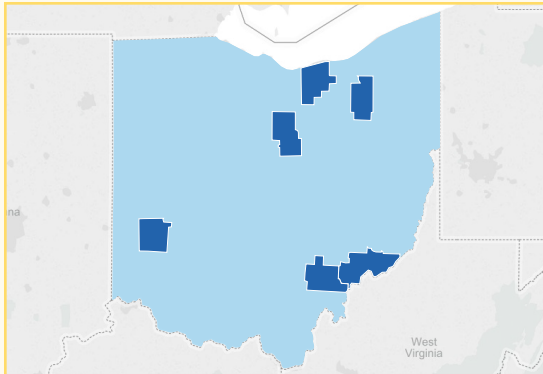


Ohio | PROGRAM PROFILE



The Ohio 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
\$3,517,118

AMOUNT TO SUBAWARDEES
\$2,125,000

PERCENTAGE OF AWARD TO SUBAWARDEES
60%

SUBAWARDEES

- Athens City-County Health Department
- Public Health-Dayton & Montgomery County
- Lorain County General Health District
- Richland Public Health
- Summit County Public Health

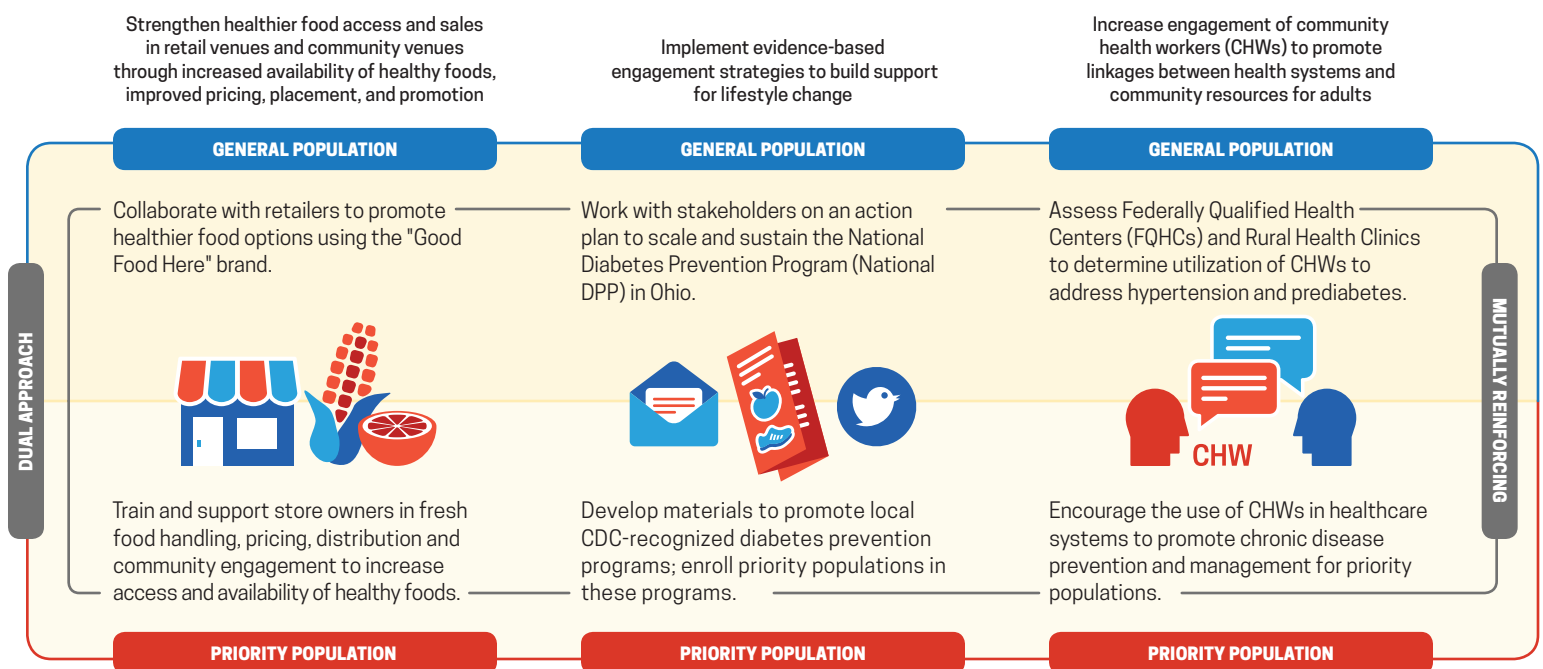
TYPES OF PARTNERS (NO.)

- Community-based organization (42)
- Nonprofit organization (11)
- Other state agencies (11)
- Coalition/collaborative (9)
- University/academic institution (7)
- Health system/healthcare provider (6)
- Other local government entity (6)
- Private business (4)

TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
Athens, Lorain, Montgomery, Richland, Summit, and Washington counties 	Low-income (poverty level of 18% or higher) and Hispanic and African American populations 	<ul style="list-style-type: none"> ▪ Community capacity/ infrastructure ▪ Disease burden ▪ Established partnerships ▪ Prior experience with priority population ▪ 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.



SUCCESS STORIES

In Ohio, diabetes, hypertension, and obesity are serious health issues that affect many residents. To address chronic disease, several Ohio counties have taken steps to promote and ensure better health for their residents. Following are descriptions of three of these initiatives.

In Richland County, 35% of adults have been diagnosed with high blood pressure. Half of the people diagnosed do not have their blood pressure under control. Local public health partnered with 10 community libraries to offer 21 **blood pressure kits** available for check out. Kits have been checked out over 254 times. Blood pressure kits are also available for onsite use at a church and the Agency on Aging district office. Easy to understand educational resources were created and included with each kit.



254 blood pressure kits checked out by residents.

158+ community members enrolled in CDC-recognized diabetes prevention programs.

23 city and county officials and partners attended a Complete Streets Workshop.

In Montgomery County, Diabetes Coalition members educate healthcare providers to identify patients with prediabetes and refer them to **CDC-recognized diabetes prevention programs**. This resulted in 158 new participant enrollments in 2017.

In Athens County, a project is underway to get residents outside and moving. A **Complete Streets Workshop** brought together 23 officials from city and county government, law enforcement, and public health to assess bike/pedestrian environments and work through a six-step process to increase safe and active transportation. This multilevel approach to active transportation planning resulted in Nelsonville passing a Complete Streets Policy, and Athens drafting a Complete Streets Policy which is expected to pass in 2018.

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

24 key community locations are implementing nutrition and beverage standards.

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

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

872,540 adults have access to community venues promoting physical activity.



DIVISION FOR HEART DISEASE AND STROKE PREVENTION

400,957 patients are participating in healthcare systems with electronic health records appropriate for treating patients with high blood pressure.

285,457 patients are participating in healthcare systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control.

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

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



DIVISION OF DIABETES TRANSLATION

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

368,946 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.

LAST UPDATED 01/31/2018

