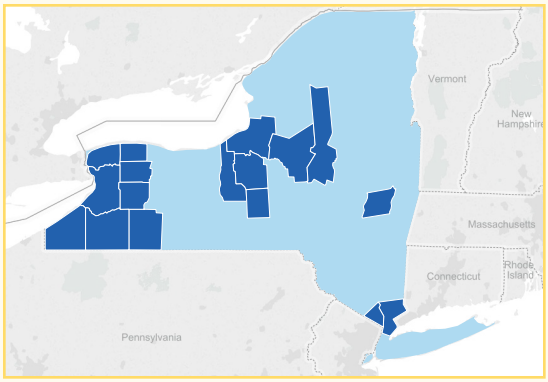
State and Local Public Health Actions 1422 Program

New York State | PROGRAM PROFILE

The New York 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
$3,519,494

AMOUNT TO SUBAWARDEES
$1,759,746

PERCENTAGE OF AWARD TO SUBAWARDEES
50%

SUBAWARDEES
- Albany County Department of Health
- Health Advancement Collaborative of Central New York (HealtheConnections)
- Hudson River Healthcare, Inc.
- P2 Collaborative of Western NY

TYPES OF PARTNERS (NO.)
- Private business* (135)
- Health system/healthcare provider (36)
- County/city health departments (18)
- Nonprofit organization (15)
- Other local government entity (9)
- university/academic institution (7)
- Community-based organization (6)
- Coalition/collaborative (6)
- Faith-based institution (4)

*Includes 112 small retail venues

TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
Albany, Allegany, Cattaraugus, Cayuga, Chautauqua, Cortland, Erie, Genesee, Herkimer, Niagara, Oneida, Onondaga, Orleans, Oswego, Rockland, Westchester, and Wyoming counties	Low income, ethnic and racial minorities, Medicaid beneficiaries or adults without insurance, and patients with uncontrolled high blood pressure and/or at risk for type 2 diabetes	▪ Community capacity/ infrastructure ▪ 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

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 (CHWs) to promote linkages between health systems and community resources for adults
GENERAL POPULATION	**GENERAL POPULATION**	**GENERAL POPULATION**
Provide training, technical assistance, and resources on healthy food products placement, pricing, and promotion.	Assess program recruitment and retention policies, and use results to inform statewide activities to support CDC-recognized diabetes prevention programs.	Develop and disseminate a CHW training on diabetes prevention and hypertension self-management.
Identify retail venues and implement strategies to improve sourcing, placement, promotion and pricing of healthy options.	Support/conduct media campaigns and provide incentives to increase awareness of and encourage participation in CDC-recognized diabetes prevention programs.	Support the integration of CHWs into team-based care within practice sites serving priority populations to promote self-management support.
PRIORITY POPULATION	**PRIORITY POPULATION**	**PRIORITY POPULATION**

MUTUALLY REINFORCING

SUCCESS STORIES

An estimated 1.3 million adults in New York State (8.2% of the population) have been diagnosed with prediabetes. Given that national data indicate only 11.6% of people with prediabetes are aware of their condition, state estimates suggest significantly more New Yorkers have prediabetes but are undiagnosed. To address this and other chronic diseases, New York State and its partners implemented 15 mutually reinforcing strategies that aim to prevent and control obesity, diabetes, heart disease, and stroke.

In the city of Yonkers, CHWs assist the health care team by increasing prediabetes awareness and promoting referrals to **CDC-recognized diabetes prevention programs**. The 1422 SLPHA program helped initiate a workflow so providers can document program referrals in the electronic health records (EHR) system to alert CHWs. Then CHWs reach out to potential participants, explain the program's time commitment, and secure consent to complete the outreach referral. To date, CHWs have generated 60 program referrals.

60 CDC-recognized diabetes prevention program referrals generated by CHWs

121 Albany County residents enrolled in CDC-recognized diabetes prevention programs.

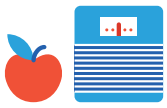
Pilot testing is underway for a centralized electronic referral platform to connect health care providers and CDC-recognized diabetes prevention program delivery partners.

In Albany County, collaborations between community-based organizations and CDC-recognized diabetes prevention program providers to offer 11 class cohorts over a 12-month period to serve communities experiencing health disparities. By strategically selecting and scheduling class locations that increase accessibility, and by engaging CHWs to increase participation, 121 people with prediabetes from these communities have been enrolled to date.

In Central New York, **a new technology-based referral platform** connecting health care providers and community-based resources, like CDC-recognized diabetes prevention programs, was piloted within a health information exchange (HIE) to allow users to select a program provider, complete a referral, and submit the referral securely through the HIE. The goal of the pilot is to generate 45 referrals within three months.

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

49 key community locations are implementing nutrition and beverage standards.

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

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

120,943 adults have access to community venues promoting physical activity.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

93,749 patients are participating in healthcare systems with EHR appropriate for treating patients with high blood pressure.

49,676 patients are participating in healthcare systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control.

11 healthcare systems are engaging CHWs to link patients to community resources that promote self-management of high blood pressure.

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

DIVISION OF DIABETES TRANSLATION

611 adults reached through evidence-based engagement strategies.

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

65,917 patients are within healthcare systems with policies or systems to facilitate identification of people with prediabetes.

11 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.

LAST UPDATED 01/31/2018