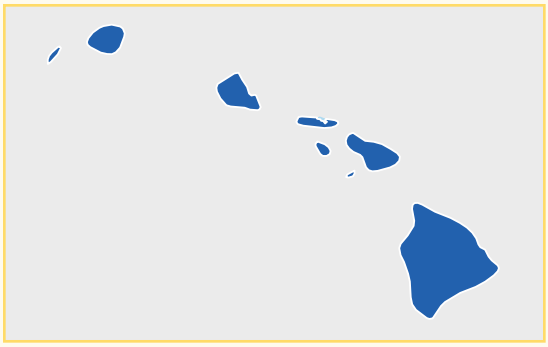
State and Local Public Health Actions 1422 Program

Hawaii | PROGRAM PROFILE

The Hawaii State Department of 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
$2,750,813

AMOUNT TO SUBAWARDEES
$2,000,000

PERCENTAGE OF AWARD TO SUBAWARDEES
73%

SUBAWARDEES
- Hawaii Primary Care Association (HPCA)
- Hawaii Public Health Institute (HIPHI)

TYPES OF PARTNERS (NO.)
- Other local government department (10)
- Health system/healthcare provider (9)
- Coalition/collaborative (4)
- Private business (4)
- Nonprofit organization (2)
- Community-based organization (1)
- University/academic institution (1)

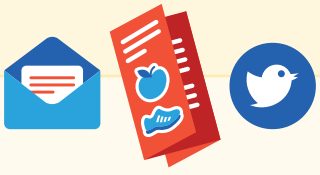
TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
The State of Hawai'i: Hawai'i County, Honolulu City and County, Kaua'i County, and Maui County. Nine Community Health Centers (CHCs) are participating in SLPHA-1422, representing three of four counties.	Patients of the 9 participating Community Health Centers (CHCs). The evaluation plan focuses on the three rural CHCs in the outlying areas of urban Honolulu on the island of O'ahu	▪ 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	Implement systems to facilitate identification of patients with undiagnosed HTN and people with prediabetes
GENERAL POPULATION	**GENERAL POPULATION**	**GENERAL POPULATION**
Work with convenience store and other retail locations statewide to increase and promote their healthy options.	Support CHCs to scale and sustain the National Diabetes Prevention Program (National DPP).	Develop trainings for practitioners statewide on the identification and treatment of undiagnosed hypertension.
		
Work with retail store locations in the three targeted rural communities to increase and promote healthy options.	Work with three rural CHCs on O'ahu to scale and sustain the National DPP for priority populations.	Work with 3 rural O'ahu CHCs to assess their systems to identify undiagnosed hypertension and develop protocols to strengthen them.
PRIORITY POPULATION	**PRIORITY POPULATION**	**PRIORITY POPULATION**

SUCCESS STORIES

According to the Behavioral Risk Factor Surveillance System (BRFSS), 33.8% (2016) of adults living in Hawaii were overweight, 23.8% (2016) were obese, 29.8% (2015) were diagnosed with hypertension, and 9.4% (2016) were diagnosed with diabetes. In response, the Hawaii State Department of Health (HDOH) has launched programs across the state to prevent these chronic diseases.

HDOH partnered with the Hawaii Public Health Institute (HIPHI) to improve food environments across the state by working with vendors to adopt nutrition and beverage standards through the **Choose Healthy Now (CHN)** program. HDOH and HIPHI created and implemented a train-the-trainer workshop and an implementation to expand the program's reach to community and retail venues. CHN trained 32 community members, and the number of CHN locations has increased from 3 locations in 2015 to 124 locations in 2017.

25 home blood pressure monitors distributed.

233 patients enrolled in CDC-recognized diabetes prevention programs.

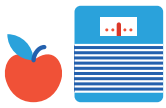
10 new CDC-recognized diabetes prevention programs established.

On the island of Hawai'i, one in three adults have high blood pressure and are unable to monitor their blood pressure without seeing a health care provider. To facilitate blood pressure monitoring at home, the Hamakua-Kohala Health Center provided **home blood pressure monitoring devices** for at-risk patients and access to a care coordinator, who would use home visits to educate local families on the importance of nutrition and physical activity.

Another concern for the state is diabetes, which impacts one in ten adults living in Hawaii, mainly Native Hawaiians, Filipinos, and Pacific Islanders. Community Health Centers are addressing this concern by providing **CDC-recognized diabetes prevention programs** in high need areas. By adding discussion on culturally relevant physical activities like net throwing for fishing or hula dancing, the community health centers saw an increase in participant enrollment and interest from the community.

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

4 key community locations are implementing nutrition and beverage standards.

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

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

1,128,104 adults have access to community venues promoting physical activity.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

59,485 patients are participating in healthcare systems with electronic health records appropriate for treating patients with high blood pressure.

58,235 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 Community Health Workers (CHWs) to link patients to community resources that promote self-management of high blood pressure.

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

DIVISION OF DIABETES TRANSLATION

Approximately **246,000** adults reached through evidence-based engagement strategies.

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

37,555 patients are within healthcare systems with policies or systems to facilitate identification of people with prediabetes.

9 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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