Seattle & King County

The *Steps to a HealthierUS* five-year cooperative agreement program aims to help Americans live longer, better, and healthier lives by reducing the burden of diabetes, overweight, obesity, and asthma and addressing three related risk factors—physical inactivity, poor nutrition, and tobacco use.

For FY 2003, this U.S. Department of Health and Human Services (HHS) program allocated $13.6 million to fund 23 communities, including Seattle and King County in Washington, to implement community action plans to reduce health disparities and promote quality health care and prevention services.

Project Area
Six contiguous cities in Seattle and King County, Washington (population 352,836); includes three school districts.

Target Population for *Steps* Interventions
People with household incomes less than 200% of the federal poverty line, English, Spanish, and Vietnamese-speaking people.

Proposed Interventions
Media

- Promote public awareness of chronic diseases and their symptoms; the importance of proper diagnosis and medical care; and the impact of nutrition, physical activity, and tobacco use on health through targeted media campaigns.

Policy

- Review a range of policies to prevent and control chronic illness, including
  - Cultural competence in asthma, diabetes, and obesity clinical management.
  - Funding mechanisms to support care coordination, self-management education/support groups, community health workers, and access to medical supplies.
  - School policies that support students with asthma and diabetes, discourage sales of nonnutritious foods, and encourage physical activity.
  - Housing and community development policies that support physical activity, nutrition, and healthy home environments for people with asthma.

School-Based

- Complete a comprehensive School Health Index (a CDC assessment and planning guide) to identify targets for interventions in *Steps* schools.
- Implement a comprehensive, prevention-oriented health curriculum.
- Train and support staff in asthma trigger reduction in the school environment and diabetes management.
- Use asthma action plans for all students with asthma.
- Provide chronic disease and healthy living education for students.
- Conduct staff wellness promotion activities.
- Increase opportunities for physical activity.
- Create an environment that supports healthy eating.

Community-Based

- Conduct diabetes education and self-management classes at community sites.
- Facilitate support groups tailored to the cultural and language needs of participants.

- Support community health workers who make home visits to encourage asthma and diabetes self-management and provide community outreach and education.
- Train child care providers in asthma management and breast-feeding promotion.
- Expand the Master Home Environmentalist program, designed to help people learn more about health risks from pollutants in their homes through free home assessments.
- Work with faith communities to train lay educators in health promotion.
- Disseminate diabetes self-screening tools.
- Work to improve asthma awareness and care through neighborhood committees.
- Promote environmental and programmatic interventions to encourage physical activity (e.g., running for adolescent girls, walking groups, biking to school) and good nutrition (e.g., food preparation demonstrations).

Workplace

- Implement point-of-decision physical activity prompts (e.g., use the stairs, not the elevator).
- Conduct food preparation demonstrations.

Health Care

- *Clinics*
  - Improve the quality of care for asthma, diabetes, and obesity using the Chronic Care Model.
  - Use chronic disease and wellness coordinators to facilitate systems change to implement quality improvement activities, link patients with community resources, and provide limited case-management services.
  - Establish and maintain tracking systems to monitor quality of care.
  - Offer training to staff in asthma and obesity management.
- *Emergency Departments*
  - Establish a reporting system of asthma and diabetes visits for epidemiological surveillance and clinical follow-up.
- *Medicaid Managed Care Organizations*
  - Share anonymous utilization and pharmacy data.
  - Coordinate member education with *Steps* community-wide education messages.
  - Coordinate case management.
  - Refer members to *Steps* and other community resources.

Evaluation

HHS will provide training and technical assistance to help each *Steps* community develop measurable program objectives and specific indicators of progress and use relevant data to support ongoing program improvement. HHS also will conduct a national evaluation of the overall program. Existing data sources, such as the Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System, will be used to identify and measure program outcomes and assess progress toward program goals.

Community Consortium

The *Steps* Consortium is open to all organizations, agencies, and persons interested in the *Steps* initiative. There are currently over 100 members, including community-based organizations, health care providers, hospitals, health plans, clinics, universities, faith-based groups, government agencies, and school districts.

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Note: *Steps* communities have until May 2004 to finalize their community action plans. Proposed interventions may change accordingly.