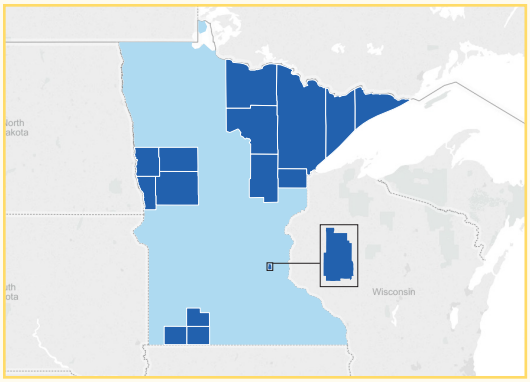
State and Local Public Health Actions 1422 Program

Minnesota | PROGRAM PROFILE

The Minnesota 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
$3,520,000

AMOUNT TO SUBAWARDEES
$2,112,002

PERCENTAGE OF AWARD TO SUBAWARDEES
60%

SUBAWARDEES

The Community Health Boards of:

- City of Minneapolis
- Des Moines Valley and Nobles County
- Healthy Northland
- PartnerSHIP 4 Health

TYPES OF PARTNERS (NO.)

- Private business (69)
- Nonprofit organization (63)
- Other local government entity (27)
- University/academic institution (17)
- Public housing sites (10)
- Coalition/collaborative (4)
- Other (3)
- County/city health department (2)

TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
Aitkin, Becker, Carlton, Clay, Cook, Cottonwood, Itasca, Jackson, Koochiching, Lake, Nobles, Otter Tail, St. Louis, and Wilkin counties, and the city of Minneapolis	Our priority populations include: low income individuals, African Americans, Latinos, Vietnamese, Hmong, Medicaid beneficiaries, Somalis, Bosnians, Lao, mental health consumers and East African immigrants.	• Community capacity/ infrastructure • Disease burden • Geographic region • Population size • 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 community promotion of physical activity though signage, worksite policies, social support, and joint use agreements	Implement evidence-based engagement strategies to build support for lifestyle change	Implement systems to facilitate identification of patients with undiagnosed hypertension (HTN) and people with prediabetes
GENERAL POPULATION	**GENERAL POPULATION**	**GENERAL POPULATION**
Implement statewide pedestrian system planning and workplace forums to create easy access to physical activity around the state.	Provide technical assistance (TA) to develop marketing plans to increase awareness of prediabetes and the National Diabetes Prevention Program (National DPP).	Provide training and TA on policy development and standardized protocols for identifying patients with undiagnosed HTN and prediabetes.
Work with low-wage workers in work sites to increase access to physical activity.	Work with all CDC-recognized diabetes prevention program providers to tailor communications to low-income clients.	Work with clinics to strengthen systems to identify Medicaid and Minnesota Health Care Program patients with undiagnosed HTN or prediabetes.
PRIORITY POPULATION	**PRIORITY POPULATION**	**PRIORITY POPULATION**

SUCCESS STORIES

In Minnesota, many communities are experiencing increasing rates of obesity, type 2 diabetes, and hypertension diagnoses. To address chronic disease, the state and its partners implemented 15 mutually reinforcing strategies. Below are two examples of these strategies at work.

In Des Moines Valley and Nobles County, **community health workers (CHWs)** are improving understanding and trust between members of diverse populations and those that seek to serve them. To increase the number of employees taking advantage of free preventive health care services at Sanford Health Clinic, CHWs assist the clinic manager and nurses in translating important patient information and providing health education. Clinics are creating systems to document, bill, and receive reimbursement for, and effectively connect CHW work to a variety of health care partners.

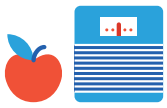
95 community members received services from CHWs in English, Spanish, and several East African languages.

20 participants joined the first Spanish-language CDC-recognized diabetes prevention program in Pelican Rapids and collectively lost 220 pounds.

These steps are critical to maintaining and expanding their presence in the community in years to come. PartnerSHIP 4 Health, a local public health partner in Pelican Rapids, worked to establish **CDC-recognized diabetes prevention programs** specifically for the city's Spanish-speaking community. PartnerSHIP met with key members of the Hispanic community to gain input on how to recruit and support the program. Participants learned strategies to lose weight, received tips on staying active, adopted new behaviors, and were encouraged to model healthy living for family and friends. By the end of the program, participants had collectively lost 220 pounds.

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

26 key community locations are implementing nutrition and beverage standards.

39 retail and community venues have increased availability, affordability, placement, and/or promotion of healthy foods.

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

7,077 adults have access to community venues promoting physical activity.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

88,643 patients are participating in healthcare systems with electronic health records appropriate for treating patients with high blood pressure.

62,210 patients are participating in healthcare systems with policies or systems to encourage a multidisciplinary team approach.

6 healthcare systems are engaging community health workers to link patients to community resources that promote self-management of high blood pressure.

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

DIVISION OF DIABETES TRANSLATION

2,681,490 adults reached through evidence-based engagement strategies.

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

36,560 patients are within healthcare systems with policies or systems to facilitate identification of people with prediabetes.

5 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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