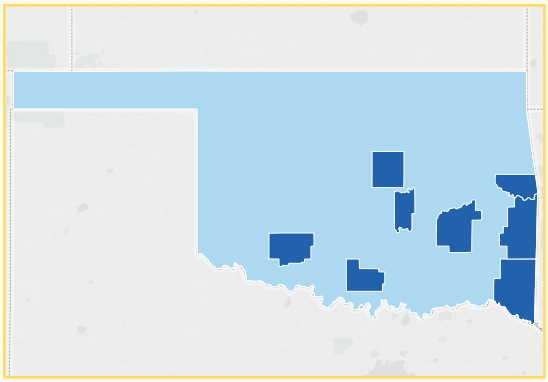
State and Local Public Health Actions 1422 Program

Oklahoma | PROGRAM PROFILE

The Oklahoma 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
$2,640,000

AMOUNT TO SUBAWARDEES
$1,320,000

PERCENTAGE OF AWARD TO SUBAWARDEES
50%

SUBAWARDEES

The Health Departments of:

- Carter County
- Comanche County
- Le Flore County
- Lincoln County
- Pittsburg County
- McCurtain County
- Seminole County
- Sequoyah County

TYPES OF PARTNERS (NO.)

- Other local government entity (25)
- Nonprofit organization (3)
- Private business (3)
- University/academic institution (3)
- Community-based organization (2)
- Other (1)

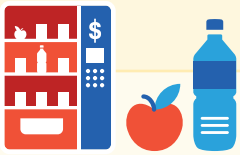
TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
Carter, Comanche, Le Flore, Lincoln, McCurtain, Pittsburgh, Seminole, and Sequoyah counties	Residents within Lincoln and Le Flore counties	• Community capacity/ infrastructure • Disease burden • Sociodemographics

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

MUTUALLY REINFORCING

Implement nutrition and beverage standards in public institutions, worksites, and other key locations	Implement systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes	Increase engagement of community health workers (CHWs) to promote linkages between health systems and community resources for adults
GENERAL POPULATION	**GENERAL POPULATION**	**GENERAL POPULATION**
Continue to implement Certified Healthy Oklahoma Businesses with a focus on the nutrition (including sodium standards) and chronic disease criteria.	Collaborate with healthcare providers to promote use of evidence-based guidelines for early diagnosis and management of hypertension, prediabetes, and diabetes across the state.	Develop a standardized CHW protocol to be utilized by county health departments (CHDs). Provide technical assistance to CHDs in assigning CHWs to Certified Healthy Businesses.
		
Recruit targeted worksites based on certification level, to address gaps at the local level related to nutrition and chronic disease prevention & management.	Provide evidence-based resources to recruited clinics to assist in identifying patients with hypertension and prediabetes and at high risk for type 2 diabetes.	Provide technical assistance in supporting CHDs' and CHWs' roles for linking patients with hypertension, prediabetes, and diabetes to community resources.
PRIORITY POPULATION	**PRIORITY POPULATION**	**PRIORITY POPULATION**

SUCCESS STORIES

According to CDC, more than 100 million U.S. adults are now living with diabetes or prediabetes (2017). In response, the Oklahoma state legislature formed the **Diabetes Caucus**. Co-authoring the Senate Bill 250 report, the Oklahoma Health Care Authority (OK Medicaid) and the state department of health collaborated in "identifying benchmarks and developing goals to reduce the incidence rates of, improve health care services for, and control complications resulting from diabetes." Beginning in 2017 and for every odd-numbered year afterward, a report must be submitted to both houses containing (1) information on the fiscal impact of diabetes on both agencies; (2) a review of benefits of type 2 diabetes prevention programs; (3) an action plan for reducing the impact of diabetes; (4) outcomes and a detailed budget identifying needs; and (5) costs and resources to implement the plan.

State legislature authorized Senate Bill 250 focused on diabetes management and type 2 diabetes prevention.

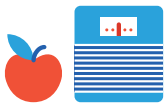
49 organizations participate in the Diabetes Caucus.

16 CDC-recognized or pending recognition diabetes prevention programs established

From the Diabetes Caucus, a prevention group emerged for those who either currently offer or want to start hosting a **CDC-recognized diabetes prevention program**. Interest in establishing new programs continues to grow, as the Centers for Medicare & Medicaid Services announced that in 2018 they will begin to cover costs for older individuals with prediabetes to participate in CDC-recognized diabetes prevention programs. Currently, Oklahoma has 16 CDC-recognized diabetes prevention programs offering classes to tribal and non-tribal members. Two of these programs have achieved full recognition. The prevention group meets quarterly to discuss ways to promote sharing of best practices across these programs.

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.

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

183,096 adults have access to community venues promoting physical activity.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

12,937 patients are participating in healthcare systems with electronic health records appropriate for treating patients with high blood pressure.

33,737 patients are participating in healthcare systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control.

5 healthcare systems are engaging CHWs 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

2,676 adults reached through evidence-based engagement strategies.

9,173 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.

LAST UPDATED 1/31/2018