHY PEOPLE 2010 OBJECTIVES RELATED TO SCHOOL

- 7-2 Increase the proportion of middle, junior high, and senior high schools that provide school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and sexually transmitted disease infection; unhealthy dietary patterns; inadequate physical activity; and environmental health.
- 7-3 Increase the proportion of college and university students who receive information from their institution on each of the six priority health-risk behavior areas.
- 7-4 Increase the proportion of the nation's elementary, middle, junior high, and senior high schools that have a nurse-to-student ratio of at least 1:750.
- 19-3 Reduce the proportion of children and adolescents who are overweight or obese.
- 19-4 Reduce growth retardation among low-income children under age 5.
- 19-5 Increase the proportion of persons aged 2 years and older who consume at least two daily servings of fruit.
- 19-6 Increase the proportion of persons aged 2 years and older who consume at least three daily servings of vegetables, with at least one-third being dark green or orange vegetables.
- 19-7 Increase the proportion of persons aged 2 years and older who consume at least six daily servings of grain products, with at least three being whole grains.
- 19-8 Increase the proportion of persons aged 2 years and older who consume less than 10 percent of calories from saturated fat.
- 19-9 Increase the proportion of persons aged 2 years and older who consume no more than 30 percent of calories from total fat.
- 19-10 Increase the proportion of persons aged 2 years and older who consume 2,400 mg or less of sodium daily.

*“I believe the children are our future. Teach them well
and let them lead the way...”*
— lyrics from *“The Greatest Love of All”* by Whitney Houston

- 19-11 Increase the proportion of persons aged 2 years and older who meet dietary recommendations for calcium.
- 19-12 Reduce iron deficiency among young children and females of childbearing age.
- 19-15 (Developmental) Increase the proportion of children and adolescents aged 6 to 19 years whose intake of meals and snacks at school contributes to good overall dietary quality.
- 22-6 Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on five or more of the previous seven days.
- 22-7 Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness three or more days per week for 20 or more minutes per occasion.
- 22-8 Increase the proportion of the nation's public and private schools that require daily physical education for all students.
- 22-9 Increase the proportion of adolescents who participate in daily school physical education.
- 22-10 Increase the proportion of adolescents who spend at least 50 percent of school physical education class time being physically active.
- 22-11 Increase the proportion of adolescents who view television two or fewer hours on a school day.
- 22-12 Increase the proportion of the public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours.
- 22-14 Increase the proportion of trips made by walking.
- 22-15 Increase the proportion of trips made by bicycling.

Conduct the School Health Assessment Index (SHI) in 300 Georgia public schools by May 2006. Address at least one policy or environmental change identified at each school that needs attention.

CONVENERS

Kids' Health Inc.; Family Health Branch; Chronic Disease Prevention Initiative (CDPI) District Coordinators (East Metro Health District, LaGrange Health District, Northwest Health District, DeKalb Health District, South Central Health District, South Health District, North Georgia Health District, Southwest Georgia Health District, Southeast Health District)

KEY PARTNERS

Georgia School Food Service Association; Georgia Association of Education Leaders; State Board of Education; Cardiovascular Health Initiative (CVHI); Georgia Nurse Association; Parent and Teacher Association (PTA); School Emergency, Health, and Wellness Committees; Georgia Dietetic Association; Advisory Panel for Student Health and Academic Achievement for the Georgia Board of Education; Diabetes Prevention and Control Program; Asthma Program

DECISION MAKERS

Department of Education, School and Community Nutrition Program, school administration, school boards, teachers, staff

TARGET GROUP/RECIPIENT POPULATION

Students K-12, staff

STRATEGY

Strategy 1.1: In collaboration with Kids' Health, provide training to public health staff and education partners, to form school partnerships to implement the School Health Index policy and environment assessment tool.

Strategy 1.2: Support public health district initiatives to conduct the School Health Index through mini-grant opportunities and technical assistance, linked to the Kids' Health initiative where applicable.

Strategy 1.3: Through the CVHI and Obesity Control Initiative mini-grant process, provide incentives to schools to carry out needed environmental changes identified by the conduct of the School Health Index to increase physical activity or improve nutritional choices.

Strategy 1.3.1: Focus on schools with large percentage priority student populations.

Strategy 1.4: Collect data on environmental and policy changes made as a result of the School Health Index through Kids Health, Inc. the chronic disease coordinators, and the school nutrition program.

Conduct a walkability assessment in a one-mile radius around Georgia elementary and middle public schools located in urban or suburban areas by 2006.

STRATEGY

Strategy 2.1: Support and encourage local public health staff, schools, and local partners to participate in the Walk-Your-Child-to-School Day.

Strategy 2.1.1: Include walkability assessment survey as part of the event.

Strategy 2.1.2: Evaluation will follow-up to determine if connectivity and community design problems identified by the walkability assessment have been addressed.

Strategy 2.1.3: Evaluation will include assessing school health policy changes and changes in county/city policies, including cross walks, sidewalks, speed limits.

Strategy 2.2: Kid's Health will encourage participating schools to stencil walking trails and participate in the Walk-Your-Child-to-School Day. (first Wednesday in October, annually) in schools where they are scheduled.

Strategy 2.2.1: Train CDPI District Coordinators and other public health staff to function as a member of the Kids' Health learning labs team.

Strategy 2.2.1.1: Conduct walkability assessment for schools participating

Strategy 2.3: Encourage local public health staff, schools, school staff, and students to participate in a physical activity program, such as the Take Charge Challenge or 20% Boost pedometer program.

Strategy 2.3.1: Kids' Health will encourage school staff and students to participate in the 20% Boost pedometer program.

CONVENER

Kids' Health, Inc; Cardiovascular Health Initiative (CVHI); Family Health Branch; Wellness, Inc.; Chronic Disease Prevention Initiative (CDPI) District Coordinators (Northwest Health District, North Georgia Health District, North Health District, Cobb/Douglas Health District, Clayton County Health District, DeKalb Health District, LaGrange Health District, South Central Health District, West Central Health District, South Health District, Southwest Georgia Health District, Southeast Health District, Northeast Health District)

KEY PARTNERS

Atlanta Regional Commission; Georgia Cooperative Extension Service; Parent Teacher Associations (PTA); Safe KIDS of Georgia; School Nurse Association; and other partners as identified; CVHI; Diabetes Prevention and Control Program; Asthma Program

DECISION MAKERS

School administration

TARGET GROUP/RECIPIENT POPULATION

Students K-8, staff, adjacent communities

SCHOOL PLAN OBJECTIVE 2 (continued)

Strategy 2.3.2: Include walkability assessment survey as part of the event.

Strategy 3.3.2.1: Evaluation will follow-up to determine if connectivity and community design problems identified by the walkability assessment have been addressed.

Strategy 2.3.3: Identify walking areas within school and on school grounds (i.e. the number of steps from the library to the office is the number of steps from the far end of the parking lot to the 5th grade classrooms).

Strategy 2.4: Assess changes in school policies and programs related to health, nutrition, and physical activity in conjunction with Kids' Health, Walk Your Child to School, 20% Boost pedometer program.

Strategy 2.4.1: Evaluation will include policy and program changes occurring after walkability assessment took place.

Strategy 2.4.2: Evaluation will include behavior change of students and staff, particularly in the participating Kids' Health schools.



Provide daily quality physical education for all Georgia public school students K-12 by 2010 that is based on standards set by the National Association of Sports and Physical Education.

STRATEGY

Strategy 3.1: Implement a physical education curriculum that meets National Association of Sports and Physical Education (NASPE) standards by 2005.

Strategy 3.1.1: Work with physical education professionals, the Georgia Association of Health, Physical Education, Recreation and Dance (GAHPERD), the Georgia Coalition for Physical Activity and Nutrition (G-PAN), and the Senate Resolution 252 Joint Study Committee and the resulting report to place a state level coordinator for Physical Education within the Department of Education.

Strategy 3.1.1: Create a task force composed of physical education teachers, physical education experts and other stakeholders to identify the scope and sequence of physical education concepts and skills that address national standards; produce a model curriculum based on national standards.

Strategy 3.1.1.1: Incorporate model curriculum into the Quality Core Curriculum (QCC).

Strategy 3.1.1.2: Promote at the local level the utilization of curricula that meets state requirements and has credible evidence of effectiveness.

CONVENER

Georgia Department of Education (DOE); Family Health Branch (FHB)

KEY PARTNERS

DOE; FHB; Chronic Disease Prevention and Health Promotion Branch; Georgia Association for Health, Physical Education, Recreation, and Dance; Physical education teachers; American Heart Association – Southeast Affiliate; Kids' Health, Inc.; Georgia Coalition for Physical Activity and Nutrition (G-PAN); Parent Teacher Associations (PTA); parents; teachers; students; Cardiovascular Health Initiative (CVHI); Advisory Panel for Student Health and Academic Achievement for the Georgia Board of Education; Diabetes Prevention and Control Program; Asthma Program

DECISION MAKERS

Georgia Board of Education

TARGET GROUP/RECIPIENT POPULATION

Students K-12

By 2005, adopt a health education curriculum that meets national standards.

CONVENER

Georgia Department of Education (DOE); Family Health Branch, American Heart Association – Southeast Affiliate

KEY PARTNERS

Georgia Coalition for Physical Activity and Nutrition (G-PAN); teachers; United States Department of Agriculture; Georgia School Nurses Association; Pre-K Healthy Curriculum; Head Start; Cardiovascular Health Initiative (CVHI); Advisory Panel for Student Health and Academic Achievement for the Georgia Board of Education; Diabetes Prevention and Control Program; Asthma Program

DECISION MAKERS

Georgia Board of Education

TARGET GROUP/RECIPIENT POPULATION

Students K-12

STRATEGY

Strategy 4.1: Create a task force composed of health education teachers, health education experts, and other stakeholders to identify the scope and sequence of health concepts and skills based on national standards; produce a model curriculum based on national standards.

Strategy 4.1.1: Include cardiopulmonary resuscitation (CPR) training and use of cardiac defibrillators in middle school health curriculum.

Strategy 4.1.2: Incorporate model curriculum into the Quality Core Curriculum (QCC).

Strategy 4.1.3: Promote at the local level the utilization of curricula that meets state requirements and has credible evidence of effectiveness.

Strategy 4.2: Assist in emergency preparedness for the school and community and provide leadership and expertise for school health issues by building the capacity of school nurses to meet the Surgeon General's 2010 Objectives and the American School Nurse Association standard of one nurse per 750 students by 2010.

Strategy 4.2.1: Place a state level coordinator for school nurses within the Georgia Department of Education.

Strategy 4.2.2: Build consensus in the community for adequate number of school nurses.

Develop and disseminate to all public schools a school event and snack model guidelines based on USDA nutrition guidelines that offers healthy food and beverage choices by 2006.

STRATEGY

Strategy 5.1: Assist Department of Education staff in the School and Community Nutrition Program to convene a task force composed of District School Food Service Coordinators, school cafeteria managers, students, parents, school home economists, and other interested experts and stakeholders to develop a snack and school event guideline that recommends appropriate healthy food choices for vending, sporting, concert, drama, and other school events, including class parties.

Strategy 5.2: Assist Department of Education staff in the School and Community Nutrition Program to convene a task force composed of District School Food Service Coordinators, school cafeteria managers, students, parents, school home economists, and other interested experts and stakeholders to promote a campaign to increase the number of fruits and vegetables that students eat to five a day.

CONVENERS

Department of Education School and Community Nutrition Program; Family Health Branch

KEY PARTNERS

Georgia School Food Service Association; United States Department of Agriculture; school/parent booster clubs; teachers: home economists, Georgia Association of Education Leaders (GAEL); Cooperative Extension Service, Georgia Soft Drink Association; Women, Infants, and Children Program; Chronic Disease Prevention Initiative (CDPI) District Coordinators (East Metro Health District, LaGrange Health District, Northwest Health District, DeKalb Health District, South Central Health District, South Health District, North Georgia Health District, Southwest Georgia Health District, Southeast Health District); Advisory Panel for Student Health and Academic Achievement for the Georgia Board of Education

DECISION MAKERS

Department of Education School and Community Nutrition Program

TARGET GROUP/RECIPIENT POPULATION

Students K-12, staff, and community

Encourage all school vending beverage operations to offer a wide variety of products including water, isotonics, and 100% fruit juices by 2004.

CONVENERS

Cardiovascular Health Initiative (CVHI); Georgia Soft Drink Association

KEY PARTNERS

Department of Education School and Community Nutrition Program; Family Health Branch; Parent Teacher Association (PTA); Chronic Disease Prevention Initiative (CDPI) District Coordinators (East Metro Health District, LaGrange Health District, Northwest Health District, DeKalb Health District, South Central Health District, South Health District, North Georgia Health District, Southwest Georgia Health District, Southeast Health District)]; Advisory Panel for Student Health and Academic Achievement for the Georgia Board of Education; Diabetes Prevention and Control Program; Asthma Program

DECISION MAKERS

School administrators

TARGET GROUP/RECIPIENT POPULATION

Students K-12, staff, community

STRATEGY

Strategy 6.1: Negotiate with representative of the Georgia Soft Drink Association to encourage soft drink vending operations to offer a wide variety of products including: water, 100% fruit juices, and isotonics, in addition to soft drinks in all school vending machines.

Strategy 6.2: Track and report implementation.

Facilitate ability of partner organizations to provide education and activities that promote increased physical activity and improved nutritional choices for students before, during, and after school. 100% of Georgia public schools will offer physical activity choices before, during, or after school by 2010.

STRATEGY

Strategy 7.1: Pair the Georgia Cooperative Extension Service county agents with district public health staff and school staff to teach healthy lifestyle choices, including life skills physical activity, good nutrition, and communities designed for walkability.

Strategy 7.1.1: Develop 4-H project booklets for use by 5th graders to explore and define livable community models.

Strategy 7.2: Increase awareness of signs and symptoms of heart attack and stroke.

Strategy 7.2.1: Train 8th graders in cardiopulmonary resuscitation (CPR).

Strategy 7.3: Share information about programs available with school officials.

Strategy 7.3.1: Include *The Georgia Learning Connection* (web-based educational tool for teachers); *Fit, Healthy, and Ready to Learn* (manual for school administrators and teachers); *Changing the Scene* (USDA); Take 10!; Fit Kids; Children's Healthcare of Atlanta; Healthy Start; Take Charge of Your Health; Organwise Guys, and others as identified.

Strategy 7.4: Facilitate partnerships between the Parks and Recreation Departments and public school systems to collaborate on enhancing physical education curriculum by utilizing existing recreation facilities that are in close proximity to public schools.

Strategy 7.5: Encourage county and city planners and Parks and Recreation Departments to collaborate with the public school systems when developing plans for future park facility development.

CONVENERS

Kids' Health, Inc.; Family Health Branch; Georgia Coalition for Physical Activity and Nutrition (G-PAN); Wellness, Inc.; American Heart Association – Southeast Affiliate

KEY PARTNERS

Cooperative Extension Service; International Life Sciences Institute; Children's Healthcare of Atlanta; Department of Education School and Community Nutrition Program; Southeast United Dairy Industry Association; Division of Public Health; Georgia Soft Drink Association; YMCA, YWCA, Boys' and Girls' Clubs; Georgia Recreation and Parks Association; United Way; Pre-School Healthy Start; Chronic Disease Prevention Initiative (CDPI) District Coordinators (East Metro Health District, LaGrange Health District, Northwest Health District, DeKalb Health District, South Central Health District, South Health District, North Georgia Health District, Southwest Georgia Health District, Southeast Health District); Advisory Panel for Student Health and Academic Achievement for the Georgia Board of Education; Diabetes Prevention and Control Program; Asthma Program

DECISION MAKERS

School administrators, district and local school boards

TARGET GROUP/RECIPIENT POPULATION

Students K-12, staff, community

SCHOOL PLAN OBJECTIVE 7 (continued)

Strategy 7.6: Conduct walkability assessment as part of planned programs.

Strategy 7.7: Identify schools not open after hours.

Strategy 7.8: Work with school to overcome barriers to community access to facilities.

Strategy 7.9: Establish baseline (% schools) currently open to public after hours, using 2000-2001 Cardiovascular Health Initiative (CVHI) school survey.

Strategy 7.10: Obtain statistics on the number of students/community members who participate in activities, before, and after school.

Strategy 7.11: Determine prevalence of risk behaviors and health status in Georgia's middle and high school student population through scientific surveillance in partnership with the Department of Education.

Strategy 7.10.1: Obtain Youth Risk Behaviors Survey (YRBS) data.

Strategy 7.10.1.1: Analyze and report.

Strategy 7.10.2: Conduct the School Health Education Profile (SHEP) survey in 2002 and 2004 school year.

Strategy 7.10.2.1: Analyze and report.

Strategy 7.10.3: Compare baseline and subsequent data from YRBS and SHEP.



Social Marketing

Create a social marketing campaign to encourage the adoption of healthy behaviors and the elimination of unhealthy behaviors.

Social Marketing

The concept of social marketing was introduced in the 1970s when researchers realized that the same marketing principles being used to sell products could be used to encourage healthy behaviors. Most people are familiar with at least one social marketing campaign. Well-known examples include *Friends don't let friends drive drunk*, *Got milk?* and *Only you can prevent forest fires*. Social marketing strategies can be used to promote behaviors that improve health, such as increasing fruit and vegetable consumption; they can also discourage behaviors that can harm health, such as eating a high-fat, high-sodium diet.

Social marketing is not as simple as creating a catchy, memorable phrase. It involves careful planning, research, design, and evaluation. Marketers refer to the "Four Ps" of planning a campaign: product, price, place, and promotion. Though these components were originally used to create plans to sell consumer goods, the concepts apply to social marketing as well.

Product can refer to several things: a behavior we are trying to promote, such as increasing fruit and vegetable consumption; an actual item, such as an asthma inhaler; or a service, such as cholesterol screening.

Price describes what a person must pay or give up in order to adopt the behavior. While most people think of money when they think of price, the cost is often intangible when it comes to changing behavior. Someone who chooses to eat more fresh fruit may give up a morning doughnut. A person who decides to increase her physical activity may have to get up an hour earlier in the morning.

Place can refer to where people will practice the new behavior, such as a walking trail; where a service is provided, such as blood pressure screenings at the health department; or where tangible products, such as fresh vegetables, are purchased.

Promotion is what most people associate with marketing. Media campaigns using billboards, newspapers, television, radio, and educational materials are commonly used to reach the target audience. The messages and the media used to relay those messages must be carefully researched and tested in order to be effective.

When used as intended, social marketing can be a powerful tool; however, we must remember that it is just a piece of the puzzle. Many other things — policy, education, access to care, economics,

personal values — influence health behaviors. Social marketing won't solve all of our problems, but it can help us have a positive and meaningful impact on our communities.



Use the *Take Charge of Your Health* (TCOYH) social marketing campaign, developed by the Nutrition Section, to promote improved nutritional intake and increased physical activity in schools and daycare, worksites, healthcare setting, and the community.



Take
charge
of your
health



STRATEGY

Strategy 1: Promote *Take Charge of Your Health* within the Division of Public Health programs, such as: *Take Charge of Your Diabetes and Cardiovascular Disease*; *Take Charge of Your Bone Health*.

Promote *Take Charge of Your Health* messages through the Nutrition Section, such as: *Take Charge of Your Health for the Busy, Growing Family*; *Take Charge of Your Health for Adolescents*; *Healthy Heart Challenge*.

Strategy 2: Promote *Take Charge of Your Health* within other state agencies such as Family Connections and the Office of Aging.

Strategy 3: Promote *Take Charge of Your Health* through universities, such as: *University of Georgia: Bringin' It Home-Healthy Generations*, *University of Georgia: Lovin' Spoonfuls*. *Georgia State University: Department of Anthropology and Geography*.

Strategy 4: Promote *Take Charge of Your Health* through private non-profit organizations such as: *Children's Healthcare of Atlanta*, *Take Charge of Your Family's Health*; *International Life Sciences Institute*, *Take 10!*; *Georgia Recreation and Parks Association*, *American Academy of Pediatrics, Georgia Chapter*.

Strategy 5: Promote *Take Charge of Your Health* through private organizations, such as: *Local Government Risk and Management Services Wellness, Inc.*

Strategy 6: Promote *Take Charge of Your Health* through professional organizations such as: *American Academy of Pediatrics, Georgia Chapter*; *Association of Black Cardiologists*.

Appendices

Appendix A: Acronyms

ACRONYMS AND OTHER COMMONLY USED TERMS

AAA	Area Agency of Aging	BPHC	Bureau of Primary Healthcare
AAHPERD	American Alliance of Health, Physical Education, Recreation, and Dance	BRFS	Behavioral Risk Factor Survey
AAHE	American Association for Health Education	BRFSS	Behavioral Risk Factor Surveillance System
AAP	American Academy of Pediatrics	CAD	coronary artery disease
ABC	Association of Black Cardiologists	CAP	Community Access Program
ABC	Atlanta Bicycle Campaign	CBS-NS-FHB	Competency Based Skills Workshops - Nutrition Section - Family Health Branch
ACE	American Council on Exercise	CDB	Chronic Disease Prevention and Health Promotion Branch
ACS	American Cancer Society	CDB-HP	Chronic Disease Prevention and Health Promotion Branch - Health Promotion Section
ACSM	American College of Sports Medicine	CDC	Centers for Disease Control and Prevention
ADA	American Diabetes Association	CDPI	Chronic Disease Prevention Initiative
ADA	American Dietetic Association	CES	Georgia Cooperative Extension Service
AED	Automated External Defibrillators	CHD	coronary heart disease
AFA	American Fitness Alliance	CHIP	Child Health Insurance Program
AHA	American Heart Association	CHILDREN'S	Children's Healthcare of Atlanta
AHA-SE	American Heart Association - Southeast Affiliate	CHS-GSU	The Center for Health Services - Georgia State University
AHEC	American Health Education Center	CHS	Children's Health Service
AJC	Atlanta Journal Constitution	CLARITAS	Consumer Purchasing Tracking System
ALA	American Lung Association	CME	continuing medical education
AMA	American Medical Association	COPD	chronic obstructive pulmonary disease
AOA	Administration on Aging	COPEC	Council of Physical Education for Children
AODM	Adult-onset diabetes mellitus; now referred to as Type II Diabetes	CRD	colorectal disease
APHA	American Public Health Association	CSHP	Comprehensive School Health Programs
ARC	Atlanta Regional Commission	CVD	cardiovascular disease
ASA	American Stroke Association	CVHI	Cardiovascular Health Initiative (formerly CVDPI)
ASSIST	American Stop Smoking Intervention Study	CVDPI	Cardiovascular Disease Prevention Initiative (now CVHI)
ASTPHND	Association of State and Territorial Public Health Nutrition Directors	DASH	Division of Adolescent and School Health
AWHP	Association of Worksite Health Promotion	DASH	Dietary Approaches to Stop Hypertension
BCBS	BlueCross/BlueShield	DCH	Department of Community Health
BFAC-WIC	Breastfeeding Advisory Committee - Georgia Women, Infants, and Children Program	DFACS	Department of Family and Childrens Services
BMI	Body Mass Index	DHHS	Department of Health and Human Services
BOC	Bureau of Census	DHR	Department of Human Resources
BOE	Board of Education	DM	diabetes mellitus
BOH	Board of Health	DAS	Division of Aging Services
BP	blood pressure		

APPENDIX A (continued)

DOAS	Division of Administrative Services	GSDA	Georgia Soft Drink Association
DOE	Department of Education	GSFSA	Georgia School Food Service Association
DOE S&CN	Department of Education School and Community Nutrition	GSU	Georgia State University
DOT	Department of Transportation	GTFFB	Georgia Task Force for Breastfeeding
DPH	Division of Public Health	HB	House Bill
DRH	Division of Rural Health	HCFA	Health Care Financing Administration
USDE	United States Department of Education	HDL	high density lipoprotein
Emory	Emory University, Rollins School of Public Health	HEDIS	Health Plan Employer Data and Information Set
EPA	Environmental Protection Agency	HEI	Health Eating Index
Epi	Epidemiology	HHS	Department of Health and Human Services
Epi-PH	Epidemiology Branch - Public Health	HMO	health maintenance organization
ETS	environmental tobacco smoke	HP2010	Healthy People 2010 Objectives
FC	Family Connections	HR	House Resolution
FDA	Food and Drug Administration	HRSA	Health Resources and Services Administration
FHB	Family Health Branch	HST	Head Start
FHB-NS	Family Health Branch - Nutrition Section	IDDM	insulin-dependent diabetes mellitus
GAEL	Georgia Association of Education Leaders	ILSI	International Life Sciences Institute
GAHPERD	Georgia Association for Health, Physical Education, Recreation, and Dance	IOM	Institute of Medicine
GASN	Georgia Association of School Nurses	JCAHO	Joint Commission for the Accreditation of Healthcare Organizations
GBHF	Georgia Better Healthcare Foundation	JODM	juvenile-onset diabetes mellitus; now referred to as Type I Diabetes
GBA	Georgia Builders Association	JSC	Joint Study Committee
GCNE	Georgia Coalition for Nutrition Education (G-PAN as of January 1, 2000)	KP	Kaiser Permanente
GDA	Georgia Dietetic Association	LDL	low-density lipoprotein
GFATF	Georgia Folic Acid Task Force	MAG	Medical Association of Georgia
GGA	Georgia General Assembly	MASSPEC	Middle and Secondary School Physical Education Council
GHSA	Georgia High School Association	MCG	Medical College of Georgia
GISA	Georgia Independent Schools Association	MCH	Maternal and Child Health
GMCF	Georgia Medical Care Foundation	MCHB	Maternal and Child Health Bureau
GNA	Georgia Nurses Association	MCO	managed care organization
GNC	Georgia Nutrition Council	MHMR	Mental Health and Mental Retardation
G-PAN	Georgia Coalition for Physical Activity and Nutrition	MMWR	Morbidity and Mortality Weekly Report
GPHA	Georgia Public Health Association	MOREHOUSE	Morehouse School of Medicine
GPSH	Georgia Partnership for School Health	MSA	metropolitan statistical area
GPTV	Georgia Public Television	NAHF	National Association for Health and Fitness
GRPA	Georgia Recreation and Parks Association	NASPE	National Association of Sports and Physical Education
GRTA	Georgia Regional Transportation Authority	NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
GSAMS	Georgia Statewide Academic and Medical System	NCEP	National Cholesterol Education Program
		NCHS	National Center for Health Statistics

NCI	National Cancer Institute	SNA	School Nurse Association
NCQA	National Committee for Quality Assurance	SPEAK	Sport and Physical Education Advocacy Kit
NHANES	National Health and Nutrition Examination Survey	SR	Senate Resolution
NHBPEP	National High Blood Pressure Education Program	SR 252	Senate Resolution 252
NHLBI	National Heart, Lung, and Blood Institute	SUDIA	Southeast United Dairy Industry Association
NIDDM	non-insulin dependent diabetes mellitus	TBD	to be determined
NIH	National Institutes of Health	TCOYH	Take Charge of Your Health
NPCR	National Program of Cancer Registries	TPA	third party administrator
NWHPS	National Worksite Health Promotion Survey	TUPS	Tobacco Use Prevention Section
OAN	Obesity Action Network	UGA	University of Georgia
ODPHP	Office of Disease Prevention and Health Promotion	UGA-CES	University of Georgia - Cooperative Extension Service
OHNA	Occupational Health Nurses Association	UGA-FCS	University of Georgia - Food and Consumer Services (formerly FHCS)
OON	Office of Nutrition	USDA	United States Department of Agriculture
PA	physical activity	WELCOA	Wellness Council of America
PAN	Physical Activity and Nutrition	WPA	Wellness Professionals of Atlanta
PATH	Georgia PATH Foundation	WIC	Women, Infants, and Children Program
PBA	Public Broadcasting Atlanta	YRBS	Youth Risk Behavior Survey
PBS	Public Broadcasting Service	YRBSS	Youth Risk Behavior Surveillance System
PCPFS	President's Council on Physical Fitness and Sports		
PE	physical education		
PEA	Physical Education Association		
PeDNSS	Pediatric Nutrition Surveillance System		
PEDS	Pedestrians Educating Drivers on Safety		
PH	Public Health		
PNSS	Pregnancy Nutrition Surveillance System		
PPO	preferred provider organization		
PRO	Peer Review Organization		
PSA	public service announcement		
PTA / PTO	Parent Teacher Association / Parent Teacher Organization		
REACH	Racial and Ethnic Approaches to Community Health		
SB	Senate Bill		
SCNP	School and Community Nutrition Program		
SE-AHA	Southeast Affiliate - American Heart Association		
SES	socio-economic status		
SHAPP	Stroke and Heart Attack Prevention Program		
SHI	School Health Index		
SHPPS	School Health Policies and Program Study		
SMARTRAQ	Strategies for Metropolitan Atlanta's Regional Transportation and Air Quality		

Appendix B: Glossary

■ Adjusted rates

Rates that have been adjusted to remove the effect of differences in composition of populations being compared (e.g., age, race, gender).

■ Advanced cardiac life support (ACLS)

The knowledge and skills necessary to provide the appropriate early treatment for cardiopulmonary arrest; includes the proper management of situations likely to lead to cardiac arrest and stabilization of the individual in the early period following a successful resuscitation; includes basic life support (BLS). ACLS may also refer to the educational program that provides guidelines for these techniques.

■ Advocacy

Active support for a cause, idea, or policy; a type of public health intervention that is related to, but distinct from, policy and environmental change interventions.

■ Age-adjusted death rate

A calculation of what the death rate for a population would be if its age composition were similar to that of a comparison population. Age-adjusting death rates removes the effect of differences in the age structure of populations that are being compared.

■ Angina / angina pectoris

A condition in which the heart muscle doesn't receive enough blood, resulting in pain in the chest.

■ Arteriosclerosis

A chronic disease which causes artery walls to thicken and harden; commonly called hardening of the arteries.

■ Atherosclerotic cardiovascular disease

A form of arteriosclerosis in which the inner layers of artery walls become thick and irregular due to deposits of fat, cholesterol,

and other substances. The resulting, known as plaque, and subsequent bleeding and clotting at the site of the plaque can eventually block the blood supply to the heart or brain, causing a heart attack or stroke. Atherosclerosis is a slow, progressive disease.

■ Attributable risk

A measure of the health impact of an exposure or characteristic (e.g., smoking) on rate of disease occurrence. For a particular risk factor (or exposure), the difference between the rate of occurrence of a disease among the entire population and the rate among persons not exposed. May be interpreted as the rate of disease in a population that would not occur if the exposure could be eliminated. This measure reflects both the prevalence of the risk factor and the increased risk of disease associated with that risk factor.

■ Automated external defibrillator (AED)

A small portable defibrillator which provides treatment for sudden cardiac arrest. The American Heart Association recommends that an AED be available wherever large numbers of people congregate.

■ Basic life support (BLS)

Emergency cardiac care that includes prompt recognition of cardiac or respiratory arrest, access to emergency medical services system, and cardiopulmonary resuscitation (CPR). BLS may also refer to the educational program that provides guidelines for these techniques.

■ Blood pressure

A measure of the force used to circulate blood through the body. When the blood pressure is high, the heart works harder. The increased pressure can damage vessels in vital organs such as the heart, the brain, and the kidneys. Systolic blood pressure measures the force when the heart contracts; diastolic blood pressure measures the force

used to move blood when the heart is at rest between beats. Blood pressure is reported as systolic pressure over the diastolic pressure (e.g. 120/70).

■ Body mass index (BMI)

The ratio of weight in kilograms to height in meters squared; used to determine if a person is underweight, normal weight, overweight, or obese. In children, BMI is calculated in relationship to normal for age.

■ Campaign

A planned, organized, and integrated set of activities with a clearly defined purpose that uses multiple strategies and channels. Campaigns are waged during a defined time and are usually long and sustained.

■ Capacity

The process of improving the ability to plan, organize, implement, and sustain comprehensive interventions. For the CVHI plan, capacity is defined as assets, resources, and commitment necessary to increase cardiovascular health through the support of population-based interventions which emphasize policy and environmental strategies. Capacity is the ability to perform the core public health functions of assessment, policy development, and assurance on a continuous, consistent basis, made possible by maintenance of the basic infrastructure of the public health system, including human, capital, and technology resources.

■ Cardiovascular Health Program – Capacity-Building Funding Level

Formerly called Core Cardiovascular Health Program. A funding level for cardiovascular health programs funded through the Centers for Disease Control and Prevention. A program funded at this level builds capacity, commitment, and resources to develop basic cardiovascular health promotion, disease prevention, and control functions and activi-

ties at the state level through the following components: (1) partnerships and program coordination related to primary and secondary prevention; (2) scientific capacity to define the cardiovascular disease burden; (3) inventory of policy and environmental strategies; (4) a state plan for cardiovascular health promotion; (5) training and technical assistance; (6) population-based intervention strategies; and (7) culturally-competent strategies for addressing priority populations.

■ **Cardiac arrest**

Cessation of the heart's mechanical activity; causes circulation to cease and vital organs to be deprived of oxygen.

■ **Cardiopulmonary resuscitation (CPR)**

Any of the broad range of maneuvers and techniques used to restore spontaneous circulation, including rescue breathing and chest compression. The main objective of CPR is to provide oxygen to the brain and heart until medical treatment can restore normal heart and breathing action (cardio = heart; pulmonary = lung).

■ **Cardiovascular disease**

Any abnormal condition of the heart or blood vessels. Cardiovascular disease includes coronary heart disease, stroke, peripheral vascular disease, congenital heart disease, endocarditis, high blood pressure, hypertensive heart disease, and many other conditions. The circulatory system of the heart and blood vessels is the cardiovascular system.

■ **Cardiovascular Health Initiative (CVHI) Strategic Plan**

A written document specifying current goals, objectives, and activities for cardiovascular health promotion, disease prevention, and control. Strategies emphasize policy and environmental approaches, in addition to education and awareness, to increase support for policy and environmental changes. The Plan is comprehensive and includes population-based interventions. Activities are

coordinated among partners with shared responsibilities and commitment.

■ **Cardiovascular Health Program – Basic Implementation Funding Level**

Formerly called *Comprehensive Cardiovascular Health Program*. A funding level for cardiovascular health programs funded through the Centers for Disease Control and Prevention (CDC). A program funded at this level continues building capacity and is expected to implement, disseminate, and evaluate intervention activities throughout and within the state, including state-level organizations and settings; monitor secondary prevention strategies; complement professional education activities; and extend resources to local health agencies, communities and organizations. Both core and comprehensive program activities would be a part of a state's overall cardiovascular health program, although there may be other strategies, objectives, and activities in addition to those funded by CDC.

■ **Cerebrovascular accident**

An illness of sudden onset caused by the blockage or rupture of a blood vessel in the brain, which can cause mild to severe brain cell damage. May result in loss of muscle function, vision, sensation, speech, or memory.

■ **Chain of survival**

An emergency cardiovascular care system which includes early access, early CPR, early defibrillation, and early advanced cardiovascular care.

■ **Champion**

A person (internal or external) who advocates for legislation, policy changes, resources, or state funding to support the Georgia Cardiovascular Health Initiative. A champion has leadership, special status, or abilities to leverage resources or convince others of the importance of this program and its activities.

■ **Cholesterol**

A form of fat found in the blood stream and animal tissue; present only in foods from animal sources such as whole milk dairy products, meat, fish, poultry, animal fats, and egg yolks. Cholesterol can be deposited in artery walls causing atherosclerosis.

■ **Chronic obstructive pulmonary disease (COPD)**

As used statistically in this document, includes asthma, chronic bronchitis, and emphysema; does not include cancer and pneumonia.

■ **Collaboration**

Group of people who work together toward a common goal and share decision making necessary to reach the goal.

■ **Community**

A social unit that usually encompasses a geographic region in which residents live and interact socially, such as a political subunit (e.g., a county or town) or a smaller area (e.g., a neighborhood or a housing complex). A community may also be a social organization (a formal or informal group of people who share common interests, such as a faith organization). In reality, an individual may be a member of several communities or subgroups defined by a variety of factors, such as age, sex, occupation, socioeconomic status, activities, culture, or history.

■ **Congestive heart failure**

The short- or long-term failure of the heart to pump blood in an efficient manner, usually due to weakened muscle or impaired rhythm. The result is backup of fluid, causing difficulty in breathing or swelling (edema) in other parts of the body.

■ **Contact**

For the purposes of evaluation reporting, contact is the establishment of communication with a person or organization in order to support the Georgia Cardiovascular Health Initiative and enhance cardiovascular health among populations.

- **Convener**
A person or group that assembles a meeting for a common purpose.
- **Core capacity**
The basic requirements needed for public health agencies and other state and local partners to adequately protect and promote health as well as prevent disease and injury.
- **Coronary heart disease**
A condition in which blood flow is restricted through a coronary artery by the thickening of the arterial wall from deposits of plaque. Also known as coronary atherosclerosis or heart disease.
- **Coronary risk factors**
Factors associated with a higher incidence of coronary heart disease. The factors include tobacco use, high blood pressure, high blood cholesterol, and family history of heart disease, diabetes, and physical inactivity.
- **Cost analysis**
The net cost of a policy; calculated by subtracting the cost of illness prevented from the cost of prevention.
- **Cost-benefit analysis**
The cost of a policy compared to improvements in health as measured in dollars.
- **Cost-benefit ratio**
The dollar value of health improvement divided by cost of prevention.
- **Crude death rate**
Number of deaths overall or due to a given cause in a particular population in a given period of time. Death (mortality) rates are expressed in terms of numbers of deaths per 100,000 persons in that population.
- **Culturally-competent intervention strategies**
Interventions that have been designed by, or with guidance from, relevant cultural or population groups; interventions demonstrate sensitivity to cultural dimensions of risk factors and behaviors related to cardiovascular health.
- **Defibrillation**
Procedure using electrical current to restore the normal rhythm of the heart.
- **Diabetes**
A disease in which the body does not properly produce or use insulin. Insulin is needed to convert sugar and starch into the energy that cells use to carry out their proper functions. The full name for this condition is diabetes mellitus. Persons with diabetes develop atherosclerosis earlier, show symptoms of cardiovascular disease sooner, and have more widespread cardiovascular disease which progresses at a more rapid rate than persons who do not have diabetes.
- **Diastolic blood pressure**
The lowest blood pressure measured in the arteries, it occurs when the heart muscle is relaxed between beats. For a blood pressure of 130/76, the number 76 indicates the diastolic, or resting, pressure.
- **Dietary fat**
The amount and type of fat in a person's diet. Fat has more than twice the calories of either carbohydrates or protein; it can adversely affect cardiovascular health. Saturated fats raise LDL ("bad") cholesterol levels in the body; main sources of saturated fats include animal products and some vegetable fats (e.g., coconut, palm kernel, and palm oils). Unsaturated fats do not directly influence cholesterol levels and include olive, canola, sunflower seed, and safflower oils, and oils found in certain fish.
- **Disease burden**
The number of people afflicted with a disease, the number of injuries, the number of deaths, or the ranking of a disease among other diseases, injuries, or causes of death.
- **Economic burden**
Includes medical cost of treating a disease and other costs to the economy, such as time lost from work.
- **Endocarditis**
Inflammation of the lining of the heart, usually caused by an infection.
- **Environment**
The physical, biological, social, cultural and political conditions surrounding and influencing an individual or community.
- **Environmental tobacco smoke (ETS)**
A mixture of irritating gases and tar particles coming from smoke exhaled by smokers (secondhand smoke) and smoke emitted from the burning end of cigarettes, cigars and pipes (sidestream smoke).
- **Epidemiology**
The study of factors which determine and influence the cause, frequency, and distribution of disease, injury, and other health-related events in a defined human population. Information gathered from epidemiological studies is used to establish programs which are created to prevent and control the development and spread of disease and injury.
- **Evaluation**
A system which measures components critical to the success of the Georgia Cardiovascular Health Initiative; includes surveillance, program monitoring, and formative evaluation. Evaluation addresses strategy implementation, changes in policies, and the physical and social environments affecting cardiovascular health, and, ultimately, changes in behavioral risk factors. Involves the systematic collection of information about the activities, characters, and outcomes of program, personnel, and products for use by specific people to reduce uncertainties, improve effectiveness, and make decisions with regard to what those programs, personnel, or products are doing and affecting.

■ **Exercise**

Physical activity that is planned, structured, and provides for repetitive bodily movement.

■ **Focus**

The areas identified for attention by the Georgia Cardiovascular Health Initiative; includes physical activity, nutrition, secondary prevention, and control of hypertension and hyper-cholesterolemia.

■ **Focus group**

A structured interview of a small group of people (usually no more than 12). A moderator asks questions designed to reveal attitudes and perceptions.

■ **Gatekeeper**

Someone to work with or through in order to reach the intended audience or accomplish a task. These individuals stand "at the gate" between the health promotion planner and the target audience and often determine whether the health promotion planner gains access to others. Examples are policymakers, decision makers, homemakers, and heads of households.

■ **Health assessment**

The regular collection, analysis, and sharing of information about health conditions, risks, and resources in a community. The assessment function is needed to identify trends in illness, injury, and death; the factors which may cause these events; available health resources; unmet needs; and community perceptions about health issues.

■ **Healthcare setting**

A setting where healthcare information or treatment is provided. The level of care may vary, depending on community needs and stage of life of the client.

■ **Heart attack**

Death of, or damage to, part of the heart muscle due to an insufficient blood supply; caused by blockage of one or more of the coronary arteries. Also known as myocardial infarction.

■ **Heart disease**

As used in this plan, heart disease refers to coronary heart disease (CHD), coronary artery disease (CAD), or ischemic heart disease (IHD), all of which are ailments of the heart caused by narrowing of the coronary arteries and characterized by a decreased supply of blood to the heart.

■ **High blood pressure**

A long-term increase in blood pressure above its normal range, currently defined by the National High Blood Pressure Education Program as systolic blood pressure at or above 140 mm Hg (millimeters of mercury) or diastolic blood pressure at or above 90 mm Hg. Also known as hypertension.

■ **Incidence**

The number of new and recurrent cases of a disease that develops in a population during a specified period of time.

■ **Individual strategies**

Strategies focused on a single individual and his/her behavior change. They are usually delivered one-on-one by a health care professional. Activities include risk factor screening, counseling, and education to help individuals identify risk and adopt healthy behaviors, as well as treatment, including medication to control risk factors.

■ **Interventions**

In health care, specific activities undertaken to reduce disease risks, treat illness, or alleviate the consequences of disease and disability. An organized or planned activity that interrupts a normal course of action within a targeted group of individual or the community at large so as to diminish an undesirable behavior or to enhance or maintain a desirable one.

■ **Inventory**

A written assessment of policy and environmental conditions relating to cardiovascular health in a specified setting at the state, regional or community level. The process of

conducting an inventory must be systematic, rational, and valid, but the data collection procedure need not necessarily be randomized nor the scale validated. The inventory provides information for planning programs and setting priorities regarding the policy and environmental interventions and activities will be addressed and evaluated for the Georgia Cardiovascular Health Initiative. An inventory should focus on physical activity, nutrition, and/or secondary prevention of cardiovascular disease, including elevated blood pressure or elevated cholesterol. For example, items inventoried for nutrition in a school could include such issues as food service policies, existence of vending machines and contents, or student access to fast food sites near school; physical activity in the community could include availability of sidewalks, access to walking trails and parks, or zoning policies requiring green space and bike lanes; secondary prevention in health care could include standards of care for those with cardiovascular disease or hypertension, inclusion of follow-up practices to promote compliance with medication, or insurance coverage for treatment of cardiovascular disease.

■ **Key informant**

An individual working with various policy and environmental change organizations and/or state and local health agencies; a key informant has valuable knowledge related to the subject and is able to provide expertise on success factors and barriers related to policy and environmental change interventions, sources of information, and roles of agencies.

■ **Maximum heart rate**

According to the American Medical Association, a person's maximum heart rate is approximately 220 minus his/her age. The target heart rate is generally between 50 and 75 percent of the maximum heart rate. This is the ideal heart rate to reach during aerobic exercise like brisk walking or jogging.

■ **Media advocacy**

The strategic use of media to apply pressure for changes in public policy. Increases the capacity of communities to develop and use their voice in order to be heard and seen.

■ **Mixed-use community design**

A plan that connects housing with commercial and recreational areas. The residents have a variety of facilities (e.g., stores, businesses, schools, and entertainment) available within walking distance.

■ **Moderate intensity activity**

Sustained, rhythmic muscular movements that are at least equivalent to brisk walking. Includes physical activities that can be part of a person's daily routine (such as climbing stairs or yard work) as well as those which are done as planned recreation or exercise (such as dancing or swimming). A moderate amount of physical activity is roughly equivalent to physical activity that uses approximately 150 calories of energy per day or approximately 1,000 calories per week.

■ **Morbidity**

A measure of disease occurrence in a given population, location, or other group of interest during an interval of time, usually a year.

■ **Mortality**

A measure of deaths occurring in a given population, location, or other group of interest during an interval of time, usually a year.

■ **911**

An emergency number telephone system to activate the emergency medical system team. By dialing 911 the caller can activate an ambulance service, the police department and the fire department.

■ **Obesity**

An excess of body fat. The standard definition of obesity in adults is having a body mass index (BMI) of 30 or over.

■ **Objective**

A quantitative measurement of change that can and should be accomplished by a specific point in time.

■ **Outcome objective**

A statement of the amount of change expected for a given health problem for a specified population within a given timeframe.

■ **Overweight**

A high level of body fat. The standard definition of overweight in adults is having a body mass index (BMI) between 25 and 29.9.

■ **Partners**

Individuals and organizations that contribute a variety of resources and skills during the development, implementation, evaluation, and realignment of the Georgia Cardiovascular Health Initiative Strategic Plan. Partnerships may be formal (written or verbal agreement, involvement, or commitment) or informal (occasional sharing of information), internal (within the Georgia Department of Human Resources) or external (the American Heart Association). Partners will be involved at different times and in different ways, but all will make positive contributions toward reducing the burden of cardiovascular disease in Georgia.

■ **Partnership**

A group of individuals or organizations working together on a common task or goal.

■ **Passive smoking**

Exposure to secondhand smoke; also known as "involuntary" smoking.

■ **Peripheral vascular disease**

A type of atherosclerotic disease; occurs in the arteries outside the heart, typically in the legs.

■ **Personal health services**

Services or treatment for acute and chronic

disease provided to individuals in one-on-one interactions in clinical settings. Includes services known as primary care.

■ **Physical activity**

Any bodily movement produced by skeletal muscles that results in energy expenditure and is positively correlated with physical fitness.

■ **Physical inactivity**

Lack of regular physical activity; also referred to as sedentary lifestyle. Physical inactivity has been linked to a wide range of chronic conditions, including coronary heart disease, hypertension, and stroke.

■ **Policy**

Rules or principles governing a social system. A policy may be established by either state, federal, or local law or by a company or organization such as a worksite, school, church, or community. Public policy refers to a formal statement of standards by a public official, a legislative body, or by the general election of the public. Organizational policy refers to a formal rule or regulation that governs behavior and practice within an organization or setting.

■ **Population-attributable risk**

For a particular risk factor (or exposure), the difference between the rate of occurrence of a disease among the entire population and the rate among persons not exposed. May be interpreted as the rate of disease in a population that would not occur if the exposure could be eliminated. This measure reflects both the prevalence of the risk factor and the increased risk of disease associated with that risk factor.

■ **Population-based strategies**

Interventions that focus on an identified population (e.g., women age 35-65) or community rather than on individual behavior change. Community-level interventions attempt to influence behavior through mass education, changes in the environment, financial incentives and other strategies that

reach the population at large. Strategies should include policy and environmental changes which are designed to improve heart health.

■ Prevalence

The total number of cases of a disease that exist in a defined population at a specific time; the percent of the population that has a disease or risk factor at any given time.

■ Primary prevention

Actions taken to reduce the susceptibility or development of a disease or risk factor.

■ Priority populations

Population groups that have higher documented rates of cardiovascular diseases and related risk factors, lack access to services, or represent greater socioeconomic disparities when compared to the general population. Groups selected by CVHI for targeted interventions include African American, Latino, rural, and low-income populations.

■ Process objective

A statement of the tasks that will be completed during the course of a project, activity, or program; describes what a program intends to accomplish.

■ Program

A set of planned activities over time designed to achieve specific goals and objectives.

■ Public health interventions

Interventions designed to influence or impact public health. May include creating or supporting laws, regulations, and rules. May also include changes to the economic, social, or physical environment.

■ Public health system

An organized and structured network designed to improve or maintain health, including organized community efforts to

prevent, identify, and respond to things which can jeopardize the health of a community. Examples of governmental agencies involved in the state's public health system include the Georgia Department of Human Resources, Division of Public Health; local health departments; and the Centers for Disease Control and Prevention.

■ Regular physical activity

Moderate intensity physical activity for a total of at least 30 minutes per day, at least five days per week. If the physical activity is vigorous, the duration and frequency can be shorter.

■ Relative risk

The ratio of the rate of occurrence of disease among those with a specific risk factor or exposure to the rate among those not exposed. It is a measure of the strength of the association of a risk factor or exposure with the disease.

■ Risk factor

A habit, behavior, characteristic, or finding on clinical examination that is consistently associated with increased possibility of a disease or complication from that disease. Risk factors addressed in this plan, such as tobacco use and physical inactivity, have been identified through research as causes of atherosclerosis, heart disease, and stroke. Prevention or modification of these risk factors will reduce probability of development of cardiovascular disease.

■ Secondary prevention

Activities which treat or rehabilitate people with established disease (e.g., those who have had a heart attack or stroke) to promote health and to prevent further disease.

■ Sedentary lifestyle

A lifestyle characterized by little or no regular physical activity.

■ Settings

The location where interventions are implemented. The Georgia Cardiovascular

Health Initiative targets worksites, schools, health care and community settings. Some examples include churches, grocery stores, health clinics, large corporations, and small businesses.

■ Social marketing

The act or process of applying advertising and marketing principles and techniques to health or social issues with the intent of influencing people to adopt a healthy behavior or change an unhealthy or undesirable one. The social marketing approach is used to increase the acceptance of a new idea or practice within a target population.

■ Special population groups

Segments of a population in which the burden of a disease falls more heavily than on others; may be described in terms of gender, age, or race. Additional cases of the disease may be reduced or prevented by using culturally appropriate intervention approaches and methods.

■ Special survey

A one-time survey that is designed for a special purpose: to increase understanding about the burden of a particular disease; to assess of community awareness, or to provide insight regarding planning appropriate and relevant programs.

■ Stakeholder

An individual or organization that has something to gain or lose as a result of a decision, idea, action, or policy; may have a unique appreciation of the issues or problems involved. Stakeholders include people who manage or work in the program or organization, those who are served or affected by the program or work in partnership with the program to achieve its goals, and people in a position to do or decide something about the program.

■ Strategy

A plan or method used to achieve a goal. Effective strategies are research-supported, cost-effective, theory-based, and data-driven.

■ Stroke

A medical condition which occurs when blood vessels to the brain burst or become clogged by a blood clot or some other particle; results in a lack of blood flow and oxygen to the brain and death of nerve cells.

■ Support

For purposes of the Georgia Cardiovascular Health Initiative, support is defined as information sharing, dedication of resources, or in-kind contributions to the Initiative.

■ Surveillance

The continuous monitoring of measures (e.g., behaviors, attitudes, diseases, or deaths) over a regular interval of time; utilizes ongoing data collection, analysis, and interpretation of data; disseminated to public health professionals for evidence-based decision making.

■ Targeted strategies

Approaches or interventions that target high-risk groups and provide assistance in preventing, reducing, or modifying risk factors. These strategies should take into account the specific needs of the target population and should be culturally appropriate.

■ Technical assistance

The act of giving of advice or consultation on specific issues relating to Georgia Cardiovascular Health Initiative and its activities.

■ Tertiary prevention

Measures to reduce impairment and disability due to an established disease or condition.

■ Training

The transfer of information in a structured situation that increases the skill level of the participants; enhances the ability of the Georgia Cardiovascular Health Initiative to achieve its goals (e.g., learning to make policy and environmental changes in a community).

■ Vigorous physical activity

Rhythmic, repetitive physical activities that use large muscle groups; represents a substantial physical challenge to an individual; results in significant increases in heart and respiration rate.

■ Walkable communities

Communities in which walking is safe and convenient. Characteristics of these communities include: a central hub that includes retail stores, housing, entertainment, businesses, and access to civic services; sidewalks on all streets; interconnected streets; few highways; good transit services; mixed land use; and public areas.

■ Wellness activities

Initiatives that are designed to improve or maintain the health of population groups, communities, and organizations.

Appendix C: References

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Appendix D: Resources

RESOURCES

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	Division of Public Health, Chronic Disease Prevention and Health Promotion Branch, Physical Activity Program	Vicki Pilgrim vcpilgrim@dhr.state.ga.us 404-657-6644
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	University of Georgia, Cooperative Extension Service (<i>Walk-A-Way</i>)	Rosemary Stancil rstancil@uga.edu 706-542-7930
	International Life Sciences Institute, Center for Health Promotion, (<i>Take 10!</i>)	Debra Kibbe dkibbe@ilsi.com 770-934-1010
	Wellness, Inc. (<i>Organwise Guys</i>)	Michelle Lombardo wellness@abrisis.com 770-495-0374
	Centers for Disease Control and Prevention, Division of Adolescent and School Health (DASH) (<i>School Health Index</i>)	Howell Wechsler 770-488-6197
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