

organizations; business, community, and faith-based leaders; and at least one lay person representative of the population to be served. Other partners may include, but are not limited to, existing community coalitions (especially those already focusing on chronic diseases), Federally Qualified Health Centers including community health centers¹, worksite wellness programs, health care purchasers, health plans, unions, health care providers for farm and migrant workers and their families, school-based and school-linked clinics, health care providers for the homeless, primary care associations, social service providers, health maintenance organizations, private providers, hospitals, universities, schools of public health, academic health centers, organizations that serve young children and youth, parks and recreation departments, departments of transportation, public housing authorities, state Medicaid officials, service organizations, food manufacturers and distributors, aging services organizations, senior centers, community action groups, consumer groups, and the media.

Note: ¹ Consolidated Health Centers under Section 330, of the Public Health Service Act are commonly referred to as community health centers. They include centers that tailor resources for populations such as low-income persons, the uninsured, homeless people, migrant and seasonal farm workers, and public housing residents.

(c) Leadership, Coordination, and Management

i. *Leadership Team.* Establish and coordinate a leadership team responsible for overseeing project activities, establishing and maintaining an organizational structure and governance for the community consortium (including decision-making procedures), determining the project budget and subcontracts, and participating in project-related local and national meetings. The leadership team must include, but is not limited to, the local health department, the local education agency or agencies, and other key leaders from the community.

ii. *Project Staff.* Establish and maintain paid project staff to include a full-time project coordinator with management experience in risk factor interventions and community-based chronic disease prevention and control. Other part-time or full-time staff, contactors, and consultants must be sufficient in number and expertise to ensure project success and have demonstrated skills and experience in coalition and partnership development, community mobilization, health care

systems, public health, program evaluation, epidemiology, data management, health promotion, policy and environmental interventions, health care quality improvement, communications, resource development, school health, and the risk factor and disease areas targeted by the program.

iii. *Project Management.* The project coordinator with the other project staff and leadership team, should:

a. Encourage active participation of consortium members in project activities and decisions, through regular meetings and other proactive methods of communication

b. Actively oversee all project activities during their planning, development, implementation, and evaluation phases

c. Track performance in relationship to the achievement of short-term and intermediate outcomes and budgetary expenditures

d. Seek technical assistance from the State, HHS agencies, other Federal agencies, other recipients, national voluntary organizations, universities, or other sources

e. Keep the Project Officer informed and seek Project Officer input and assistance

f. Take corrective action promptly when necessary to ensure project success

g. Participate in STEPS-wide program evaluations.

iv. *Coordinate with State Plans and Activities.* Ensure that community objectives, activities, and interventions are consistent with and supportive of state plans and activities for the prevention and control of diabetes, asthma, obesity, and associated risk factors. Ensure that community objectives, activities, and interventions do not duplicate existing efforts.

(d) *Community Action Plan, Community and School-Based Interventions*

Identify and implement high priority, eligible intervention strategies proven to prevent and control diabetes, asthma, and obesity. To establish such priorities, communities must examine their chronic disease burden, at-risk populations, current services and resources, and partnership capabilities to develop a comprehensive community action plan.

Communities can select particular areas of programmatic focus within STEPS. However, all communities must address nutrition, physical activity, and tobacco use and exposure since these areas will positively impact primary and/or secondary prevention in diabetes, asthma, and obesity. Additionally, communities are expected

to implement other specific interventions to reduce the burden of the diseases/conditions addressed by STEPS (asthma, diabetes, and obesity). Such interventions might include: (1) Conducting community-wide campaigns to implement a diabetes assessment questionnaire (e.g., American Diabetes Association's "Are You at Risk?"); (2) promoting quality care by providing health care settings with effective systems for handling referrals, follow-ups, and patient reminder systems; and (3) providing training for health care providers on how to establish effective asthma care plans with patients and their families.

i. *Community Interventions.* Programs are expected to employ multiple, evidence-based public health strategies based on the existing and emerging research base and careful scientific reviews such as the Guide to Community Preventive Services (<http://www.thecommunityguide.org/>), the Guide to Clinical Preventive Services (<http://www.odphp.osophs.dhhs.gov/pubs/guidecps/>) and <http://www.ahrq.gov/clinic/prevnew.htm>), and the National Registry for Effective Programs (<http://modelprograms.samhsa.gov/template.cfm?page=nrebutton>). Effective public health strategies may include changes to the social and physical environments; health promotion, public education, and information; media and other communication strategies; technological advances; economic incentives and disincentives; system improvements; provider education and medical office-based improvement strategies. (See Attachment C for additional, example intervention strategies).

While project activities should reach all persons in an identified intervention area, special efforts should be taken to ensure focus on populations with disproportionate burden of chronic diseases/conditions who also tend to experience disparities in access to and use of preventive and health care services. Populations of special focus might include racial and ethnic minorities, low-income persons, the medically underserved, persons with disabilities, and others with special needs. Programs must be culturally competent, and meet the health literacy and linguistic needs of target populations in the intervention area.

Programs should optimize resources by coordinating and partnering with existing programs and resources in the community, surrounding areas, and the state (e.g., state incentive grant programs). Programs should expand the resources available through public-