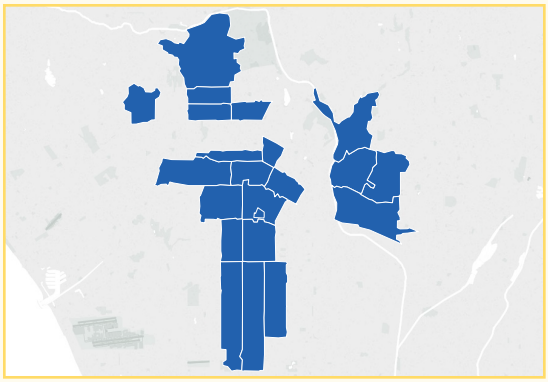
State and Local Public Health Actions 1422 Program

Los Angeles | PROGRAM PROFILE

The Los Angeles County Department of Public Health is a city 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

MAIN PARTNERS

- 211 LA County
- AltaMed Health Services Corporation
- American Diabetes Association
- Black Women for Wellness
- City of Los Angeles Department of Transportation
- Los Angeles County Department of Health Services
- Los Angeles Food Policy Council
- YMCA

TYPES OF PARTNERS (NO.)

- Nonprofit organization (4)
- Health system/healthcare-provider (2)
- Coalition/collaborative (1)
- Other local government entity (1)

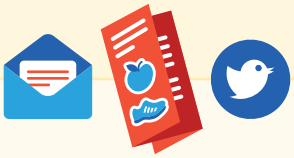
TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
▪ Boyle Heights ▪ Metro (Promise Zone) ▪ South Los Angeles	The Boyle Heights community in Los Angeles which is predominantly Latino and low-income	▪ Disease burden ▪ Sociodemographics

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 health workers (CHW) to promote linkages between health systems and community resources for adults
GENERAL POPULATION	**GENERAL POPULATION**	**GENERAL POPULATION**
Outreach to restaurants and provide technical assistance to join the Choose Health LA Restaurants program.	Establish CDC-recognized diabetes prevention programs at worksites, community-based organizations, and clinics.	Increase use of health navigator (CHW) programs at targeted medical facilities.
		
Identify restaurants serving high rates of low-income individuals and provide targeted technical assistance to join the program.	Identify mechanisms to screen low-income and priority population members at highest risk and refer to CDC-recognized diabetes prevention programs.	Implement screening and referral protocols to enhance bi-directional referrals between priority populations and surrounding clinics/providers.
PRIORITY POPULATION	**PRIORITY POPULATION**	**PRIORITY POPULATION**

SUCCESS STORIES

Since 1999, heart disease and stroke have been the leading causes of death in Los Angeles; approximately 1.8 million residents have been diagnosed with hypertension and are at high risk for chronic diseases. As part of the 1422 SLPHA program, the Los Angeles County Department of Public Health (LADPH) has implemented several programs to combat chronic disease.

In 2015, LADPH expanded the LA Healthline telephone support service to include a **Chronic Disease Assessment (CDA)**. The CDA allows for dialogue with community members regarding their risk for cardiovascular disease and evidence-based lifestyle intervention programs that can improve health behaviors and prevent chronic disease. The expansion has allowed live operators to offer screening and referral services in six different languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), providing a powerful tool to link underserved groups to evidence-based lifestyle programs.

56% **of LA Healthline clients have been offered a CDA since the service was launched.**

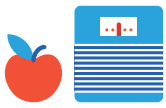
32% **of clients who completed the CDA were identified as chronic disease suffers.**

3 **diabetes prevention symposia have been held, attended by approximately 100 stakeholders per year.**

LADPH also worked to scale and sustain the **National Diabetes Prevention Program (National DPP)**. As a cornerstone of this work, LADPH partnered with the YMCA of Metropolitan Los Angeles to establish the Los Angeles Diabetes Prevention Coalition. The Coalition focused on increasing the number and capacity of CDC-recognized diabetes prevention program providers, increasing public demand for the program, and engaging healthcare systems to regularly identify and refer members at high risk of developing type 2 diabetes to the program. The Coalition organized three Diabetes Prevention Symposia, convening over 100 stakeholders annually to discuss issues related to program expansion. Since the initiation of 1422 SLPHA activities, the number of CDC-recognized diabetes prevention programs in Los Angeles has increased by over 400%, from 12 to 62, including six agencies supported with SLPHA 1422 funds.

LARGE CITY 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 the awardee performance measure results by division.



DIVISION OF NUTRITION, PHYSICAL ACTIVITY, AND OBESITY

5 key community locations are implementing nutrition and beverage standards.

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

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

1,012,245 adults have access to community venues promoting physical activity.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

114,687 patients are participating in healthcare systems with electronic health records appropriate for treating patients with high blood pressure.

114,687 patients are participating in healthcare systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control.

1 healthcare system is engaging community health workers to link patients to community resources that promote self-management of high blood pressure.

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

DIVISION OF DIABETES TRANSLATION

42,397 adults reached through evidence-based engagement strategies.

1,057 adults at high risk for type 2 diabetes enrolled in CDC-recognized diabetes prevention programs.

300,911 patients are within healthcare systems with policies or systems to facilitate identification of people with prediabetes.

1 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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