

## Steps to a HealthierFL-Pinellas County

U58/CCU423316-02

### 2004-2005 ANNUAL PROGRESS REPORT

## Program Overview and Activities

### 1. Program Overview

#### a. Background Information and History

**Overall Project:** Steps to a Healthier Pinellas is designed to impact the diseases and associated risk factors of obesity, asthma and diabetes in the selected intervention area (IA) of Pinellas County, FL. The **Pinellas County Health Department** (PinCHD) serves as **lead agency**.

PinCHD continued the Steps Project in Year 2 with key community partners through formalized agreements and contracts. Steps interventions have been designed at two levels, School and Community, using evidence – based, culturally inclusive strategies with specific short term and long-term measurable outcomes. The interventions have been designed to deliver education and awareness of diseases and risk factors and not treatment or research.

**Demographics:** Pinellas County (921,482), part of the Tampa Bay area, is the most densely populated county in Florida. Located in the South part of Pinellas, the intervention area (area) contains four (4) contiguous cities: St. Petersburg (248,232), Pinellas Park (45,658), Gulfport (12,527) and Kenneth City (4,400), with a total population of 310,817 (W: 74.9%, B: 18.5%, O: 6.6% H: 4.5%) **The IA contains 58 schools** (W: 60.6% B: 26.2% O: 7.1% H: 6%) with a total enrollment (based on 2003-04 data) of over 57,900.

Demographics*	Intervention Area/St. Petersburg	Pinellas County
Black Race	18.5%	9%
Over 44 Yrs of age	41.6%	47%
Median Age	39.3 Yrs	43 Yrs
Income < \$35,000	51%	47.1%
Families < FPL with children <5	18%	14.5%
WIC Participants – Black Race	38.3%	29.9%
Subsidized school lunches	48.6%	35.8%
Schools – Students’ Race: Black	26.2%	18.8%
No high school diploma	18.4%	16%

\*Complete US Census 2000 data

**Target Populations:** Steps target populations include both the schools and minorities. The IA area was selected because its population has a larger proportion of minorities and is younger, poorer and less educated than the county leading to health disparities. The County’s largest minority population (B:18.5%) is located in the Greater South Central Neighborhood Front Porch Community that covers 1.75 sq. miles of St. Petersburg with a population of 7,956 (B: 91%) including 4,520 African-Americans (45%) with incomes below the poverty level.

Community Barriers/deficiencies	State Barriers/deficiencies
Population not ready to change (food culture)	Budget shortfalls
Lack of funding, resources and insurance	Redirection of funding to bioterrorism issue
Poverty/low education levels	Changes in legislative mandates
Poor transportation system/safety issues	Funding cut: youth tobacco program (2003)
Funding cuts in hospital wellness programs	Hot summer weather in Florida
Limited no cost smoking cessation, nutrition classes, adolescent weight loss classes	Lack of counter media campaign for healthy food choices
Tourism industry promotes fast food choices	Lack of PE requirement in HS curriculum

**b. Summary of Disease Burden and Relevant Risk Factors**

Education and Health Literacy: The Pinellas School District is the 7th largest in Florida and the 22<sup>nd</sup> in the US with 143 public schools (over 148,000 students), plus nearly 100 private schools. A study, “Literacy and Health in America,” from Educational Testing

Service (ETS) and Harvard School of Public Health identifies the health-related literacy skills of U.S. adults and finds marked differences among adults based on their education, age, wealth and country of birth. Literacy appears to be a major factor linking health and education and contributes to disparities in health status, access to care and the quality of health care for many.

**Racial Literacy Disparity**

Race	White		Black	
	2004 <sup>#</sup>	2005*	2004 <sup>#</sup>	2005*
% of students reading at or above grade level	61%	63%	26%	30%
% of students scoring at or above grade level in math	64%	69%	24%	30%
% students earning a standard diploma	67%	72%**	37%	43%**
Black students were 4 times more likely to be placed in special education classes <sup>#</sup> .				
Black students were 3 times more likely to receive out-of-school suspension <sup>#</sup> .				
*Source: St. Pete Times, June 9, 2005				
**Source: St. Pete Times, August 17, 2005				
<sup>#</sup> Source: St. Pete Times, May 16, 2004				

**Disease Burden:**

**Diabetes**

Diabetes	Pinellas		Florida		Pinellas Disparity AADR			
	2003	2002-04	2003	2002-04	1999		2002-04	
Race					White	Black	White	Black
AAADR	21.7	20.7	21.2	20.8	18.4	71.4	18.6	64.4
BRFSS*	Pinellas (IA)		Florida		Pinellas – AHCA 2003			
	2004	2005	2002	2004	Over 1,600 hospitalized at a cost of \$ 36.2 million			
	8.5%	11%	6.5%	7.7%				

\* Diabetes diagnosis

**Asthma**

Asthma	Pinellas		Florida		Pinellas Disparity AADR			
	2003	2002-04	2003	2002-04	1999		2002-04	
Race					White	Black	White	Black
AAADR*	37.0	38.5	38.5	38.1	45.5	35.9	39	33.9
BRFSS**	Pinellas (IA)		Florida		Pinellas – AHCA 2003			
	2004	2005	2002	2004	Over 500 hospitalized at a cost of \$ 7 million (Asthma)			
	10.9%	13%	10.7%	12.3%				

\* Chronic Obstructive Lung Disease \*\*Ever had asthma

**Overweight/Obesity**

Adult	US	Florida	Pinellas	Pinellas (IA)	
BRFSS	2002	2002	2002	2004	2004
Race					<b>Black</b> <b>White</b>
<b>Overweight</b>	37%	35.1%	36.8%	35%	36.9%   34.3%
<b>Obese</b>	22.1%	22.3%	20.6%	19.8%	39.3%   17.7%

Youth	Florida	Pinellas						
Source	YRBSS	YRBSS (IA)	Fitness Gram Data					
	2003	2005	2004	2005	2004	2005	2004	2005
School Grade	<b>9-12</b>	<b>9-12</b>	<b>9-12</b>		<b>6-8</b>		<b>1-5</b>	
<b>Overweight</b>	12.4%	10.7%	49%	32%	53%	30%	35%	27%

**Youth Tobacco**

Florida Youth Tobacco Survey (FYTS) – Tampa Bay Area				
	Middle School		High School	
	2002	2004	2002	2004
<b>2<sup>nd</sup> hand Smoker</b>	65.1%	63%	75.1%	74.7%
<b>Never Smoker</b>	56.1%	58.8%	41.7%	43.1%
<b>Current Smoker</b>	9%	9.6%	19.3%	21.3%
<b>Lifetime Smoker</b>	No Data	29%	No Data	51.3%

**Adult Risk Factors**

BRFSS		Pinellas	Pinellas (IA)	
Adult Risk Factor	Indicator	2002	2004	2005
<b>Nutrition</b>	Consume at least 2 fruits per day	No data	No data	19%
<b>Asthma</b>	Ever told by doctor they have Asthma	12.8%	10.9%	13%
<b>Tobacco</b>	Current Smokers	23.4%	26.4%	26.8%
<b>Diabetes</b>	Ever told by doctor they have Diabetes	10.4%	8.5%	11%
<b>Obesity</b>	Adults who are Obese	20.6%	19.8%	No data
<b>Physical Activity</b>	No leisure time physical activity	21.2%	25.5%	18%
<b>Physical Activity</b>	Engage in moderate physical activity	46%	74.5%	81%

## **2. Program Goals and Objectives**

### **a. Program Accomplishments and Progress in Year 2**

In Year 2 **Steps exceeded or met 77% of a total of 95 short term and intermediate outcomes.** Through the influence and participation of the Steps project, continued progress was made in the fight against obesity, asthma and diabetes. Steps was a constant presence influencing achievements at the state, county and local levels. The Steps media campaign continued to showcase Steps community events and activities. With the creation of the new Steps to a Healthier FL logo the program was able to move forward “branding” the program logo and messages.

#### **State Wide Accomplishments:**

**Continued State Efforts to Address Obesity** – Steps was an active participant in statewide obesity initiatives. In October 2003, Florida’s Governor created the **Governor’s Task Force on the Obesity Epidemic.** The Task Force was created to recommend ways to promote the recognition of overweight and obesity as a major public health problem in Florida. Through the Steps connection with the **Florida Department of Health**, the **Pinellas County Schools were invited and delivered a presentation** at the School Setting summit highlighting the partnership between Steps and the School District.

The task force will be considering future policy initiatives at the state and local level that will ultimately impact positive behavior change and improve lifestyles of citizens.

Between October 2004 and May 2005 the Task Force held **four (4) summits throughout the state** focusing on the topics of: Worksite Wellness, the **School Setting**, Clinical Setting (NHLBI Guidelines), and Community and Faith Based solutions. At the

request of the **FL Department of Health’s, Office of Chronic Disease Prevention** Steps was asked to spearhead the “**Step Up, Florida – On our way to healthy living**” campaign in Pinellas County. This annual statewide initiative promotes physical activity and healthy lifestyles to Florida’s citizens and visitors. The Steps projects in **Pinellas and Hillsborough Counties** capitalized on this event by passing the “Step Up” flag in relay fashion on the Friendship Bridge that **links both counties** across Tampa Bay. This event kicked off a successful and ongoing partnership between the two counties.

**County Wide Accomplishments:**

While Steps intervention area is located in the south end of Pinellas County, the influence of an active media campaign, the success of program initiatives and word of mouth, “Steps-like” services have reached far beyond the IA to all areas throughout the County. As a result the **Partnership for a Healthier Pinellas** has formed a subcommittee to determine methods to get funding to expand the existing Steps projects beyond the borders of the IA. One example of this success was a partnership with Steps partner **All Children’s Hospital** and the **Suncoast branch of the YMCA**. These two agencies have worked together to bring the “**KidShapers**” family weight management program into the Y’s in North County.

After witnessing the success of programs in the Steps IA, the school district has **expanded the salad program** as well as enhanced nutrition education to the north county schools. The Steps school staff nutritionist has been working with the district’s food service staff offering technical assistance to implement the programs. An additional collaboration has recently occurred between the school district and the **Pinellas County Health Department**. Because of the success of the indoor air quality assessments being

conducted by the **Steps environmental specialist**, the school district has asked for assistance checking the air quality in schools throughout the county. The district has had some negative publicity because of a mold situation in one of the areas elementary schools. They invited the Health Department into the school for evaluation and recommendations and will continue to increase monitoring throughout the district. **This can become a self sustaining program funded by the school district.**

### **Local (IA) Accomplishments**

A large part of the Steps accomplishments in Year 2 have been through the collective efforts of the partners. Through the oversight of the Pinellas County Health Department (Lead Agency) the Steps Leadership Team increased collaborative efforts for the benefit of all the members. The Leadership Team meeting was one of the highlights of the CDC site visit report. The following is an excerpt from the report, *“The Pinellas Steps Leadership Team is a close knit group, almost a family. It was exciting to hear each of the members discuss their part of the Steps program and best of all how they were all working together.”*

### **Partner Accomplishments:**

The majority of the Steps partners provided exemplary programs throughout Year 2 and worked tirelessly to achieve short term outcomes as described in section b. Community Action Plan. Additional accomplishments beyond those included in the Community Action Plan are described below.

## Pinellas County School Districts

The Pinellas County School District has been extremely supportive of the Steps grant initiatives. The Steps School Coordinator is a member of the Leadership Team and has been very proactive throughout the school system. Some highlights from Year 2 are:

- The Steps program was a featured program of the Pinellas County Schools Journal on Channel 14. The program provided an overview of the program with interviews with the school Steps staff.
- Steps participated in a televised panel discussion on obesity with Channel 18. The panel consisted of physicians, families, and Steps partners involved with nutrition and physical activity. The program was filmed with a live audience and received live calls for a question and answer session.
- The Steps Pinellas County Food Service program was published in **The 5 A Day the Color Way School Food Service Guide**. This was created by *Produce for Better Health*.
- The Steps to a Healthier FL- Pinellas County presented at the following conferences:

Florida Obesity Summit	(Dec. 04)
Florida State Food Service Association	(April 05)
USF's Sixth Annual Obesity Conference	(April 05)
CDC 2 <sup>nd</sup> Annual Steps to a Healthier US	(June 05)
Pinellas County Wellness Expo	(July 05)
National Food Services Association	(July 05)

- The Pinellas County School District is now requiring a School Improvement Goal focused on student fitness. As a result of Steps, every school is required to write a fitness goal with a focus on the **FitnessGram** assessments being done in the physical education classes. It is to be part of the school improvement plan submitted each year.
- Three schools within the Steps grant intervention area received state funding to implement the **School Health Index**. The Steps school coordinator provided technical assistance to each school as incentive to implement the SHI.
- A **Wellness Policy Task Force** has been created and the Steps Program manager was invited to participate in order to develop healthy guidelines for food and physical activity within the school system. The first meeting was held March 31, 2005. Members include school administrators, community representatives, the

medical profession and parents. A **district wellness policy** is being developed to meet federal law requirements for the 2006-2007 school year.

- The new Automated Dialing telephone communication system within the school district has opened a wider door for Steps information/activities to get into every students home within the intervention area.

**YMCA of Greater St. Petersburg:**

The YMCA has been an active partner in Year 2 increasing school and community physical activity programs. The YMCA also applied for and received \$10,000 from the YMCA of the USA. The funding was used to produce videos that can be shown in clinics, health provider offices and other areas to promote physical activity and the Steps program. Another highlight for Year 2 at the YMCA was the **Lunch Bunch Program** conducted at Gulfport Elementary. This voluntary program was held during the lunch period. The program consisted of ten minutes of exercise, and a healthy lunch during which the importance of good nutrition and exercise were discussed. The Lunch Bunch was **a success in its first year**. During the first nine week session, the enrolled children started vegetable gardens. Five gardens were planted and maintained by students on campus. The children helped to harvest, clean and prepare the vegetables. The cafeteria utilized them as part of the students' meals, and parents met at night to preserve and can the vegetables. **Overall, the cafeteria manager reported that the students at Gulfport Elementary were choosing more salads and healthy choice menu items.** Parents of students involved in the program reinforced this statement through stories to the Lunch Bunch instructor of their children choosing healthy items at fast food restaurants.

**Pinellas County Extension:**

The Pinellas County Extension continued to expand on activities in Year 2.

Accomplishments included:

- Steps staff delivered a program to the Pinellas District Dietetic Association.
- 4-H student mentor presented to the Institute of Medicine in Washington D.C.
- Staff presented to the Florida Restaurant Association on “Meeting The Challenge of Obesity”, October 23, 2005, in Orlando, Florida
- Participated in two television program segments highlighting Steps in after school and summer programs. Programs were produced in conjunction with Juvenile Welfare Board and the City of St. Petersburg.
- Collaborated with the American Heart Association’s Search Your Heart program to offer faith-based organizations programs in the community. Provided a monthly nutrition program preceding their Search Your Heart Session. In addition, Extension provided the nutrition training for participants in the program.
- Provided a Head Start nutrition program for participants in their Fatherhood program.

**b. Progress made in achieving short-term and intermediate outcomes.**

**c. Relevant barriers, unmet goals objectives, activities, and specific plans to address them.**

**e. Description of activities, including the extent to which activities were implemented; and changes to planned implementation.**

The project chooses to combine sections b. c. and e. in the Community Action Plan. The

Community Action Plan Matrix is contained in section h.

**The Community Action Plan** is divided into two sections: Community and School-based Interventions. The Plan breaks down activities into six (6) areas: Nutrition (**N**), Obesity (**O**), Diabetes (**D**), Physical Activity (**P**), Tobacco (**T**), and Asthma (**A**). Other abbreviations include: Long Term Outcomes (**LTO**), Short Term Outcomes (**STO**), Elementary (**ES**), Middle (**MS**), and High (**HS**) schools and Intervention Area (**IA**).

**Section 1: Community Interventions**

**Area: Nutrition (N)**

**N-1:** Continue Expansion of *PinCHD* general nutrition services by assigning a part time nutritionist to the project and by a renewed contract with *Pinellas Cooperative Extension Center* to provide outreach community nutrition services.

**Status:** Met

Due to increased requests from partners and community members for nutrition services the part-time position was increased to a full time position 12/04. Pinellas Cooperative Extension Center contract renewed, 10/01/04.

**N-2:** Conduct 1 hr class to children in after-school programs consisting of 30 minutes of 5 -A -Day and 30 minutes of physical activity.

**Status:** Exceeded

42/25 sites

337/550 classes

7,151/7,000 children

**Activities:** A 6-week curriculum that included nutrition, fitness and healthy snack preparation activities was used to teach hour-long sessions focusing on exercise, the food guide pyramid, fruits and vegetables, portion distortion, healthy snacks, the food label, and fast foods. Hands on activities involved the youth in learning about various aspects of nutrition.

A food preparation activity featuring fruits and vegetables was used to help bring the learning home. At the end of every lesson, the children were given a lesson-related health challenge to meet during the week. If a child met the challenge for the week that child received a star next to his/her name on the Challenge Chart. At the end of the six-week program children who met all five challenges were given a small prize. Certificates

of completion with the Steps logo were provided to children at the end of the six-week session.

**R'Club Sites**

Skyview Elementary  
Pinellas Park Elementary  
Blanton Elementary  
Shore Acres Elementary  
Bay Vista Elementary  
Pinellas Park Elementary  
74<sup>th</sup> Street Fundamental  
Pasadena Elementary  
Rawlings Elementary  
Bay Vista Elementary  
Cross Bayou Elementary  
Gulfport Elementary  
Lakewood Elementary  
Lealman Elementary  
Tyrone Elementary  
Maximo

**YMCA Sites**

North Shore Elementary  
Azalea Elementary  
Jamerson Elementary  
Baypoint Elementary  
Pinellas Central  
Bear Creek Elementary  
Mt. Vernon  
Northwest  
Perkins  
Sawgrass  
Woodlawn  
Clearview  
Fairmount Park  
Sexton Elementary  
Rio Vista  
Gills YMCA  
Harbordale YMCA

**City of St. Petersburg Sites**

Child's Park Recreation Center  
Campbell Park Recreation Center  
Northwest Recreation Center  
Lake Vista Recreation Center  
Shore Acres Recreation Center  
Walter Fuller Recreation Center  
Wildwood Recreation Center

**City of Gulfport Sites**

Gulfport Recreation Center

**City of Pinellas Park**

Forbes Recreation Center

**N-3** – Conduct AHA Step 1 and 5 A Day to youth and adults. (This Objective was a combined effort of the PinCHD Nutritionist and the Cooperative Extension.)

**Status:** Unmet

48/33 sites established                      337/550 classes                      4416/5500 participants

**Barriers:** The County Extension found it difficult to reach the required number of class participants in spite of aggressive marketing and promotions.

In addition due to staffing changes the PinCHD nutritionist was not fully trained and oriented until mid year.

**Barriers Addressed:** Through integration with other Steps partners the Extension is providing three (3) nutrition programs weekly for the eight week Parent and Adolescent Conditioning Program (YMCA). Extension is also working with the diabetes program to present the nutrition portion of the series. Plans are underway to do programs at Gulfport and Blanton ES. These efforts will provide additional audiences and programming opportunities to help meet this deliverable.

The PinCHD nutritionist is now trained and oriented to the project. This will allow for classes to be promoted and outside referrals can now be completed.

**Program sites in Year 2 are listed below:**

Gulfport Senior Center  
St. Petersburg Sunshine Center  
St. Petersburg Free Clinic  
Sanderlin Center  
Gills YMCA  
Perkins Elementary  
Harris Tips  
Wesleyan Church  
Lutheran Apartments  
Transitions Optical  
R'Club Administrative Office  
Roberts Recreation Center  
Willis S. Johns Recreation Center  
Lealman Family Center  
Sanderlin Center  
PACE Center For Girls  
Harbordale YMCA

St. Joe's Catholic Church  
Hope Lutheran Church  
Village Green Mobile Home Community  
Habitat For Humanity  
Boyd Hill Park  
John Hopkins Middle School  
Head Start  
Mt. Zion Church  
Presbyterian Apartments  
Juvenile Welfare Board  
Frank Pierce Recreation Center  
Gladden Park Recreation Center  
Johnnie Ruth Clarke  
Woodlawn Center  
Pinellas Park Boys and Girls Club  
Academy Prep

**N-4:** *PinCHD* will maintain contract with *Bayfront Medical Center* to retain 2 part-time dietitians. The dietitians will be out posted to 2 *FQHC clinic sites* to provide 5 A Day education to pediatric clients.

**Status:** Exceeded 1222/1000 pediatric clients

**N-5:** Expand *PinCHD* Healthy Kids' Restaurant campaign to label, "Heart Healthy," choices for adults in community and ethnic restaurant menus. Nutritionist will evaluate menus for AHA "Heart Healthy" guidelines.

**Status:** Exceeded 62/50 Restaurants

**Activities:** The program has expanded both healthy kids (Strong Heart) and adults (Steps) restaurants. The number of approved healthy restaurants through Years 1 and 2 has reached a total of 87. The healthy restaurant program has been a success and is promoted not only to the DOH employee's but it is on the *PinCHD* Wellness website for public view. Each restaurant is sent a certificate to display for their customers informing them that the restaurant provides "healthy heart" adult and kid's menu choices.

**Note:** The initial number of restaurants posted in Year 1 for the IA of 85 was inaccurate the actual number was 25.

**N-6:** Promote and expand *PinCHD* Pinellas Wellness website to include BMI information and links to major health sites and nutrition and exercise classes/programs.

**Status:** Unmet 1340/2125 Average "hits" per month.

**Barriers:** Website hits have decreased and leveled off in Year 2. This could be due to a variety of reasons including the website design and fewer repeat visitors.

**Barriers Addressed:** The web address, [www.PinellasWellness.com](http://www.PinellasWellness.com) will continue to be mentioned at every interview on TV, radio and print media. The web address is on all pieces of literature from the PinCHD Office of Chronic Disease Prevention. At the end of Year 2 the website was redesigned to be more user friendly and contain more links and highlight upcoming events. The new format has received positive reviews and it is anticipated the average monthly hits will increase in Year 3 with continued updates.

**N-7:** Promote and expand *PinCHD* "Parent Health Bulletin" featuring healthy eating tips for parents.

**Status:** Exceeded 80/75 sites

**N-8:** Conduct 5 A Day and healthy choices promotion as part of major media campaigns described earlier. Expand Year 1 partners and increase # of messages by 5% in year 2.

**Status:** Exceeded 4780/455 messages

**School Action Plan:**

**Area: Nutrition (N)**

**N-1:** *PinCHD* will maintain contract with schools to retain a Nutrition Educator.

**Status:** Met

**N-2:** Expand "Five a Day the Color Way Salad Program"

**Status:** Met 10/10 ES in the IA

**Activities:**

In Years 1 and 2 a total of ten (10) schools have implemented new salad programs.

Sawgrass Elementary, Rio Vista Elementary, Clearview Elementary, Azalea Elementary were added this 2004-05 grant year. During salad promotions at 4 schools there were a total of 1602 participants. Most students will choose 1-2 fruits or vegetables when going

through the lunch line if a salad is not selected. Every school cafeteria manager in the district has been trained to produce 15 different varieties of pre-packaged salads. Some of the district schools have taken the initiative to offer these salads prior to a salad promotion day sponsored by the Steps.

**N-3:** Offer "Organ Wise Guys" characters and materials interactive classroom curriculum in ES schools.

**Status:** Exceeded 15/10 ES 90% (4217/4683) students receiving curriculum

**Activities:** The Organ Wise curriculum has been implemented in Steps schools reaching a total of 4217 students. As a result of Steps success Organ Wise Guy Curriculum and/or nutrition education has been expanded to 17 additional schools outside the IA.

**N-4:** Maintain "MORE Health-Fit for Life" 8<sup>th</sup> grade curriculum (2-50minutes presentations) to all 11 MS & introduce "More Health-Eating Disorders to all 7 HS and "More Health Nutrition Pyramid Power" to all 35 ES.

**Status:** Met in MS and HS, Unmet in ES by 1 school  
MS 11/11, HS 7/7 ES 34/35

**Discussion:** MORE Health: "Fit for Life" – implemented in 8<sup>th</sup> grade classes in 11 middle schools and reached 2,245 students. The "Food for Thought" was implemented in all 7 high schools and reached 1,710 students. "Pyramid Power" was implemented in 34 of the 35 elementary schools and reached 3,084 students.

**Barrier:** Pinellas Park Elementary school did not receive the lesson because of difficulties scheduling with the administration.

**Barrier Addressed:** Additional attempts will be made to coordinate with school administration in the one ES.

**N-5:** Produce and disseminate Healthy Eating and physical activity media materials (district TV channel, posters in school cafeterias, video materials, etc.) and expand in Yr. 2-5.

**Status:** Exceeded 268,244/15,750

**Activities:** Healthy Eating and Physical Activity Materials – a variety of materials have been printed for use in the program and distributed to schools within the intervention area including posters, folders, letters, certificates, survey forms, calendars, agendas, educational worksheets, brochures, charts, information sheets, color books, post cards, report forms, program applications, memos and menus. Healthy Eating Videos – In addition students are participating in creating healthy eating videos for IA schools. During the district Wellness Expo training in August 2005, over 500 teachers were provided training and resources in health and physical education. The *Super Size Me* DVD was distributed along with 20 lesson plans to all teachers attending the training session. The Steps grant provides a resource center for distributing on a free loan basis to all Steps schools.

**N-6** Administer a customized YBRS in 3<sup>rd</sup> grade in Years 1, 3, and 5.

**Status:** Not scheduled for Year 2

**Community Interventions**

**Area: Asthma (A)**

**Children’s Outreach/Case Management and Environmental Interventions:**

**A-1:** *PinCHD* will contract with *ACH* to retain an **outreach case manager** in Year 2.

**Status:** Met

**Activity:** A new case manager was hired 11/22/04, following the October 1<sup>st</sup> resignation of previous case manager.

**A-2:** *ACH* to provide **outreach** and **case management (CM)** services for children with asthma. Services includes monthly face to face or telephone contact, monitoring medication compliance, patient and family counseling, education, appointment reminder system, referral and follow-up for community, family, or mental health services, and documentation of self-report of number of days missed for school/work.

**Status:**

Unmet for # of CM children	162/400
Met for # hospitalizations (ACH) <18	311/346
Met for # ER visits for children	894/965
Met for CM children with primary care provider	162/162
Met for CM children compliance with medication	162/162
Met for CM children completing referral process	100/162
Unmet for CM school days missed	327/263

**Barriers:** Loss of momentum with resignation of previous case manager.

No consistent case manager for a 12-month period. In addition the new case manager was new to the community and needed to develop relationships with the Steps partners and with community health providers. It was necessary to learn community resources. Most

of the clients referred are from a low socio-economic level and often are faced with multiple social challenges. The case manager has had to work hard to help clients understand that he is not there to report them to child welfare authorities or law enforcement agencies. The CM has been told directly “oh, I thought you were from the police” or “I thought you were an inspector.” Other challenges are related to the client’s lack of experience in making appointments and keeping them. It may take multiple phone calls to get an appointment for a home visit; then, the case manager arrives only to find no one at home. He usually leaves a polite note and a brochure, which sometimes promotes the family’s willingness to reschedule.

Most clients are not voluntary in the sense that they have not approached the case manager for services. The above description also explains the difficulty in reaching the target for community referrals. Goal achievement is based upon client self-report, which is likely to skew the numbers in a positive direction.

**Barriers Addressed:** This Objective will be reevaluated. In spite of active marketing and promotion throughout the IA with a variety of healthcare providers it remains difficult to increase the number of case managed children. A meeting has been set up with partners and other interested parties to brainstorm more effective ways to promote asthma awareness, particularly the message of “Is your asthma under control?” It is possible that many asthmatics in the IA do not have their asthma under control but are unaware. In the meantime Steps will continue case-finding efforts by contacting patients to follow up on visits. Case finding was initiated this past summer. Steps will continue marketing efforts with physician practices, emergency rooms, schools, and others.

**A-3:** *PinCHD* to provide **indoor air quality (IAQ) assessments** consisting of standard tests and observation to identify environmental asthma triggers for children referred by *ACH, ALA*, and the *PARAT* Coalition. Reports with recommendations for improving the indoor air quality, informational materials, and referral to other agencies will be given to the family and to the outreach case manager.

**Status:** Exceeded 174/145 inspections  
Exceeded 175/50 phone consultations 202/191 information packets

**Activities:**

Requests for inspections increased in Year 2. This was a result of several factors including marketing efforts by the Steps media coordinator, word of mouth by clients, presentations, physician and other health care professionals referrals, and call ins for general indoor air quality questions. The media has also brought attention to mold issues which have caused concern among the general public. As a result the general public has called in regarding mold issues in their residences and offices. If they were located in the Steps geographical coverage area, information about the asthma program was given, which usually resulted in a request for a home visit.

Commercial visits proved more difficult to conduct due to several factors. Staff cannot go into a commercial establishment based on complaints by an employee. Management or the building owner must request this service. Staff has found that management as well as building owners are generally reluctant to have an inspector come in because of what might be found and the costs associated with remediation and sometimes fear of litigation.

Staff has recently implemented a plan with the general environmental health inspectors were they will note conditions in child care centers and schools regarding IAQ issues.

This information will be passed on to the Steps Environmental Specialist and appropriate visits will be made to these facilities. As discussed earlier in this report, recent problems with mold in schools have prompted the Pinellas County School Board Maintenance Department to request help from PinCHD. A recent problem in an elementary school and media attention resulted in meeting between Steps staff, private industry, and the school board to address the problem. Steps staff were asked to visit the school and make recommendations. The Steps school board representative set a meeting with the maintenance department to further expand Steps role in the school system. Staff is seeing more requests for general indoor air quality presentations as a result of more awareness of IAQ issues. Two especially significant presentations were made to All Children's Hospital Grand Rounds and the Sun Coast Pediatric Conference. Various health care professionals attended these presentations resulting in more referrals. During the past year **Steps Environmental Specialist was invited to attend an EPA/National Environmental Health Association Asthma conference in Washington D.C.** A presentation was made at this conference regarding the Steps asthma program of the Pinellas County Health Department.

**A-4:** Provide phone consultations and serve as information center for CM children.

# of referrals to ACH for case management

**Status:** Met 166/166

**A-5:** ACH to identify **asthma champions** in private physician offices, health care facilities, and FQHC clinic sites.

**Status:** Unmet 9/13 Asthma Champions Identified

**Barriers:** Due to personnel changes, including a change in of the Asthma Outreach Case Manager, and change in leadership of PARAT this performance measure was not monitored.

**Barriers Addressed:** Efforts will be coordinated with the ACH Outreach Services representative for South Pinellas County to identify Asthma champions in physician practices. In addition ACH will address this measure at the Leadership Team meeting to work with partners to identify new asthma champions.

**A-6:** *ACH* to conduct assessment to establish number of Certified Asthma Educators in the community.

**Status:** Met in Year 1

**A-7:** Provide financial support to train two health care professionals to receive asthma certification.

**Status:** Met 4/4/

**A-8:** Distribute **simplified tools** to assist consumers and health care providers to comply with standard of care

**Status:** Met 337/250

**A-9:** *PinCHD, ACH, and Medical Societies* will provide educational opportunities through **grand rounds, resident lectures, and seminars** for health care providers on practical use of NAEPG guidelines in the clinical setting.

**Status:** Exceeded 16 /4 events 723/300 health care providers

**Activities:**

ACH provided 4 educational events for a total of 358 attendees

- Pediatric Grand Rounds-Allergy - Demystified

- 28th Annual Florida Suncoast Pediatrics Conference
- Run with Asthma - Practical Pearls for the Pediatrician
- Pediatric Grand Rounds - Management of Acute Asthma
- Pediatric Grand Rounds - Role of Beta2-Agonists and the Art of Aerosol Delivery

PinCHD provided 12 presentations for 365 attendees. Notable conferences included:

- CDC Asthma Conference Washington D.C
- Suncoast Pediatric Conference

### **Asthma Community Education and PARAT Coalition Building**

**A-10:** ACH/PARAT to develop an **Asthma Resource Directory** and update yearly.

**Status:** Met

**A-11:** ACH to develop and promote an **Asthma website** to include resource directory, speakers' bureau, local asthma education classes, and links to major asthma websites.

**Status:** Met 748 hits (2months)

**Activity:** Website went active in August with a 748 hits for August and September. The site will be monitored for 6 months before establishing a baseline.

**A-12:** Establish asthma **speaker's bureau** (PARAT).

**Status:** Exceeded 9/2 presentations, 428 attendees.

**A-13:** Conduct an annual **Asthma Family Day**, an education program for children with asthma and their families.

**Status:** Exceeded 156/140 participants

**A-14:** Contract with ALA to provide the **Asthma U** half-day education seminar for adults with asthma or care for someone with asthma.

**Status:** Unmet 12/200 participants

**Barriers:** Despite marketing the program through doctors, pulmonary and respiratory programs, mass media channels, Asthma U. continues not to attract the number of people intended.

**Barriers Addressed:** Two new strategies will be attempted in Year 3. First, ALA is working with the Pediatric Asthma Resource and Action Team (PARAT) to add adult asthma education to its already successful Family Asthma Day. Second, ALA will offer asthma management education to area groups and businesses. It seems to work much better to take programs to the people instead of trying to get people to come to the programs. This asthma objective will also be reevaluated for redirection.

**A-15:** Contract with *ALA* to provide the “**A is for Asthma**”

**Status:** Exceeded 8/2 trainings 100/50 participants

**Activities:**

The success of this program is an excellent example of what can happen when community groups work together. In Year 1, a nurse from Head Start was trained at an “A is for Asthma” training. The nurse in turn trained 62 day care providers in Year 2. ALA also partnered with the Cooperative Extension who provides continued education for licensed day care providers to conduct 2 trainings.

In addition to partnering with Cooperative Extension, the asthma care coordinator at All Children’s Hospital provided the in-depth asthma information. This provided the opportunity to promote the program to over 100 day care providers.

**A-16:** Establish **asthma support groups** for *ACH* CM children and *FQHC* patients (open to others).

**Status:** This objective was not continued in Year 2.

**A-17:** Expand PARAT **Coalition** from an informal discussion forum to a **formalized decision making board**.

**Status:** Ongoing      Complete by the end of Year 3

**A-18:** Establish a PARAT subcommittee to assess the feasibility of a local asthma registry. **STO:** report in Yr. 3.

**Status:** Ongoing      Complete by the end of Year 3

**A-19:** Conduct asthma awareness component of **major media campaigns** described earlier.

**Status:** Exceeded      5,488/343

**School Action Plan:**

**Area: Asthma (A)**

**A-1:** *PinCHD* will contract with American Lung Association (ALA) to provide the Open Airways Program to 4<sup>th</sup> and 5<sup>th</sup> graders with asthma

**Status:** Unmet      2/30 programs      23/250 participants

**Barriers:** The current demands of the school nurses prohibited them from conducting the program. In an attempt to try different sites and trainers the ALA turned to the YMCA, a Steps partner that provides a summer program for elementary school-aged children at 22 sites in the Steps intervention area. An OAS training was held at the program coordinators regular training meeting in April. Over 26 people were trained to implement the program and 10 expressed an interest. On May 16, 10 sets of materials were delivered to the YMCA for the interested facilitators. Despite numerous calls and follow-ups, no one from the YMCA ever implemented the program—not during their summer or session nor during the after-school programming this fall.

**Barriers Addressed:** The Steps Program Manager contacted the Respiratory Care Program at St. Petersburg College and they agreed to allow Steps to train their students to implement the program. The College is willing to make it part of the students required clinical program. ALA is currently working with the college to get all the necessary paperwork arranged for that partnership. In addition another attempt will be made with the YMCA. Also in Year 3 the Pinellas County Schools will assign a nurse to the IA schools for diabetes and asthma initiatives

### **Community Interventions**

#### **Area: Tobacco (T): 1. Environmental, 2. Prevention and 3. Cessation**

##### **Environmental Tobacco Smoke:**

**T-1:** Maintain Tobacco Coordinator

**Status:** Met

**T-2:** Tobacco Coordinator and *Tobacco Free Coalition of Pinellas County* to provide smoke-free car kits.

**Status:** Exceeded 403/250 kits distributed

**Activities:** Packaged and distributed smoke-free car kits to families of children with asthma, diabetes patients, and community agencies that serve medically disadvantaged clients. The program has distributed 403. That is 153 beyond the target of 250 kits scheduled for distribution. This kit has become a very popular item among parents who want to maintain a smoke-free car for themselves and their children as well as those who want to begin keeping their car smoke-free. It provides a variety of visual reminders to smokers and non-smokers that the car is smoke-free.

**T-5:** Conduct Tobacco component of **major media campaigns** as described earlier.

**Status:** Exceeded 6069/798 tobacco ads placed

**Tobacco-Smoking Cessation:**

**T-6:** Tobacco Coordinator and *Coalition* to develop and distribute doctor's reminder kits for smoking cessation assistance to patients including office display posters, smoking status stickers for patient files, cessation self-help materials, referral list, and coupons for nicotine replacement therapy.

**Status:** Exceeded 539/250 kits distributed

**Activities:** The program has distributed 539 kits to local health care providers. The large increase over goal is because two hospitals in the IA wanted to use the kits for their progressive care units. This is the final unit to treat patients recovering from heart and lung diseases before their hospital release and is an optimal time to counsel patients to quit smoking.

**T-7:** Promote use of Florida Quit-For-Life smoking cessation hotline

**Status:** Exceeded 254/250 smokers in IA utilizing hotline

**Activities:**

The Florida Quit-for Life Line, the toll-free smoking cessation hotline has been actively promoted throughout the target area. The quitline tracks the number of calls made from our county and data shows that calls have increased from 194 in Year 1 to the current 254 in Year 2. Steps has made a concerted effort to promote the quitline among IA and County residents as many people are interested in making the lifestyle change, but do not want a series of group classes. The quitline offers counseling for both adults and teens. Over 2050 quitline information cards have been distributed. Steps media partners also

ran radio ads during the week of World No Tobacco Day, May 31 which encouraged people to quit and offered the quitline number as a contact point.

### **School Action Plan**

#### **Area: Tobacco Use (T)**

**T-1:** Train all ES teachers yearly to implement grade level instructional material on tobacco use and addiction into daily lesson plans.

**Status:** Unmet (5%) 12/219 teachers trained, will be redirected for Year 3

**Barriers:** Due to teacher training days lost for various storms throughout Years 1 and 2 Steps staff have been unable to access teacher training days to implement trainings. The limited number of training days are limited and availability is prioritized by school administration.

**Barriers Addressed:** Steps school staff will continue to train teachers as time is available. Training materials and curriculum will be made available in at least 95% of IA schools.

**T-3:** Partner with *ALA* and *ACH* to implement the **Students Teach Students** tobacco education program in *schools*.

**Status:** Exceeded 130/100 trained 2224/1000 4<sup>th</sup> graders

**Activities:** 130 high school facilitators from three schools were trained and implemented the Students-Teach-Students program in 27 elementary schools reaching 2224 fourth-grade students.

The Students-Teach-Students program is such a success thanks to synergy with Safe and Drug-Free Schools. The Intervention Specialist from that department of Pinellas County Schools makes the initial contact with each school and schedules the programs. Being an

“internal” member of the school district, the guidance counselors at the elementary schools respond to her with an efficiency that is rarely accomplished by an outsider. The area high schools also are a vital part of the program. One high school in particular, Dixie Hollins, had two school-based organizations (Interact and Future Educators of America) interested in providing the program. Thanks to their enthusiasm, we were able to serve three additional elementary schools.

### **Smoking Prevention (Counter-advertising Campaigns)**

**T-4:** Partner with *community agencies* to train **youth advocates** in public speaking and schedule presentations on tobacco industry targeting of youth at school and community sites.

**Status:** Exceeded 74/20 advocates trained

**Activities:** Youth Advocate Training was ongoing throughout the year with a final training completed on September 10, 2005. Trainings were led by high school peer educators and 74 youth received training. The youth advocates provided 12 community presentations throughout the year. The young people gain confidence as they develop their presentation skills and often become more active advocates as their self-esteem rises. These advocates frequently become role models for younger students as well as partners with adult groups who are interested in supporting their mission.

The County Council of PTA invited the students to participate in the fall PTA leadership training, as well as a series of community meetings which unite community members with their legislative representatives in open forums.

**T-8:** Provider will conduct 5 teen cessation programs N-O-T.

**Status:** Unmet          2/5 NOT programs 16/50 participants

**Barriers:** In order to implement this program ALA first contacted the six “experienced” facilitators in the Steps intervention area to offer the program. Only one responded and conducted two clinics for 16 youth (his organization only serves male youth). ALA then advertised training for others who might be interested in providing the program, even reinstating the facilitator stipends and did not receive one response.

**Barriers Addressed:** For the upcoming grant year, ALA has been able to add an additional residential site that serves both males and females. That way, two groups can be offered simultaneously. An attempt to hold a community-based program for boys and girls at a local library will also be tried. Classes will be marketed through the normal media channels and with the help of the Steps school coordinator. ALA will also partner with a tobacco outreach educator who serves at-risk youth and youth who have been suspended from school for tobacco-related violations.

**T-9** Tobacco Coordinator, ALA, and Community organizations to provide cessation programs.

**Status:** Exceeded          8/8 programs          105/80 participants

**Activities:** With the request of community and partner organizations adult classes were reinstated. St. Petersburg General Hospital and Northside Hospital both offered space and access to patients to conduct classes.

### **Community Interventions**

#### **Area: Diabetes (D):**

**D-3:** Conduct ADA Diabetes Self-Management Education (DSME) in community neighborhood centers.

**Status:** Unmet          6/5 sites          468 /1000 diabetics          216/300 family members

#### **Barriers Encountered:**

Barriers continue to include attendance of the DSME classes despite being advertised by Steps Community Calendar, Flyers, and media ads.

#### **Barriers Addressed:**

The DSME program has been expanded into Pinellas Park and Gulfport. In addition a Saturday class has been started in an attempt to attract participants unable to attend during the week due to jobs and/or other obligations. The Kenneth City project is beginning to attract more participants and the diabetes coordinator is working with other Leadership Team members to increase class size. If these efforts do not expand class participation this objective will be redirected as needed.

**D-4:** Conduct weekly diabetes awareness seminars in south St. Petersburg targeting minority population and refer participants identified as diabetic to DSME programs.

**Status:** Unmet          57/75 seminars          1183/2750 participants

**Barriers:** Attendance and interest has dropped for the seminars.

**Barriers Addressed:** The Kenneth City project is beginning to attract more participants and the diabetes coordinator is working city officials to promote the seminars. In addition the Steps Community Liaison is working with churches and other faith based

organizations to promote this objective. Steps is also working to bring health awareness presentations to corporate sites.

**D-6:** Administer the Diabetes Assessment Questionnaire, “Are you at Risk?” to residents in the IA using health promoters, volunteers, faith-based groups and community partners.

**Status:** Unmet            898/1500 surveys implemented    460/898 scored “at risk”

**Discussion:** ADA “Risk Assessment” questionnaires were administered in conjunction with Office of Minority Health activities. Participants at risk by a score of **10** or higher were referred for follow-up using the Steps diabetes referral guide.

**Barriers:** As discussed in D-4 attendance has dropped off in the awareness seminars where many of the questionnaires were administered.

**Barriers Addressed:** In Year 3 the Diabetes Coordinator will work closely with the Steps Leadership team to disseminate more questionnaires at local events and also through faith based groups and corporate sites.

**D-7:** *PinCHD, hospitals, and Medical Societies* to provide educational opportunities through grand rounds, resident lectures, and seminars for health care providers on a) practical use of FMQAI/FDCP standards and guidelines and b) availability of DSME resources.

**Status:** Exceeded      4/4 events                      600/300 providers

**D-8:** Continue contract with *Bayfront Hospital* to conduct monthly group nutrition education for diabetics in *FQHC* clinic sites including label reading, cooking classes and menu planning.

**Status:** Exceeded      111/12 sessions            183/120 participants

**Activities:** To meet this deliverable, Bayfront opened the weight management classes to the community. Each weight management class is 1 ½ hours long. The dietitian provides specific information about nutrition and diabetes via education material and verbal communication. The America Dietetic Diabetes Exchange List is distributed to diabetic participants.

**D-9:** Offer one-on-one dietary intervention (open to the public) for diabetics in *FQHC* clinic sites

**Status:** Exceeded 157/120 diabetics

**Activities:** The dietitian met with 157 diabetics one-on-one. Because JRC and CHCPP have an OB clinic, the dietitian also meets with gestational diabetic patients. Bayfront just recently offered gestational diabetes nutrition counseling to the patients of OB physicians on staff at Bayfront.

**D-10:** Refer overweight diabetics to Choose To Lose® weight management program at *FQHC* clinic sites.

**Status:** Exceeded 157/120 referrals

**D-11:** Provide mini grants of \$1000 to 15 *faith-based groups* to start health ministry to provide exercise, healthy eating, and diabetes awareness education.

**Status:** Exceeded 17/15

**D-12:** Conduct diabetes awareness promoting ADA “Are you at Risk?” as part of major media campaigns described earlier.

**Status:** Exceeded 5012/389

**Discussion:** Ads promoting of ADA “Are You are Risk?” component have been disseminated by including it on the Pinellas Wellness website, in articles and on printed

material such as brochures and newsletters. The Diabetes Coordinator and Steps' Nutritionist were the guests of a 30-minute Radio Disney interview show hosted by Disney's "Kidcasters."

### **School Action Plan**

#### **Area: Diabetes**

**D-5:** Conduct youth diabetes prevention class integrating exercise and healthy eating.

**Status:** Unmet          76/200 classes          1441/1500 participants

**Barriers:** These classes are administered through contracted Health Promoters. In Year 2 there were turnovers in the staff. In addition attendance decreased in classes.

**Barriers Addressed:** The Steps Diabetes Coordinator will work with the other Steps partners to increase participation in this project.

### **Community Interventions**

#### **Area: Physical Activity (P)**

**P-2:** *Pinellas Cooperative Extension Center* will provide the physical activity portion of the combined nutrition/PE education in the after-school programs.

**Status:** Exceeded      51/25 sites      337/550 classes      7546/7000 children

**Activities:** See N-2 for the description of the program.

**P-3:** *YMCA* to conduct weekly physical activity/fitness one hour sessions to youths and adults in a) 12 neighborhood community centers, city recreation centers, and churches focusing on under-served areas, and in b) 2 *FQHC* clinic sites.

**Status:** Exceeded      12/6 sites      968/630 classes      9,705/7,275 participants

**Activities:** The YMCA continued the programs in existing locations which included churches, schools, recreation and community centers, and one FQHC. The programs were expanded to an additional FQHC, and also to several recreation centers, schools,

and local YMCA branches. The YMCA also expanded the class formats offered at the sites to include Pilates, yoga, senior fitness, water aerobics, tai chi, youth sports, muscle conditioning, hip hop dance, and kid's aerobics.

One focus of the year was to increase the programming for children and teenagers. The most successful programs were kiddie aerobics for ages 3-5, FitBlast for ages 6-12 and hip hop dance. These classes had attendance averages of 15-20 participants per class., and there were numerous requests for additional classes – especially a hip hop class for adults.

Another focus was to expand to the Kenneth City area. The Y started a Tai Chi class at Blanton Elementary, and the class has thus far has been very successful. There were 6 participants the first night of the class, and it has grown to average attendance of 10-12 participants.

**P-3 a.** Administer the Lunch Bunch Program at one elementary school.

**Status:** Met, baseline for Year 2 was 20 sessions, 385 participants

**Activities:** A pilot program was the **Lunch Bunch Program** at Gulfport Elementary School. This is a voluntary program providing ten minutes of exercise, a healthy lunch and 15-20 minutes of lecture and discussion of good nutrition and the importance of exercise. The Lunch Bunch Program is offered three times per week during the three lunch-time periods. Each of the three lunch periods has fifteen to twenty students enrolled for nine weeks. During the first nine-week session, students expressed the desire to start a garden of fresh vegetables. As a result, five gardens were planted and maintained on the campus, four by the Lunch Bunch Program and one by a physical education class. Students maintained the garden during lunch period as part of their

physical activity or after school. This pilot program was very successful and will be easily replicated. However, successful implementation is dependent on an effective partnership with the school administration. **The program was highlighted at the Grantees annual meeting in Denver.**

**P3b:** School based exercise classes/physical activity

**Status:** Baseline established. 1 site 111 classes 395 participants

This is a new program for Year 2 offering physical activity sessions in after school programs.

The final component facilitated by the YMCA is the family weight management class, PACT (Parent and Adolescent Conditioning and Training). The Pinellas County Schools promote the program and provide referrals. This program was offered in a YMCA location and at a local high school after hours. The high school was utilized to appeal to participants who might be intimidated by participating at a fitness center. Participants at the school site received bands, hand weights, exercise mats and books at the onset of the program in an effort to encourage daily exercise at home. We found that once the participants received these items, there was a sense that they could do the exercises at home and it wasn't necessary to come back to class. As a result, during future sessions, the items were collected after each class and not given to participants. Classes offered at the YMCA experienced greater success in maintaining participation compared to the school site. Participants like the variety of activities they could engage in at the YMCA compared to a group exercise class at the school site. As a result, all future classes will be held at the YMCA.

**P-4:** *PinCHD* re-contract with *Dundu Dole dancers* in year 2 to provide cultural dancing classes for minorities consisting of dancing, physical fitness, and nutrition for children and adults.

**Status:** Unmet      43/45 classes      873/1600 participants.

**Barriers:** Class attendance decreased in Year 2.

**Barriers Addressed:** Steps staff will increase promotion of classes through media and Leadership meetings.

**P-5:** Partner with *county* and *city recreation departments* to expand existing fitness activities at low or no cost to under-served areas in providing free swimming passes and other scholarships for children and adults.

**Status:** Exceeded      210/200 Scholarships

**Activities:** Scholarships were given to recreation departments for swimming and summer camp activities promoting physical activity. Scholarship determination was made by the City Recreation Centers based on financial need. The majority of the scholarships were granted to underserved minorities in the IA. Swimming lessons give a two fold benefit. Physical activity is promoted and drowning prevention lessons are given to youth.

**P-6:** a) Promote stairwell point of decision prompts in *county, city, and partner agencies* buildings encouraging use of stairs. b) Improve stairwells environment to aesthetically pleasing.

**Status:** Unmet      1/25 stairwells with prompts

**Discussion:** 1/25 buildings. To date Steps has worked primarily on the PinCHD stairwell.

**Barriers:** Many of the Municipal buildings are only one or two stories. In addition local fire codes prohibit placing signs in stairwells.

**Barriers addressed:** The municipal fire codes cannot be changed. In order to address this issue at the Health Department, the wall were actually painted which required many man hours that other organizations are not willing to commit to. This objective will be re-evaluated for feasibility and redirected as necessary.

**P-7:** Expand and promote community walking groups

**Status:** Met 5/5 walking groups

**P-8:** Promote and expand employee physical activity programs among *partner agencies* by a) expanding *PinCHD* Healthy Behaviors after-hours Fitness Teams, b) establishing Pedometer Walking Programs in partner agencies

**Status:** Exceeded 5/4 programs  
Unmet 7,230,918 / 8,089,810 steps walked  
Unmet 155/250 participants in employee programs

**Barriers:** Due to personnel changes the *PinCHD* walking program was not being promoted or monitored for several months.

**Barriers Addressed:** The responsibility for reporting and promoting steps walked has been reassigned to a Healthy Behaviors Team member, who has begun to reintroduce and promote the program.

**P-9:** Promote and expand *PinCHD* Pinellas Wellness website to include BMI information and links to major health sites and nutrition and exercise classes/programs.

**Status:** Unmet 1340/2125 average hits per month.

**Discussion:** See barriers N-6.

**P-10:** Promote and expand *PinCHD* “Parent Health Bulletin” featuring healthy behavior tips for parents.

**Status:** Exceeded 84/75 sites monthly

**P-11:** Conduct physical activity component of major media campaigns described earlier.

**Status:** Exceeded 3901/295

**Activities:** Ads have been aired. Promotion of Physical Activity-related information and services is also on **PinellasWellness.com**. Please see **Media Log** and other documentation included in the **Marketing Report Package** for media campaign details.

### **School Action Plan**

#### **Area: Physical Activity (P)**

**P-1:** Increase number of students meeting minimum cardio-vascular fitness levels./Increase number of students with normal BMI.

**Status:** Year 2 End: 4770(yr2) /3664(yr1) met minimum cardiovascular fitness.  
19,846(yr2)/16,908(yr1) students had normal BMI

**Activities:** The district is now requiring a school improvement goal based on data collected from the Fitnessgram assessments. Physical fitness data is collected and reported in the fall and spring of each school year. Comparison Data between 2004 & 2005 grant year has been completed and is presented in the Evaluation section of this report.

**P-3:** Expand "Take 10!" classroom fitness curriculum to 20 new ES, 4-6/Yr. **STO:** # of students participating in "Take 10!"/Yr.

**Status:** Unmet 3/4 schools in Year 2

**Discussion:** Two schools have been trained to implement the *Take 10* program. Teachers were trained in grades K-5 providing it to 1063 students. Due to the lack of time available for training teachers, and hurricane season it has been extremely difficult to implement.

This objective will be reevaluated and redirected as necessary in Year 3.

**P – 4** Establish a Staff Walking Program with pedometers to model & promote fitness activities.

**Status:** Unmet        84,177,753/102,063,289 steps walked  
Exceeded        361/81 school staff in walking program

**Discussion:** 14 schools have participated in a successful staff walking program during in Year 2. Boca Ciega High School, Gulfport Elementary , Pinellas Central Elementary, Northwest Elementary, Azalea Elementary, Azalea Middle School, Pinellas Park Middle School, Meadowlawn Middle School, Perkins Elementary, Clearview Elementary, Campbell Park Elementary, Gibbs High School, Bay Vista Elementary and Title 1 Center.

**Barriers:** The walking program has been very well received by staff; however it seems that a 25% increase in steps walked from Year 1 to Year 2 may have been overly ambitious.

**Barriers Addressed:** Because of the success of the program, the District’s Risk Management department has expressed interest in partnering with Steps to increase participation throughout the school system. This will increase participation and as a result the number of steps walked.

**P-5:** Establish after school Family Obesity Education Services to increase physical activity for obese students and their families.

**Status:** Exceeded        2/2 sites        474/67 participants

**Activities:** The YMCA in collaboration with the PCS established a family obesity education class called PACT which stands for Parent/Adolescent Conditioning Training. PACT is a parent/child fitness program designed to educate parents and kids on the importance of proper nutrition and exercise. With 55 families completing the program,

PACT exceeded its objective of 50 families for a very successful first year. A total of 44 classes were held at Dixie Hollins High School and at the Jim and Heather Gills YMCA. The collaboration also included All Children's Hospital's KidShaper's program. The YMCA and the school system have created a waiting list for the Family Weight Management programs. Programs will increase capacity in Year 3.

### **Community Interventions**

#### **Area: Obesity (O)**

**O-1:** *PinCHD, Medical Societies and Hospitals* to present obesity prevention and reduction presentations to health care providers at local hospital grand rounds and other educational forums encouraging use of NHLBI Obesity Guidelines and of NDEP "Small Steps Big Rewards" health care providers toolkit.

**Status:** Exceeded 650/250 participants 3/2 presentations

**O-2:** Distribute BMI charts, posters and wheels to physician practices to encourage them to consider BMI as a "vital sign."

**Status:** Exceeded 145/128 BMI "kits" distributed

**O-3/O4:** Bayfront Medical Center to offer weight management programs for children and adults at 2 FQHC clinic sites.

**Status:** Exceeded 201/120 participants

**Activities:** In January 2005, Bayfront changed the weight management curriculum at Johnnie Ruth Clarke Health Center (JRC) from Choose To Lose to Real Solutions. The weight management participants at the JRC have a higher illiteracy, drop out and noncompliance rate than the participants at the Pinellas Park site. JRC participants are

more likely not to use the cookbook, keep food diaries or complete pre and post % body composition. Our biggest challenge is working with our participants to complete the program. With that challenge in mind, BMC used FOCUS PDSA to look at the processes and discovered that they were not documenting the reasons for people not completing the program, reasons for missing class and reasons for not completing pre and post body composition. BMC also held a focus group to learn what people expect from a weight management program. Information from these two sources lead to the adoption of Barbara A. Bichelmeyer, Ph.D, “What Every Steps Community Should Know About Training”, specifically the “impact of training design on transfer” model; develop a form that will improve documentation and the case management process; design Real Solutions curriculum so that it has a beginning and ending, create an exit packet that includes an evaluation, Steps to a Healthier Florida information; and create a sign up sheet for pre and post body composition.

**O-6:** Promote BMI awareness in local area supermarket pharmacies. BMI posters will be placed on scales and Steps BMI informational brochures will be distributed, monitored and refilled as necessary. Other literature/brochures will be placed in stores that include Steps brochures on nutrition, obesity, diabetes, and smoking cessation.

**Status:** Met 18/18 charts distributed

**O-8:** *FQHC* to continue to follow a local policy to perform BMI on clients as part of “vital signs.”

**Status:** Met

**O-9:** Conduct obesity awareness component of major media campaigns described earlier.

**Status:** Exceeded 6384/1411 ads

## **School Action Plan**

### **Area: Obesity (O)**

**O-7:** *PinCHD* nutritionist to establish Nutrition Youth Team modeled after the tobacco “SWAT” teams to promote healthy lifestyles i.e. street marketing at parks, concerts and food festivals.

**Status:** Met                    24/24 events    413/75 participants

**Activities:** Two Nutrition Youth Teams have been formed. The teens are part of the Youth as Resources group at the Cooperative Extension Service 4-H. Teens participating earn community service hours here in order to qualify for full college scholarship programs from the State. The 2004-2005 nutrition team was comprised of twelve youth from various schools throughout the county. They performed 24 times during the year to various groups throughout the Steps focus areas reaching 445 youth. The skits focused on a variety of subjects including eating disorders, teen’s busy schedules, peer pressure, and body image. Again this year the team surveyed the participants about their current health habits. In addition, the team added more educational programming. In partnership with Family & Consumer Sciences (service provider for N-3), a six-week curriculum was designed to educate the youth on some of the health topics that were addressed in the survey. The series can be presented as a single session or up to a six weeks series. The skits and survey were completed in week one. The next four interactive lessons were on a specific nutrition topic. At the last session the results from the survey were shared with the group to tie in what they had learned at each week’s lesson and to help them see what they were already doing well and where they might need to make some adjustments in their lifestyle.

**Area: (All) Community wide media campaign:**

**All-1:** PinCHD retained the marketing coordinator in year 2.

**Status:** Met

**Activities:** With input from the leadership team and consortium the marketing coordinator planned and conducted the area wide comprehensive media campaign promoting key health messages related to all Steps behaviors and conditions.

**All-2:** Conduct focus groups to ascertain what kind of activities/messages/programs would appeal to them.

**Status:** Unmet        7/14 focus groups  
                  Met:        257/250 participants

**Discussion:**

In Year 2, the established goal was to continue to conduct **Focus Groups** with children and adults inclusive of minorities and low literacy populations to ascertain what kinds of messages/activities/programs would appeal to them and encourage them to adopt healthy behaviors.

Focus groups were conducted at various times throughout Year 2. The groups were racially and ethnically representative of the grant's intervention area. Each group was shown various advertising concepts, art elements under consideration, possible web site elements, brochure designs, newsletters and various outreach concepts. Their input continues to be influential in establishing and modifying the marketing concepts and key

messages, the effectiveness of campaign ideas and the development of various marketing components and events.

**Barriers:** The Steps Marketing Coordinator faced challenges coordinating the 14 focus groups. This is a labor intensive, time sensitive deliverable.

**Barriers Addressed:** In Year 3 Steps will be contracting with an outside Media Buyer to conduct the focus groups.

**All-3** Continue timeline for 5-year plan with types of messages and media outlets used.

**Status:** Met

**All-4:** Develop incentives/disincentives: Development and promotion a healthy kids *Passport Pinellas* to be distributed to children.

**Status:** Exceeded 2000/200 passports distributed 600/200 passports redeemed

**Activities:** Passports were distributed and collected during the **STEP-tacular** event held at the St. Petersburg Pier. Details of the event are included in the attached Marketing Report Package.

**All-5** Continue campaign theme from Yr. 1 to focus on two targeted groups: prevention and those with existing conditions.

**Status:** Met

**All-6:** Existing media outlets will be used to promote Steps activities and consumer awareness.

**Status:** Exceeded 21/18 outlets 57,145/22,050 responses to media messages

**All-7:** Expand Pinellas Wellness website to have a Steps resource center including postings of information about existing health resources, events, classes, and programs.

**Status:** Exceeded 21/20 links to [PinellasWellness.com](http://PinellasWellness.com)

**Activities:** Year 2 saw encouraging progress and growth in community awareness and the site's popularity. Pinellas Wellness/Steps has grown to include a Steps Resource Center including postings of information about existing health resources, various health events, classes and programs. It is host to a wide array of educational information on the six grant areas. Additionally, general education materials have been developed and posted regarding asthma, diabetes and obesity.

The second half of Year 2 saw further expansion of the Pinellas Wellness/Steps website and the further development of the Steps pages. The site address is currently featured in all on-air and print advertising. A new and more user-friendly design is now completed and "live."

**All-8:** (moved to school plan as **O-7**)

**All-9:** Continue to implement the marketing campaign; continuing with rotational sub themes using all media available in the area (Tampa Bay market); continue focus groups for feedback and continuous development of media strategies. Web based surveys will give continuous feedback from those visiting the Pinellas wellness website. Feedback will be used for evaluation of activities, media campaigns and for further development.

**Status:** Met

**Activities:** Rotational sub themes are well established and media strategies have been and will continue to be developed as partnerships with media outlets evolve. Web-based surveys were built into the existing contract with Clear Channel stations that will help

track the effectiveness of the local Steps program(s). A multi-component, community-wide media campaign is well underway and is currently slated to continue throughout Years 3-5.

**All-10** 1) PinCHD contracts to hire a part time Faith Based Coordinator to oversee and coordinate faith-based objectives. 2) PinCHD contracts with Parish Nurses to coordinate and deliver DSME classes in area churches.

**Status:** Met

**All –11** PinCHD will hire a full time Certified Health Education Specialist to integrate Steps educational activities.

**Status:** Met

**All – 12** PinCHD contracts with 2-1-1 Tampa Bay Cares hire/train a part time worker to answer and respond to calls from clients requesting information and referral to Steps related activities.

**Status:** Met

**d. Utilization of Evidence Based Public Health Strategies**

Steps to a HealthierFL-Pinellas County continued to use evidence based resources in Year2, including the *Guide to Community Preventive Services*. New classes are assessed for an existing research base prior to implementation. A complete evidence based list follows.

(follow with pages 49, 50, 51, 52)

**INSERT Evidence Based Sheet**

**INSERT Evidence Based Sheet**

**INSERT Evidence Based Sheet**

**INSERT Evidence Based Sheet**

**f. Coordination of Chronic Disease Prevention Activities at the Local Level**

The Steps Program is housed in the PinCHD Office of Chronic Disease Prevention, which comprise other state funded chronic disease prevention activities addressing cardiovascular disease and their risk factors and this office works closely with other divisions to integrate services. Examples are the Family Health Division which administers BMIs in its clinics and the Community Health Division which also administers BMIs, a Women’s Health Questionnaire and an interconceptional health curriculum that are both related to chronic disease.

Activities are well coordinated so as to avoid duplication. There currently are no state funded programs at the County level targeting specifically Diabetes, Obesity and Asthma and the associated risk factors. The following table lists Community and State assets the Steps Program supports but does not duplicate.

Community Asset	State Asset
Partnership for a Healthier Pinellas	DOH CHARTS (BRFSS, AADR tracking)
Periodic screenings for chronic diseases at health fairs and malls	Amendment- 2002: bans smoking in indoor workplaces & restaurants began 7/1/03.
Comprehensive Sequential Health Education Curriculum for elementary, 6 <sup>th</sup> , 8 <sup>th</sup> , 10 <sup>th</sup> grades	Youth Tobacco program remaining components (survey every other Yr.)
City and County Parks and Recreation areas	DOH Employee Smoking Needs Assessment
211 Helpline	
Wellness Programs in area hospitals/business	DOH technical assistance, statewide conferences and training for health depts.
Smoking Cessation (American Lung Assn)	DOH reorganization/integration of youth and adult tobacco programs
BMI program in grocery stores/pharmacies	
Pinellas Cooperative Extension (Nutrition)	WIC (Women, Infants and Children) Nutritional Supplement Program
Strong public-private collaborative partnership	

**g. Cultural Competence, Health Literacy and Reduction of Health Disparities**

**Closing the Gap Community Coalition:** The Coalition was born when members of the Front Porch Community and other groups joined their efforts with other community based organization representatives to foster the development of **coordinated, collaborative, and broad-based participation** in the Closing the Gap Program. Membership is composed of at least 75% African American. Two other pre-existing groups are: The Pinellas County Health Department **Closing the Gap Task Force** which was established in June 2000 to address ethnic and racial health disparities, and **PATRICIA**. **PATRICIA** is an alliance of partners that aims to mobilize the community around the elimination of racial disparities in infant mortality in Pinellas County. It is comprised of representatives of the African American leadership, experts in MCH, government officials, media, social service providers, physicians, corporate representatives, and members of the faith-based community, public school personnel and private citizens.

The Office of Chronic Disease Prevention is collocated with the **Office of Minority Health** and staff work very closely together. Community outreach to minority populations including **African American, Hispanic and Asian** is done mostly by contracted staff hired by those communities in order to meet the linguistic and cultural challenges that may be encountered in the delivery of services. Steps recently hired an African American nutritionist and contracted with an African American faith based coordinator. Both the Steps Diabetes Coordinator and the Steps Community Liaison are African American. In addition PinCHD has embraced culturally diverse program education that is delivered during new employee orientation and periodically thereafter.

All literature is reviewed by community health workers for cultural competency and literacy levels.

**Surveillance and Evaluation**

**a. Expansion of existing surveillance**

**1. BRFSS**

PinCHD in partnership with the Florida State BRFSS Coordinator utilized the approved state contracted agency **Schulman, Ronca and Bucuvalas, Inc. (SRBI)** to administer **core Florida BRFSS** surveys which were completed in August 2005. The **core Florida BRFSS**, plus additional Steps specific questions and modules was administered to 1550 people within the intervention area. Year One (**03-04**) results and Year Two (**04-05**) initial results have been analyzed and will be utilized by the partners to adjust their logic models, and goals for the next grant year. BRFSS baseline data was from countywide data in the year 2002 and long-term objectives were set based on the available data. Some of the long term objectives are being revised according to newly established baseline from intervention area BRFSS data (see section f). Some of the results toward achieving **Steps objectives** are as shown in Table 1.

**Table 1**

**Intervention area BRFSS 2004 and 2005**

<b>BR</b>	<b>20</b>	<b>2</b>	<b>Question</b>	<b>20</b>	<b>2</b>
<b>FSS</b>	<b>04</b>	<b>0</b>		<b>04</b>	<b>0</b>
<b>(IA)</b>		<b>0</b>			<b>0</b>
		<b>5</b>			<b>5</b>
<b>Mal</b>	37.	3	<b>No leisure time activity.</b>	25.	1

Steps to a HealthierFL-Pinellas County

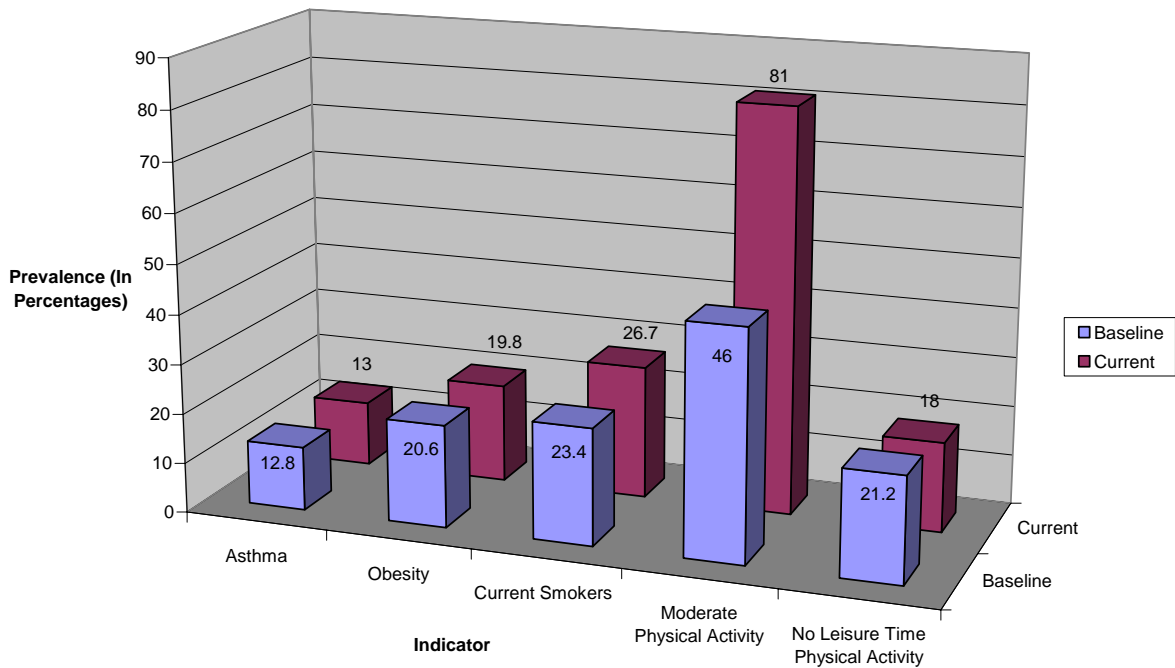
<b>e</b>	4%	4		5%	8
		%			%
	62.	6			5
<b>Fem</b>	60	6	<b>Smoked at least 100 cigarettes in</b>	49.	7
<b>ale</b>	%	%	<b>life.</b>	1%	%
		8			3
<b>Whi</b>	77.	3		39.	9
<b>te</b>	7%	%	<b>Smoke every day.</b>	6%	%
		1			
<b>Blac</b>	11.	1		9.5	8
<b>k</b>	9%	%	<b>Smoke some days.</b>	%	%
					4
<b>Oth</b>	2.5	6	<b>Of those that smoke every day or</b>	60.	7
<b>er</b>	%	%	<b>some days have not stopped</b>	1%	%
			<b>smoking for one day or longer.</b>		
<b>Not</b>		1			1
<b>Insu</b>	18.	5		10.	3
<b>red</b>	5%	%	<b>Told by a doctor you have asthma.</b>	9%	%
					7
			<b>If so do you still have asthma?</b>	63.	4
			<b>Yes.</b>	5%	%
			<b>Told by a doctor you have</b>		
			<b>diabetes?</b>		
					1
				8.5	1
			<b>Yes.</b>	%	%

	Yes, during pregnancy.	1.3	1
		%	%

Comparisons of various long term objectives are as shown in graph 1 (Baseline results are from county wide data).

**Graph 1**

**Comparison of Long Term Objectives (BRFSS Data)**



**2. YRBS**

In January 2005, a **customized YRBS** was administered to 836 high **schools students** within the intervention area and the summary results are presented in Table 2. Some questions were modified to address specific STEPS areas. The Evaluator and Leadership Team will monitor the results and assess progress toward project objectives. Demographics of the intervention area differ significantly from that of the entire county.

Current YRBS data will be used as the baseline for future reports since the earlier baseline was from county wide data. Pinellas County Schools will provide **data** on absenteeism, academics, health conditions, and risk information. An **elementary school health survey** was piloted within the intervention area in grade 3 for 2003-04 and results are as shown in Table 3. This survey was not implemented this year due to time constraints caused by the hurricanes and the administration of the **YRBS**.

**Table 2: Intervention Area YRBS (HS) 2005**

Demographics		Question	%
Male	50.	Fruits – 2 or more times per day	1
	6%		5
Female	49.	Ever tried smoking	.
	4%		8
White	59.	Smoke Cigarettes daily (1 cigarette everyday for 30 days)	4
	5%		3
Black	27.	Students who participated in physical activity that made them sweat and breathe hard for 20 minutes or more on 3 or more of the past 7 days	7
	8%		.

Other	3.7	Students who participated in physical activity that did not make them sweat and breathe hard for 30 minutes or more on 5 or more of the past 7 days	2
	%		9
Hispanic/Latino	6.9	Told by a doctor or nurse that they have asthma	.
	%		7
Multiple races	2.1	Told by a doctor or nurse that they have diabetes	3
	%		.
		Played video or computer games or used computer for something that is not school work for 3 or more hours per day on an average school day	2
			2
		Students who were overweight	3
			.
			7
			1
			0
			.
			7

**Table 3: Pinellas County School Elementary Health Survey (2003-04)**

Elementary School Health Survey		Valid
		%

<b>Male</b>	51.6
<b>Female</b>	48.4
Play video or computer games for 4 or more hours on an average school day	16.1
Watch TV for 4 or more hours on an average school day	30.7
Never wear a helmet when you ride a bicycle	27
Do not play outside on most days in free time after school	15.7
Regular member of sports team or a physical activity group	58.5
Ever tried cigarette or cigar smoking (even 1 or 2 puffs)	4.2
Smoked cigarettes everyday for a week or more	1.5
Had a drink of beer, wine, or alcohol, other than a few sips	15.6

**b. Data sources used to design and monitor Steps interventions**

- **Statewide Data Sources**

- 1) **Florida Youth Tobacco Survey (FYTS)**

The **FYTS** for 2005 was completed during the reporting period. While results are available at the state level for year 2005, Tampa Bay regional data is available for the

year 2004. The **Florida Youth Tobacco Survey (FYTS)** 2006 will be administered in the spring of 2006 to MS and HS students to track outcome indicators of the Florida Youth Tobacco Control Program.

2) Florida Department of Health **CHARTS** (Community Health Assessment Resource Tool Set) is another tool utilized to monitor STEPS indicators. This web based application includes health statistics such as births, deaths, disease morbidity, population and behavioral risk factors. The system can produce a chronic disease profile for each county in Florida. **CHARTS** can also compile county maps of certain health indicators at the census tract level. Data is available in report form with the complete census tract number included.

3) **Medicare Data:** The evaluator continues to work on the possibility of using Medicare data on asthma and diabetes medications/lab tests to help monitor Steps indicators. The Agency for Health Care Administration (AHCA) agreed that data pertaining to asthma and diabetes medications could be released in an annual report and possibly bi-annually once the procedure is in place. This data will be stripped of any identifiers such as race, etc. but can possibly be pulled by zip code.

- **BMI Surveillance System**

The Pinellas County Health Department has already identified the main elements that constitute a BMI surveillance system and will continue to work together with the Florida Department of Health to develop a statewide BMI surveillance system.

**BMI measurements** are currently obtained in schools, Community Health Centers, and the Pinellas County Health Department. The evaluation team has been working with all partners to develop a BMI surveillance system within the county.

- **BMI in Schools:** BMI measurements are taken on all intervention area students taking P.E. The baseline information was collected from the Fitness-grams and revealed that **27% of students were overweight or obese.** BMI measurements are collected annually to determine trends and changes within the intervention area school population. This information is also presented to the partners to discuss other ways that BMI surveillance can be enhanced.
- **BMI in Federally Qualified Health Centers:** The FQHC's report BMI data by the 15<sup>th</sup> of every month to the evaluator. BMI measurements are taken on each client upon check-in and written on a data sheet that is kept by the scales. FQHC's continue to provide BMI measurement on their patients. However, the rate continues to be higher than expected even after excluding pregnant women and the project has not yet been able to identify the source of this issue.

- **BMI in Pinellas County Health Department:**

**PinCHD** uses the following two statewide computer databases that are linked to every local county health department in Florida.

- **Health Clinic Management System (HCMS):**

BMI data is extracted from the HCMS on a monthly basis. Once the client is screened in the health department clinics, the BMI is given a code and reported on an encounter form that is input into the HCMS data base. Data is then extracted to determine: 1) If BMI's are being administered 2) Results of BMI screens. BMI data is obtained from family health and community health programs (home visiting program and interconceptional health data). Currently **35.5% (888/2502) of PinCHD clients have abnormal BMI's.** (Abnormal is inclusive of overweight and obese).

- Part of the HCMS system is a statewide Healthy Start prenatal screening module that is used to collect prenatal risk factors including pre-pregnancy weight and height fields, from which the BMI can be calculated. Local physicians are mandated to administer the screening and send it to the Health Department to be entered into the HCMS prenatal screening module. Reports are generated by the PinCHD maternal child health epidemiologist on an annual basis. The 2004-05 data showed that **41% (909/2199) of women screened had a BMI that classified in the overweight or obese category.**

- **Women, Infant and Children (WIC) Statewide Database**

The WIC program is part of the local health department. The **WIC data system** collects height and weight on all children 2-5 and post partum mothers receiving WIC services and automatically calculates BMI. Reports are generated by the state WIC office and have recently been upgraded to a web-based reporting system. 3,439 WIC children from 2-5 years of age were served in the intervention area during Year 2004-05. **33.32% (1146/3439)** screened between the 85<sup>th</sup> to 100th percentile on the BMI growth chart; **meaning they were either overweight or at risk for overweight. 63% (1111/1760) of the mothers were either overweight or obese** (WIC collects data on breastfeeding mothers for one year and non-breast feeding mothers for six months).

- **Other Data Sources:**

- 1. Diabetes**

The “**Are You At Risk?**” assessments for diabetes are completed monthly by the health educators and placed in a database by the evaluator. Approximately **900 screens** were completed with about **51% (460/898) scoring “at risk” for diabetes**. These screens will be evaluated further to cross-reference race, gender, and age of “at risk” clients as well as BMI data that was collected. A report will be finalized at the end of each grant year and used by the diabetes program to adjust their target population. **CHARTS data** is also used to monitor trends in diabetes throughout the county.

## **2. Asthma**

The PinCHD is in the process of applying for the FHIN (Florida Health Information Network) grant. The grant proposal has been written to include the Steps program. The FHIN grant is being funded by Florida Agency for Health Care Administration (AHCA). Its purpose is to plan, deploy and evaluate interoperable health information exchange projects in clinical settings. The FHIN grant will allow for facilitation of the exchange of patient information among provider organizations for patient care and public health purposes. All Children's Hospital (ACH) will work in conjunction with the PinCHD for this project. The leadership team is working with Pediatric Asthma Resource Action Team (PARAT) on a feasibility study to determine if an asthma registry can be developed. Currently asthma indicators are being tracked by number and types of persons served by various interventions, local hospital discharge data from All Children's Hospital, Agency for Health Care Administration (AHCA) web-based database, Medicaid and Medicare data, and our Florida Department of Health **CHARTS** system.

### **c. Participation in Coordinated Monitoring and Evaluation:**

- 1) **National Evaluation:** During the year 2004-05, the Pinellas evaluator was a volunteer participant with the Core Performance Measures Workgroup.
- 2) **State Evaluation:** The Pinellas evaluator worked with the State BRFSS Coordinator to insure that the appropriate contractor and instrument were used to collect the data. As stated previously the BRFSS was implemented within the intervention area. The state of Florida did not collect any county specific data this year but will use a three year average of data collected state-wide.

3) **Local Evaluation:** Pinellas Steps coordinated with Hillsborough Steps to use **the core BRFSS** to monitor most of the indicators with additional questions from the Optional Modules and added questions targeting required performance measures which are shown in the table below:

**Table 4**

**BRFSS Module questions (2005)**

<b>Questions</b>	<b>Response</b>	
	<b>Yes</b>	<b>No</b>
<b>Heard about Steps to a Healthier Pinellas Project?</b>	8%	90%
<b>Ever received education or counseling regarding Physical Activity or Exercise?</b>	38%	61%
<b>Ever received education or counseling regarding Diet and Nutrition?</b>	48%	51%
<b>Ever received education or counseling regarding Smoking Cessation?</b>	26%	73%
<b>Ever received education or counseling about Diabetes Screening?</b>	28%	72%
<b>Ever received education or counseling about Body Mass Index?</b>	30%	68%
<b>Ever been screened for Asthma?</b>	20%	77%

These added questions address the core performance measures required by the National Evaluation Team. Any additional questions that are required to address the performance measures will be added to the 2006 BRFSS survey. The evaluator will continue to work with project management, partners, and Hillsborough County Steps to insure that all data for performance measures are collected and reported in a timely manner as needed by CDC contractor.

**d. Progress on Local Program Monitoring and Evaluation**

The evaluation team is using **standard methodology** to assure essential elements are measured throughout the project period: • Number and types of persons served by various interventions • Achievement of related short-term, intermediate and long-term objectives • Link between program activities and the achievement of the initiative’s overarching goals • Selected “Healthy People 2010” objectives • Comprehensive evaluation plan • Participation in a national independent, external evaluation to examine and document the effectiveness of the cooperative agreement • Examination and action regarding project successes/barriers/failures • Collection and submission of data regarding selected outcome and performance measures • Participation in other evaluation activities including regular debriefings and descriptive case studies • Special analysis and mid course adjustments.

**Tracking of future policies** within the state and county are monitored by the evaluation team as they move toward systems change within intervention area. Some of the policies targeted to be tackled by the partners include implementing mandatory physical education in the schools and reporting mandates for diabetes, asthma, and BMI. Progress on these policies is followed by the leadership team and reported to the partners on a monthly basis. The following policies are currently in place:

- **BMI:** Policies established in year one to perform BMI by the FQHC’s as well as the PinCHD to perform BMI on clients visiting the family health clinics, community health, and WIC clients have been implemented in year two. BMI measurements are also mandated by the state board of education in all elementary schools (FitnessGram).

- **Wellness Training:** As per policy established in year one, PinCHD requires its staff to complete four (4) wellness hours as a part of required employee training each year. The scope of this class has been expanded to include diabetes and asthma awareness.
- **Smoking Policy:** Within PinCHD policies developed regarding smoking were modified. The revised policy bans use of tobacco or tobacco products (instead of no smoking) and also bans use of tobacco or tobacco products on Health Department property thereby eliminating all designated smoking areas. In addition, all new employees will not smoke or use tobacco products, and are being required to sign an acknowledgement to that effect.

Evaluation of program administration and dissemination of information is assessed through tracking of **outcome indicators, quality assurance and improvement activities, and contract monitoring.** Each contractual partner prepares a monthly report summarizing activities. These reports are analyzed and compiled by the evaluator and distributed to partners during monthly Leadership Team Meetings. The evaluator presents data sources and other information to the Leadership team to use in strengthening their programs. The CHARTS system was explained to the partners for assistance with future grants they might be planning as well as for tracking indicators related to this grant. At the end of each six months, the evaluator compiles all monthly reports into a bi-annual report that is distributed to each partner. At this time the Leadership Team is able to determine

which indicators are being measured appropriately to meet the long term objectives.

The **evaluation plan and logic model** are

structured to demonstrate and document measurable progress toward achieving the revised **Healthy People 2010 project goals**, ongoing program monitoring of interventions, specific outputs, and sustainability. The evaluation report always accompanies the **Community Action Plan Matrix and Priority Indicator List** (found on the following pages). The logic models have been developed and are currently being updated by the partners to facilitate discussions within their organizations to affect change within that agency and the community.

**Pre-Post test measures:** Various partners are providing classes within the targeted intervention area. These classes and activities vary from “5 A Day” presentations to cooking classes, to asthma and diabetes awareness classes. Partners continue to use **pre- and post- test measures** to capture knowledge acquired and help determine the needs of each community. Pinellas County Schools uses **pre- and post- tests** to determine increases in knowledge from the student participating in the “Organ Wise” classes and “5 A Day” programs. Results for some of the pre- and post- tests are summarized in the table below.

**Table 5**  
**Pre and Post Test Results**

<b>Health Problem</b>	<b>Program</b>	<b>Result</b>
<b>Nutrition</b>	<i>Organ Wise</i>	87% increase in pre/post knowledge questions.
	<i>More Health</i>	42% increase in pre/post knowledge question.
	<i>Pyramid Power</i>	
	<i>Fit For Life</i>	96.5% increase in pre/post knowledge question.
	<i>Food For Thought</i>	95.6% increase in pre/post knowledge question.
<b>Asthma</b>	<i>Open Airways</i>	All children scored 70% or higher on post-test.
	<i>Asthma U</i>	92% scored 80% or higher on post –test.
	<i>A is for Asthma</i>	Average score: Pre-test 60%. Post-test 76%.
<b>Physical Activity</b>	<i>Take 10</i>	Nutrition questions – 83% scored 4/8 correctly.
		Physical Activity questions – 91% scored 4/8 correctly.
		General Health questions – 80% scored 4/8 correctly.

The evaluator found that reporting of results for pre- and post- tests was not always standardized. As a result, the evaluator will hold a workshop to standardize reporting from all partners. There have been efforts to standardize the questions used in pre- and post- tests. For example, the PinCHD nutritionist organized several meetings with all Steps nutritionists and the evaluator to determine core questions that should be asked regarding 5 A Day. These questions are utilized by anyone in the project that might target this area specifically. The results are collected and given to the evaluator and coordinator at each 6 month interval. The results of each component's evaluation are listed under their specific objective in the preceding narrative.

**A work plan survey** was developed this year based on core issues cited by the partners throughout the year. The survey was administered to the members of the team. While most of the results were positive, a recurring message was the need for **increased communication and coordination among partnering agencies**. This information was presented at the monthly meeting and the partners agreed to work on more ways to integrate similar programs. One of the suggestions was to form subcommittees of partners with similar responsibilities to assist in collaboration of activities. This falls in line with the recent restructuring of the project to include a day to day operations manager who supervises five main coordinators. The coordinators are over topic areas such as nutrition/obesity, asthma/tobacco, physical activity, diabetes and community/faith based. The closer coordination of these areas with a single line of report to one main coordinator should effectively strengthen communication among the partners. The team is in the process of determining ways to **measure integration**

among all agencies. One way to measure this would be to report number of times each partner collaborates with other agencies. The Leadership team has developed a monthly newsletter that details different types of services provided, innovative STEPS programs that have been implemented, outreach strategies and what different providers are doing to promote program sustainability.

The **Consortium** also participates at various levels of the evaluation process by reviewing the logic models for input and determining which areas need to be re-focused to meet the goals of the project. At one consortium meeting, discussions were held regarding various ways to evaluate the program and heighten public awareness. A consortium member suggested that a **Steps “model community”** should be developed that would target Steps health components. This idea was approved for implementation because it will provide a valid technique to evaluate a small portion of the intervention area while also giving the project much needed visibility in “grass roots” areas. The neighborhood selected was to be a **disparate** community with an active neighborhood association that will have members on the Consortium and the Leadership Team.

A shortened Steps BRFSS needs assessment survey was administered throughout eight (8) Steps neighborhoods. Over 300 surveys were returned and analyzed. Kenneth City was selected as the Steps Model Community and kick off event was held in an elementary school on August 13<sup>th</sup> 2005. Currently weekly classes are being offered on nutrition, exercise, asthma, smoking cessation and diabetes. An open house was held at the elementary school to inform parents about the classes offered on August 23<sup>rd</sup> 2005. A core planning group has been developed for this project that includes a City Council

representative, an area elementary school representative and a representative from the local home owner's association.

**Media Campaign Evaluation:** The Marketing Coordinator designed a survey to help determine the effectiveness of the media campaign. This was a telephonic survey that was administered to 500 people. Questions asked in the survey were “Do you know what the initials B-M-I stand for in the health field?”, “What does B-M-I stand for?”, as well as a few other questions on asthma, diabetes and cigarette smoking. While 20 % surveyed replied they knew what BMI stood for, only 15 % actually knew what BMI stands for. Another survey was orally administered to participants at STEP-tacular event that was held at the St. Petersburg Pier. 120 children were asked if they knew who was sponsoring the STEP-tacular event and 98% knew that STEPS to a Healthier Florida was sponsoring the event. Pinellaswellness.com carried a 30 day survey on physical activity the question asked was “How do you get your physical activity?” 66 answered that they get their physical activity outside, 44 at home, and 26 in the gym/spa with few choosing more than one option. Also, **211- a community hotline used to distribute resources within the county**, has partnered with the project to help evaluate the progress with the media. 211 is asking similar media related questions when people call to determine where services are offered. 211 is also tracking demographic information from callers in the intervention area. Currently, 211 has determined that only three (3) of the callers heard about Steps through television or radio and that the other 33 heard it from their community center or flyers at social service agencies. This is a small sample but should grow as the project markets the use of 211 as a Steps partner.

The **Community Action Plan Matrix, Program, Long Term Objectives and Data Inventory/Priority Indicator** sheet are based on data obtained from various sources listed in this document. As more data is collected in Yrs 3-4, the action plan strategies will be modified to reflect findings. If needed, the budget and subcontractors will be amended based on the data. Please refer to Section **3f.** for the **Modified Long Term Objectives**, Section **2h.** for the **Community Action Plan Matrix**, and Section **3e.** for the **Priority Indicator Sheet** for current progress, baselines, and data sources for the evaluation.

## **Sustainability**

The Pinellas County Health Department as lead agency for the Steps projects continues to advocate to all the Steps community partners the importance of sustaining current activities at the end of the Project cycle. The message is reinforced at each monthly Leadership meeting. As a result many partners have already put in place resources to sustain their accomplishments. Some examples include:

### **Pinellas County Health Department**

PinCHD actively seeks out alternate sources of funding for Chronic Disease Prevention. A full time grant writer continually seeks out opportunities to finance programs. In addition the Offices of Chronic Disease Prevention and Minority Health are providing health awareness and educational events throughout the community.

### **Pinellas County Schools**

- Food Services is working on a plan to centralize the district food service program in order to fund the nutrition educator.
- The Steps grant is providing Organ Wise Guy Curriculum for all schools requesting presentations. These materials will be housed in the school media center for all teachers to use to continue the program when the project is completed.
- A health and wellness resource center is being housed at the district office to provide materials for teachers to use after the project is completed.
- The district has purchased a district server for PE teachers to report Fitnessgram scores to record fitness data from year to year. A teacher will be able to follow the fitness track of his/her student from grades K-12.

## **YMCA**

The YMCA Group Exercise Programs have already experienced some sustainability with the community physical activity classes. Steps programs sites are contracting with the YMCA to provide additional classes, expanding Steps activities. In another initiative for sustainability, the YMCA plans to establish a time frame for each participating site. The facility will need to assume responsibility for the classes by the end of the designated time frame, several options are being offered. One is to contract with the YMCA or another wellness provider to continue the classes, another option is for the facility to send a representative to the YMCA for training to become a certified group exercise instructor for the classes.

The YMCA is also reconfiguring the Lunch Bunch program in an effort to promote sustainability by developing a universal curriculum which can be implemented in multiple schools. The goal is at that the program will become one that a volunteer or other school staff could continue.

## **Pinellas Cooperative Extension**

In order to sustain programs the Extension has provided “train the trainer” workshops to staff of after school programs. Training focused on nutrition, healthy snacks, and provided participants ideas on healthy recipes they can make with their children enrolled in their after school programs. Additionally, a portion of the training focused on the importance of modeling positive nutrition behaviors.

The activity directors at the St. Petersburg recreation centers were asked to design lessons for youth in their after school programs. One of the directors used all of the Steps materials that foundation for nutrition based activities

### **2-1-1 Tampa Bay Cares**

The 2-1-1 agency mission is to provide information to community members on health and human service concerns and 2-1-1 will continue to promote the Steps agenda by participating in community outreach and making referrals to partner agencies during and after the Steps program is completed. The relationships developed with partner agencies through Steps has strengthened the 2-1-1 presence in the community and supported the mission.

### **Diabetes Intervention and Prevention Program (DIPP)/Steps**

This year the DIPP/Steps program awarded certificates to its first DSME graduating class of diabetic “train the trainers.” The intent is for these volunteer trainers to now go out and train other diabetics in the community. These trained enrollees are committed to being health ambassadors for the Steps program and will add to sustainability of this project component.

### **c. Staffing Changes**

The PinCHD, Office of Chronic Disease Prevention had two upper level staffing changes. In April, 2005 the previous director, Patricia Colantonio was replaced by Susan Gilbert. At the beginning of Year 3, the Steps Evaluator Dorothy Miller was replaced by Mr. Olety. Resumes for both are attached as well as an updated Table of Organization.