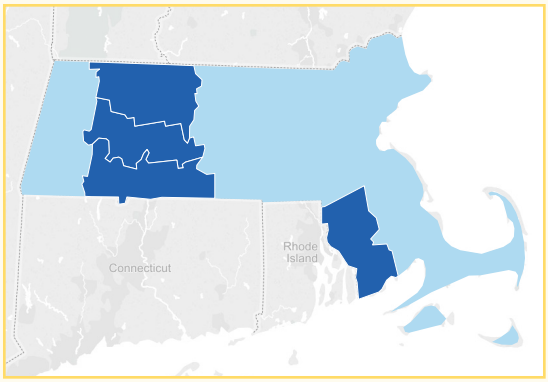
State and Local Public Health Actions 1422 Program

Massachusetts | PROGRAM PROFILE

The Massachusetts 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
$1,760,000

PERCENTAGE OF AWARD TO SUBAWARDEES
50%

SUBAWARDEES
- City of Fall River Health Department
- City of Northampton Health Department
- City of Springfield Health Department
- Franklin Regional Council of Governments

TYPES OF PARTNERS (NO.)
- Coalition/collaborative (22)
- Other local government entity (18)
- University/academic institution (6)
- Health system/healthcare-provider (5)
- Community-based organization (4)
- Private business (4)
- Nonprofit organization (2)

TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
Bristol, Franklin, Hampden, and Hampshire counties	Residents of low socio-economic status in all targeted communities	• Community capacity/ infrastructure • Disease burden • Established partnerships • Population size

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

Develop and/or implement transportation and community plans that promote walking	Implement evidence-based engagement strategies to build support for lifestyle change	Implement systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes
GENERAL POPULATION	**GENERAL POPULATION**	**GENERAL POPULATION**
Create, signpost, and publicize walking routes with an emphasis on implementing and testing walking routes to measure the difference between utilitarian and recreational trips.	Establish CDC-recognized diabetes prevention programs in the targeted community to provide more convenient access for all clinic patients and town residents.	Provide feedback reports to clinical sites identifying patients with undiagnosed hypertension and people with prediabetes.
		
Track equity metrics and refine walking maps based on evaluation results; improve walking infrastructure for high-need neighborhoods.	Establish a CDC-recognized diabetes prevention program at a wellness center that services patients of predominantly low socio-economic status.	Include a section to provider feedback reports stratified by SES to ensure progress is being made both in the general and priority populations and provide information for care teams.
PRIORITY POPULATION	**PRIORITY POPULATION**	**PRIORITY POPULATION**

SUCCESS STORIES

Massachusetts residents are facing increasing rates of diabetes and hypertension. To address chronic disease, the state and its partners implemented 15 mutually reinforcing strategies. Below are examples of two of the strategies at work.

In Franklin County, an increase in prevalence of type 2 diabetes has led to a partnership between Mass in Motion, the 1422 program, the YMCA in Greenfield, the Athol YMCA, Community Health Center of Franklin County, and Franklin County Council of Governments to launch an initiative to scale and sustain **the National Diabetes Prevention Program (National DPP)**. The Community Health Center of Franklin County and other community-based organizations have connected residents to CDC-recognized diabetes prevention programs at local YMCAs where lifestyle coaches teach residents how to incorporate healthy eating, physical activity, and problem-solving/coping skills into their daily lives.

3 new CDC-recognized diabetes prevention programs established.

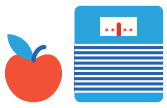
70% of participants in CDC-recognized diabetes prevention programs met or exceeded the 5-7% weight loss goal.

The first CDC-recognized diabetes prevention program started at the Greenfield YMCA in February 2016 and maintained a 90% participant attendance rate. Seven of 10 participants met or exceeded the program's weight loss goal. A second class launched on July 14, 2016.

In Springfield, MA, Caring Health Center has integrated **community health workers (CHWs)** with an aim to improve the detection of patients with undiagnosed hypertension and to manage those with uncontrolled hypertension. Caring Health Center developed a hypertension registry; provided training for CHWs on contacting and providing community and clinic-based interventions to patients with undiagnosed hypertension; and facilitated collaboration between CHWs, pharmacists, and primary care providers to review cases and address patient social, environmental, clinical, and behavioral challenges.

SUBAWARDEE PERFORMANCE MEASURE HIGHLIGHTS

The Centers for Disease Control and Prevention 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

3 key community locations are implementing nutrition and beverage standards.

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

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

206,205 adults have access to community venues promoting physical activity.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

48,461 patients are participating in healthcare systems with electronic health records appropriate for treating patients with high blood pressure.

48,461 patients are participating in healthcare systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control.

DIVISION OF DIABETES TRANSLATION

2,101,212 adults reached through evidence-based engagement strategies.

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

48,461 patients are within healthcare systems with policies or systems to facilitate identification of people with prediabetes.

4 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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