STATE PUBLIC HEALTH ACTIONS (1305)

Year 3 Performance Measures Snapshot

Four distinct CDC chronic disease prevention programs are working together to strengthen state actions to address health risk behaviors, environments, and systems associated with diabetes, heart disease, obesity, and school health.

- **Improve communities to support healthy choices and behaviors.**
- **Improve prevention and control of chronic conditions in schools.**
- **Improve care to facilitate prevention, early diagnosis, and quality management of heart disease, stroke, and diabetes.**
- **Increase access to community-based diabetes prevention and self-management education programs.**

The following is a snapshot of select performance measures reported by the 1305 grantees in year 3 of the program.

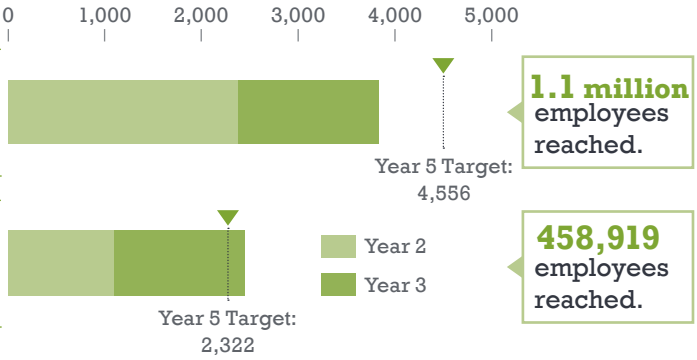
States worked within different community settings—including worksites—to improve nutrition and physical activity.

Physical Activity (PA) Policies

3,855 worksites have adopted PA policies.

Nutrition Guidelines

2,467 worksites have adopted nutrition guidelines.



1.1 million employees reached.

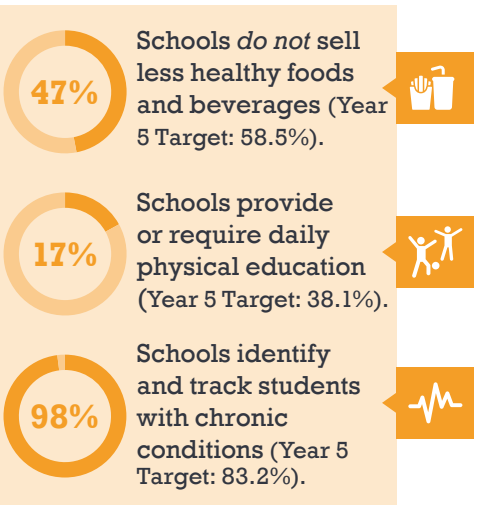
458,919 employees reached.

States worked with local education agencies (LEAs) to improve nutrition, physical education, and the management of chronic conditions in schools.

5,835 LEAs with over **23.8 million** students were supported in creating healthy school nutrition environments (Year 5 Target: 7,277 LEAs, 25.1 million students).

2,723 LEAs with over **15.2 million** students were supported in creating physical education policies (Year 5 Target: 5,272 LEAs, 21 million students).

79 LEAs supported in assessment, counseling, and referrals to community-based medical care providers for students on activity, diet, and weight-related chronic conditions (Year 5 Target: 133 LEAs).

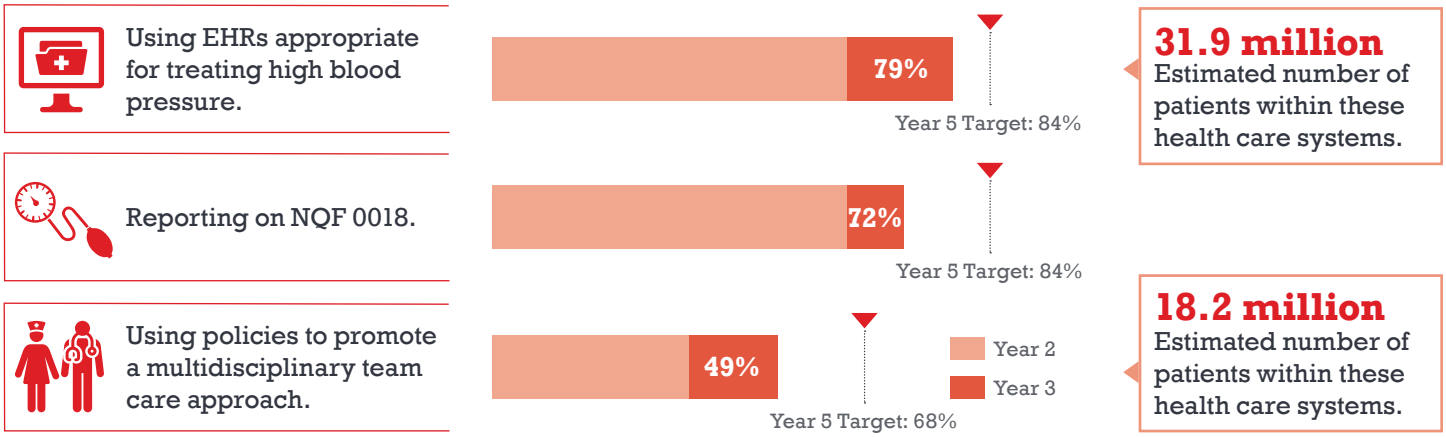


Note: The number of grantees reporting differs for each measure.

Improved diagnosis and control of heart disease and stroke within health care systems.

Effective use of electronic health record (EHR) systems and promotion of quality improvement and population reporting of patients aged 18 to 85 years who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90 mmHg) during the measurement period (National Quality Forum (NQF) Measure 0018), improves identification and monitoring of diagnosed and undiagnosed patients with uncontrolled high blood pressure. Use of a multidisciplinary team care improves the quality of care provided to patients with hypertension.

Percentage of health care systems:



31.9 million
Estimated number of patients within these health care systems.

18.2 million
Estimated number of patients within these health care systems.

63% of adults with known high blood pressure have achieved blood pressure control.

Note: The number of grantees reporting and data source types differ for each measure.

Increased use of community-based diabetes prevention and self-management education programs.

National Diabetes Prevention Program (National DPP) supports a structured, year-long lifestyle change program that is offered in-person and online to prevent or delay the onset of type 2 diabetes among those at high risk. States are working to increase prediabetes awareness, increase referrals to CDC-recognized diabetes prevention programs, and secure the program as a covered benefit for state or public employees and Medicaid beneficiaries.

Improved referral policies

34% of health care systems have policies to refer persons at high risk for type 2 diabetes to a CDC-recognized diabetes prevention program (19% increase from baseline).

Improved Medicaid coverage

891,848 Medicaid recipients at high risk for type 2 diabetes now have access to a CDC-recognized diabetes prevention program as a covered benefit (411% increase from baseline).

Increased Use

32,267 people with prediabetes or at high risk for type 2 diabetes enrolled in a CDC-recognized diabetes prevention program.

60.5% of participants were referred by a health care provider.

National DPP participants experienced an average weight loss of **4.7%.**

Diabetes Self-Management Education (DSME) is the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care to improve clinical outcomes, health status, and quality of life. The 1305 grantees are working to increase use of DSME by increasing referrals to, coverage for, and availability of programs.

Increased availability

3,308 DSME programs were offered across 56% of counties in 43 states (5% increase from baseline).

Improved Medicaid coverage

1.7 million Medicaid recipients with diabetes now have DSME as a covered benefit (17% increase from baseline).

Increased Use

1.1 million people with diabetes participated in an American Diabetes Association (ADA)-recognized or American Association of Diabetes Educators (AADE)-accredited DSME program in targeted settings (17% increase from baseline).

Note: The number of grantees reporting differs for each measure.