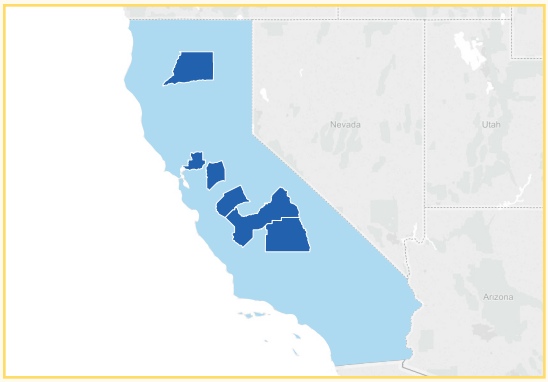
State and Local Public Health Actions 1422 Program

California | PROGRAM PROFILE

The California Department of Public Health is a state awardee of the State and Local Public Health Actions 1422 (SLPHA-1422) program, which aims to promote and reinforce healthful behaviors, best practices, and decrease health disparities to prevent and reduce chronic disease.



TARGETED COMMUNITY

AWARD
$3,520,000

AMOUNT TO SUBAWARDEES
$2,999,998

PERCENTAGE OF AWARD TO SUBAWARDEES
85%

SUBAWARDEES

The Local Health Departments of:

- Fresno County
- Merced County
- San Joaquin County
- Shasta County
- Solano County
- Tulare County

TYPES OF PARTNERS (NO.)

- Coalition/collaborative (24)
- Private business (20)
- Health system/health care-provider (15)
- Other local government entity (15)
- Community-based organization (14)
- Nonprofit organization (9)
- University/academic institution (9)
- Other (2)
- County/city health department (1)
- K–12 School/school official (1)
- Tribal nation (1)

TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
Fresno, Merced, San Joaquin, Shasta County, Solano and Tulare counties	Non-white immigrant populations with limited education in the Central Valley	▪ Disease Burden ▪ Sociodemographics

FOCUS ON HEALTH FOR ALL: DUAL APPROACH AND MUTUALLY REINFORCING STRATEGIES

The SLPHA-1422 program aims to reduce health disparities by supporting states, large cities, and local communities working together to implement the Dual Approach using a set of comprehensive environmental, health system, and community-clinical linkage strategies. These strategies aim to reach both the general population at the state or large-city level and priority populations across the state or large city, and within targeted communities. The implementation of each approach supports the other in a mutually reinforcing way that strengthens their combined impact. The graphic below depicts examples of the Dual Approach and mutually reinforcing strategies with three strategies selected by the awardee.

DUAL APPROACH

MUTUALLY REINFORCING

Strengthen healthier food access and sales in retail venues and community venues through increased availability of healthy foods, improved pricing, placement, and promotion	Implement evidence-based engagement strategies to build support for lifestyle change	Increase engagement of community pharmacists in the provision of medication-management for adults with high blood pressure
GENERAL POPULATION	**GENERAL POPULATION**	**GENERAL POPULATION**
Implement training for local health departments to collect data in retail environments related to the access and availability of healthy foods.	Convene strategic planning sessions to finalize the state and regional action plan to scale and sustain the National Diabetes Prevention Program (National DPP) in California.	Engage retail pharmacy leaders on implementing comprehensive medication management and assess activities around medication therapy management and patient self-management.
Develop materials and conduct one workshop for store owners in neighborhoods to build capacity and knowledge about Solano County Healthy Retail Program.	Identify low-socioeconomic status (SES) populations within Solano County who are at high risk for type 2 diabetes and provide access to CDC-recognized diabetes prevention programs.	Identify opportunities for student pharmacists to participate in medication management pilot programs in pharmacies that serve low-SES populations at high risk for cardiovascular disease.
PRIORITY POPULATION	**PRIORITY POPULATION**	**PRIORITY POPULATION**

SUCCESS STORIES

According to the California Health Interview Survey, more than 2.3 million California adults were diagnosed with diabetes in 2012. To address diabetes and other chronic diseases, the state Lifetime of Wellness Program (Lifetime), six subcontracted local health jurisdictions, and statewide partners implemented several mutually reinforcing strategies designed to work in concert in high-need areas. Implementing and scaling the **National Diabetes Prevention Program (National DPP)** was one of these strategies.

In Fresno County, where 49% of adults are estimated to have prediabetes, the United Health Centers of the San Joaquin Valley (UHC) collaborated with the Fresno County Department of Public Health (FCDPH) and the Lifetime program to implement the National DPP. UHC used a grant provided by the FCDPH to train 15 health educators and patient navigators to serve as lifestyle coaches for **CDC-recognized diabetes prevention programs**. The classes, offered at three sites in both Spanish and English, successfully helped 24 patients lose a combined total of 175 pounds. UHC plans to add more CDC-recognized diabetes prevention programs in the future.

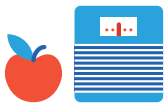
306 California residents supported by 1422 funds enrolled in CDC-recognized diabetes prevention programs since 2015

176,312 people were reached by multi-channel, community-wide communication activities promoting the National DPP in the six 1422-funded local CA health departments

In Solano County, the Public Health Department and Touro University California (TU) facilitated the partnership between staff and students to form the Solano Diabetes Prevention Program Phalanx and develop a framework for diabetes prevention. Solano County Public Health (SCPH) and TU held monthly meetings to schedule, screen, and recruit class participants for the CDC-recognized diabetes prevention program. Program staff provided over 300 pharmacy students with lifestyle coach training. SCPH also partnered with neighboring counties to train additional lifestyle coaches, assess organizational capacity to host classes, and build a diabetes prevention network. Since 2015, SCPH has started CDC-recognized diabetes prevention program classes with 16 cohorts.

SUBAWARDEE PERFORMANCE MEASURE HIGHLIGHTS

The Centers for Disease Control and Prevention's National Center for Chronic Disease Prevention and Health Promotion funds the SLPHA 1422 program. The following are subawardee performance measure results by division.



DIVISION OF NUTRITION, PHYSICAL ACTIVITY, AND OBESITY

39 key community locations are implementing nutrition and beverage standards.

14 retail and community venues are increasing availability, affordability, placement, and/or promotion of healthy foods.

15 community venues are promoting physical activity through signage, joint use agreements, and/or worksite policies.

1,023,264 adults have access to community venues promoting physical activity.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

1,101,164 patients are participating in healthcare systems with electronic health records appropriate for treating patients with high blood pressure.

783,414 patients are participating in healthcare systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control.

9 healthcare systems are engaging CHWs to link patients to community resources that promote self-management of high blood pressure.

12 healthcare systems are implementing a community referral system to evidence-based lifestyle change programs for people with hypertension.

DIVISION OF DIABETES TRANSLATION

176,312 adults reached through evidence-based engagement strategies.

306 adults at high risk for type 2 diabetes enrolled in CDC-recognized diabetes prevention programs.

158,395 patients are within healthcare systems with policies or systems to facilitate identification of people with prediabetes.

16 healthcare systems engaged with CHWs to link patients to community resources that promote the prevention of type 2 diabetes.

For more information, please email **1422evaluation@cdc.gov**.

* Targeted community, for the purpose of this funding opportunity announcement (FOA), is defined as a county, metropolitan statistical area, or a group of contiguous counties. These communities must have significant disease burden and sufficient combined populations to allow the strategies supported by this FOA to reach significant numbers of people.

** Priority populations are high-risk, high-burden populations with prediabetes or uncontrolled high blood pressure that experience racial/ethnic or socioeconomic health disparities, including inadequate access to care, poor quality of care, or low income.

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