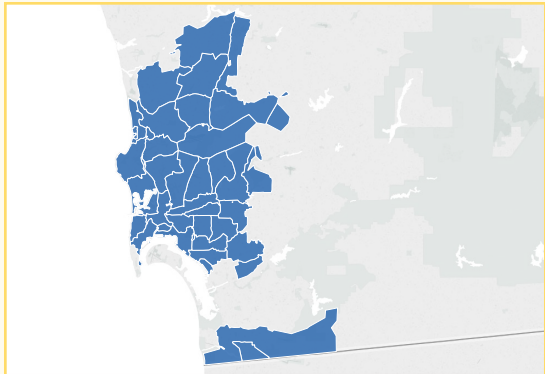


# San Diego | PROGRAM PROFILE



The County of San Diego Healthy Works: Prevention Initiative 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**  
**\$3,520,000**

**MAIN PARTNERS**

- Be There San Diego (Collaborative)
- City of San Diego Local Government
- UCSD Center for Community Health

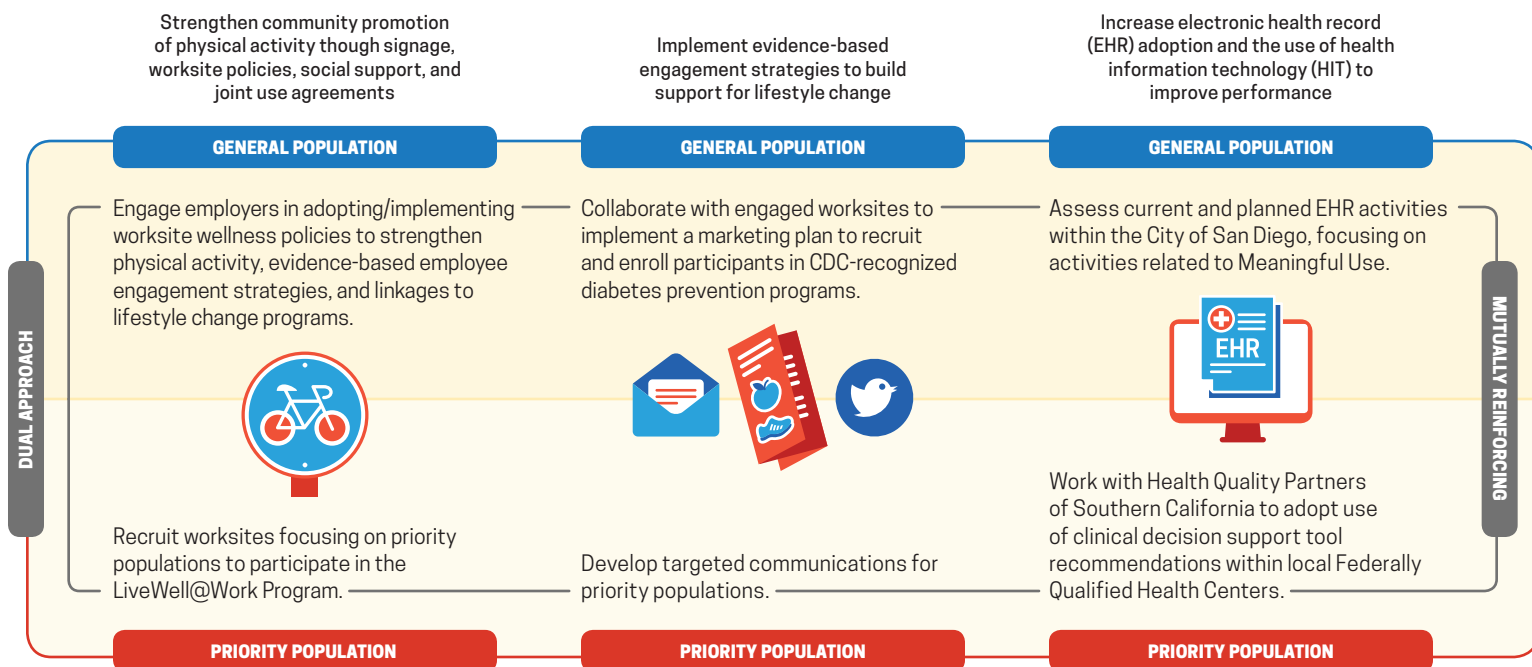
**TYPES OF PARTNERS (NO.)**

- Coalition/collaborative (1)
- County/city health department (1)
- Other local government entity (1)
- University/academic Institution (1)

TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
<p>The center region of the city: City Heights, Southeast San Diego</p>	<p>Low-income African Americans and Latinos</p>	<ul style="list-style-type: none"> <li>▪ Burden of disease</li> <li>▪ Community capacity</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 by the awardee.



## SUCCESS STORIES

**Live Well San Diego is the County of San Diego's vision for a region that is Building Better Health, Living Safely, and Thriving.** It aligns the efforts of individuals, organizations, and government to help all 3.3 million San Diego County residents live well. **The Live Well Community Market Program**, led by the County of San Diego Health and Human Services Agency, expands the scope of the healthy food retail environment in the City of San Diego. The program is focused in underserved neighborhoods and provides market owners with technical assistance and resources to increase the amount of produce they provide, the promotion of their produce, and the placement of their produce, in addition to improvements to the markets' physical environment.

As part of its efforts to prevent type 2 diabetes, San Diego is scaling the **National Diabetes Prevention Program** and using a collaborative approach to ensure sustainability. With support



**10** local markets provide residents with affordable healthy food options.

**15** CDC-recognized diabetes prevention programs were established in San Diego County.

**12** health care organizations are implementing recommendations to identify and manage hypertension and link patients with prediabetes to CDC-recognized diabetes prevention programs.

of community partners, low-income and ethnically diverse priority populations can now access a CDC-recognized diabetes prevention program nearby. In 2014, only one program in San Diego County existed. Today, there are 12 programs and 19 newly trained lifestyle coaches from 11 different organizations.

**Be There San Diego**, a local coalition of patients, communities, health care systems, and others working together to prevent heart attacks and strokes, hosted a 2017 summit to increase awareness of the prevalence and incidence of heart disease, diabetes, and stroke. Participants received resources and ideas for positive changes that could be implemented in their respective organizations. A panel of San Diego clinical leaders shared best practices as a part of the process to develop regional recommendations to improve outcomes countywide.

## 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**

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

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

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

**17,059** adults have access to community venues promoting physical activity.



**DIVISION FOR HEART DISEASE AND STROKE PREVENTION**

**1,115,854** patients are participating in healthcare systems with EHRs appropriate for treating patients with high blood pressure.

**944,012** patients are participating in healthcare systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control.

**7** healthcare systems are engaging community health workers to link patients to community resources that promote self-management of high blood pressure.

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



**DIVISION OF DIABETES TRANSLATION**

**374,139** adults have been reached through evidence-based engagement strategies.

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

**944,012** 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](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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