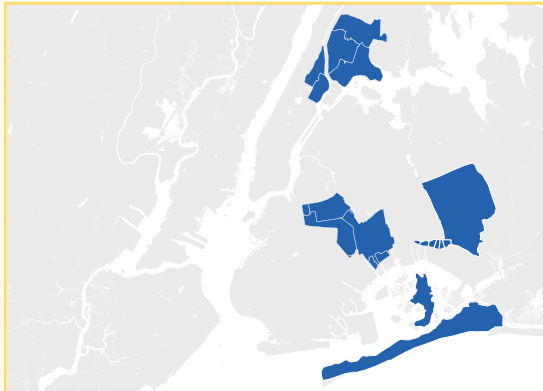


# New York City | PROGRAM PROFILE



The New York City Department of Health and Mental Hygiene 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**

**\$3,519,079**




**MAIN PARTNERS**

- New York State Quality Technical Assistance Center
- New York City (NYC) Department of Parks and Recreation
- NYC Department of Transportation
- Department of Parks and Recreation
- Department of Education
- Department of Transportation
- Department of City Planning
- Department of Housing Preservation & Development

- Department of Small Business Services
- Economic Development Corporation
- Office of Labor Relations

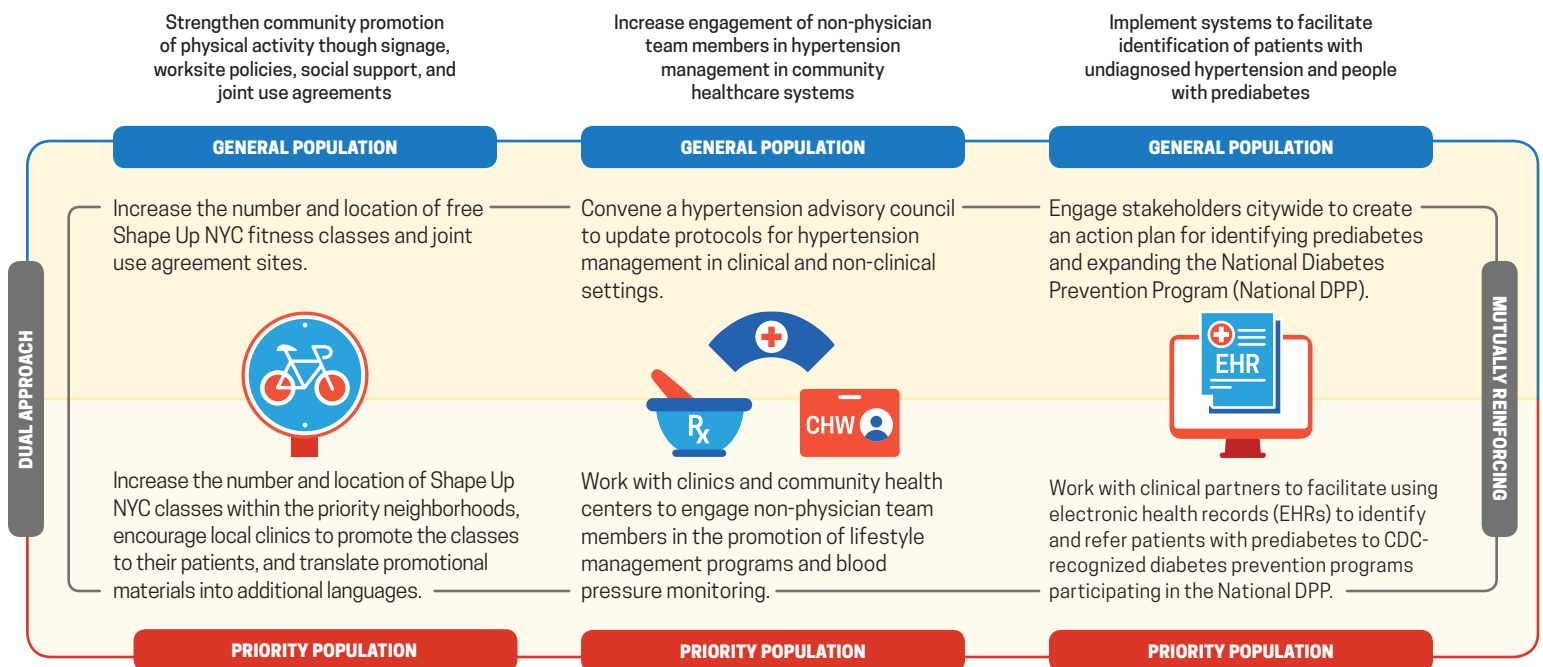
**TYPES OF PARTNERS (NO.)**

- Health system/healthcare provider (152)
- Private business (58)
- Community-based organizations (31)
- Faith-based organizations (23)
- Other local government entity (8)
- University/academic institutions (4)
- Nonprofit organizations (2)
- Coalition/collaborative (1)

TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
East and Central Harlem, North and Central Brooklyn, the South Bronx, and Southeastern Queens 	Adults in the South Bronx, North and Central Brooklyn, East and Central Harlem, and Southeastern Queens 	<ul style="list-style-type: none"> <li>▪ Community capacity/ infrastructure</li> <li>▪ Disease burden</li> <li>▪ Sociodemographics</li> </ul> 

## 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.



## SUCCESS STORIES

**Four New York City neighborhoods—including East and Central Harlem, the South Bronx, North and Central Brooklyn, and Southeastern Queens—have persistently higher rates of obesity, uncontrolled diabetes, and hypertension than the citywide average.**

The New York City Department of Health and Mental Hygiene (NYC DOHMH) has partnered with numerous clinical and community stakeholders, private companies, and other city agencies to create and promote programs that can help prevent chronic disease in these communities of focus.

In 2011, a study published in the *New England Journal of Medicine* found that only 51% of Americans treated for hypertension adhere to their long-term therapy. To advance the prevention and management of hypertension and heart disease, NYC DOHMH began training community pharmacists in **medication therapy management (MTM)** and medication synchronization. The agency began working with pharmacists to



**233** community pharmacists engaged in MTM training.

**42** new Shape Up NYC locations providing free adult fitness classes were added in priority neighborhoods.

bolster hypertension and heart-healthy lifestyle awareness and medication adherence rates. To date, 233 pharmacists have received MTM certification training through this initiative.

Another prevention-minded program designed to increase free fitness opportunities for adults in NYC is **Shape Up NYC**. Through a partnership between the NYC Department of Parks and Recreation, the First Lady of the City of New York, Empire Blue Cross Blue Shield Foundation, and the NYC DOHMH, Shape Up NYC increased the number and location of classes offered, increasing availability both citywide as well as in the local neighborhoods. In 2015, Shape Up NYC added over 100 new classes, with over 80 classes in neighborhoods with disproportionate rates of chronic diseases. Shape Up NYC also began offering the fitness instructor training program in Spanish, along with several bilingual fitness classes throughout NYC.

## 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 subawardee performance measure results by division.



**DIVISION OF NUTRITION, PHYSICAL ACTIVITY, AND OBESITY**

**64** key community locations are implementing nutrition and beverage standards.

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

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

**347,735** adults have access to community venues promoting physical activity.



**DIVISION FOR HEART DISEASE AND STROKE PREVENTION**

**270,226** patients are participating in health care systems with EHRs appropriate for treating patients with high blood pressure.

**78,258** patients are participating in health care systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control.

**16** health care systems are engaging CHWs to link patients to community resources that promote self-management of high blood pressure.

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



**DIVISION OF DIABETES TRANSLATION**

**63,081** adults reached through evidence-based engagement strategies.

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

**227,423** patients are within healthcare systems with policies or systems to facilitate identification of people with prediabetes.

**16** 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](mailto: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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