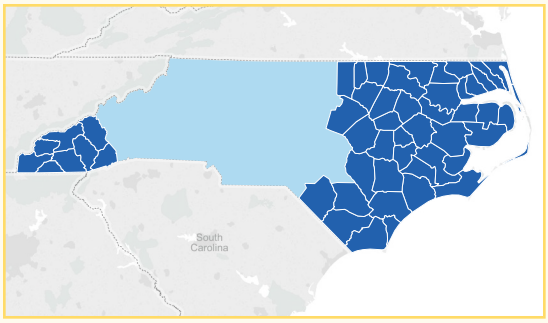
State and Local Public Health Actions 1422 Program

North Carolina | PROGRAM PROFILE

The North Carolina Department of Health and Human Services 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
- Region 1 health district
- Region 7 health district
- Region 8 health district
- Region 9 health district
- Region 10 health district

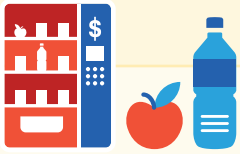
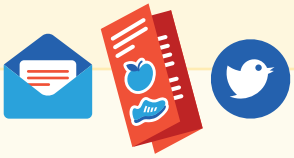
TYPES OF PARTNERS (NO.)
- Other local government entity (17)
- Health system/healthcare-provider (16)
- Private business (7)
- University/academic institution (5)
- Coalition/collaborative (3)
- Community-based organization (3)
- Faith-based institution (3)
- Nonprofit organization (3)
- County/city health department (1)

TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Cherokee, Chowan, Clay, Columbus, Craven, Currituck, Dare, Duplin, Edgecombe, Franklin, Gates, Graham, Granville, Greene, Halifax, Haywood, Hertford, Hyde, Jackson, Johnston, Jones, Lenoir, Macon, Martin, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Robeson, Sampson, Swain, Transylvania, Tyrell, Vance, Wake, Warren, Washington, Wayne, and Wilson counties	Medicaid eligible individuals with hypertension and/or at high risk for type 2 diabetes within the selected counties.	▪ Sociodemographics ▪ Community capacity ▪ Disease burden

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

Implement nutrition and beverage standards in public institutions, worksites, and other key locations	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**
Develop and provide resources to support implementation of nutrition and beverage standards at worksites and faith communities.	Develop systems for CDC-recognized diabetes prevention programs to receive referrals from primary care settings.	Establish Electronic Health Records (EHR) system to identify persons to be screened for diabetes and offer resources to patients with uncontrolled hypertension.
		
Recruit and provide technical assistance to priority population worksites and faith communities identified through interviews conducted at Federally Qualified Health Centers.	Train CDC-recognized diabetes prevention program providers to promote the use of the CDC Prediabetes Screening Test at worksites and faith communities.	Promote the use of EHRs to systematically screen for hypertension and prediabetes.
PRIORITY POPULATION	**PRIORITY POPULATION**	**PRIORITY POPULATION**

MUTUALLY REINFORCING

SUCCESS STORIES

Heart disease, diabetes, and stroke are leading causes of death in North Carolina. Haywood Vocational Opportunities, a company that provides training and employment to adults with disadvantages and disabilities, applied to a local foundation for funds to install three **blood pressure monitoring stations**. Since installation, the stations have been used over 8,000 times. Within two weeks, two employees prevented possible strokes by identifying dangerously high blood pressure numbers. Ten additional sites have installed stations through NC's 1422 SLPHA funding, with six more pending.

In Duplin County, heart disease is the leading age-adjusted cause of death. Cooperative Extension worked with Cornerstone Community Development Corporation to implement **Faithful Families Eating Smart and Moving More**, increasing access to and providing classes on healthy eating and active living in faith-based communities. Nine people participated in the first round, eventually decreasing their cholesterol. Similar results have been observed at 26 other faith communities through NC's 1422 SLPHA funding. All 26 have increased access to healthy eating and/or active living opportunities, supporting the health of approximately 3,000 members.

8,000 patients measured their blood pressure, and 2 potential strokes were prevented using the new monitoring stations.

1,900 Perdue Foods employees have increased access to healthy food and physical activity opportunities.

Lastly, in Bertie County, Perdue Foods worked to improve **access to healthy food and physical activity** for its 1,900 employees. The company provided healthier snacks and used conference room space to encourage movement throughout the day. As a result, Perdue has seen an uptick in employee physical activity and healthy snack consumption. Eighty-nine other worksites have taken similar steps through NC's 1422 SLPHA funding, supporting the health of approximately 18,000 employees.

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

88 key community locations are implementing nutrition and beverage standards.

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

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

1,991,638 adults have access to community venues promoting physical activity.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

68,647 patients are participating in healthcare systems with EHRs appropriate for treating patients with high blood pressure.

54,649 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.

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

DIVISION OF DIABETES TRANSLATION

14,081,143* adults reached through evidence-based engagement strategies.

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

62,556 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.

*This number includes all people reached and is not exclusive to adults (people 18 and over).

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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