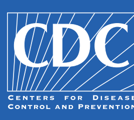
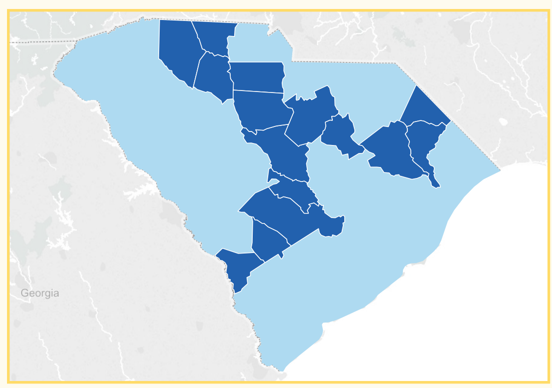
State and Local Public Health Actions 1422 Program

South Carolina | PROGRAM PROFILE



The South Carolina Department of Health and Environmental Control 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
$3,520,000

AMOUNT TO SUBAWARDEES
$2,869,266

PERCENTAGE OF AWARD TO SUBAWARDEES
81%

SUBAWARDEES
- Lowcountry Region
- Midlands Region
- Pee Dee Region
- Upstate Region

TYPES OF PARTNERS (NO.)
- Other local government entity (14)
- Health system/healthcare provider (6)
- Coalition/collaborative (5)
- Private business (5)
- Faith-based institution (1)
- K–12 school/school official (1)
- Nonprofit organization (1)
- Other (1)
- University/academic institution (1)

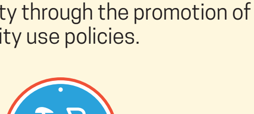
TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
Allendale, Bamberg, Calhoun, Cherokee, Chester, Dillon, Fairfield, Florence, Kershaw, Lee, Marion, Orangeburg, Richland, Spartanburg, and Union counties	Medicaid and Medicaid eligible populations and Title I schools	▪ Community capacity/ infrastructure ▪ Disease burden ▪ 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.

DUAL APPROACH | MUTUALLY REINFORCING

Strengthen community promotion of physical activity though signage, worksite policies, social support, and joint use agreements



GENERAL POPULATION

Provide technical assistance (TA) to subawardees to strengthen promotion of physical activity through the promotion of open community use policies.

Provide TA to community members and local school districts to promote the adoption of the "Open Community Use of School Recreational Areas" policy.

PRIORITY POPULATION

Implement evidence-based engagement strategies to build support for lifestyle change

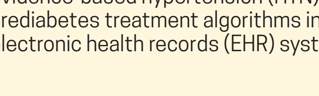
GENERAL POPULATION

Provide TA around the 2016-2021 *Statewide Comprehensive Diabetes Prevention Plan for South Carolina* to reach and recruit populations at high risk for type 2 diabetes into CDC-recognized diabetes prevention programs.

Utilize the 2016-2021 *Statewide Comprehensive Diabetes Prevention Plan for South Carolina* to reach and recruit Medicaid and Medicaid eligible populations into local CDC-recognized diabetes prevention programs.

PRIORITY POPULATION

Implement systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes



GENERAL POPULATION

Promote the adoption and integration of evidence-based hypertension (HTN) and prediabetes treatment algorithms in the electronic health records (EHR) system.

Provide TA to medical practices on the adoption and integration of evidence-based HTN and prediabetes treatment algorithms in the EHR system.

PRIORITY POPULATION

SUCCESS STORIES

In South Carolina, two out of every five adults have high blood pressure, and 350,000 adults have prediabetes. Lack of access to healthy food and physical activity contributes to high rates of obesity and obesity-related chronic diseases. To address these serious chronic diseases, the state and its partners implemented 15 mutually reinforcing strategies. Three successful initiatives are described below.

Twenty-six worksites within the 1422 SLPHA program targeted communities are working to impact employee health by **focusing on policy, system, and environmental changes** reaching 19,254 employees. Nine worksites have achieved excellence in nutrition and/or physical activity, creating a sustainable culture of wellbeing.

The South Carolina Pharmacy Association recruits and trains community pharmacists to provide one-on-one coaching sessions to eligible patients within 15 counties. Pharmacists tailor **adherence and lifestyle management counseling** to a patient's individual needs based on a thorough evaluation of baseline assessments. Since October 2016, 106 patients enrolled in the hypertension adherence coaching program. As of September 2017, 71% of patients attended at least five coaching sessions.

Health Care Partners in the Pee Dee community successfully implemented a **CDC-recognized diabetes prevention program** with the support of the local health department. Of the 23 participants initially enrolled, 21 were still participating at the end of the 16-week core phase of the program. The group reported healthier eating habits, increased levels of physical activity, and a combined weight loss of 88 pounds. As of November 2017, 33 organizations are implementing CDC-recognized diabetes prevention programs in four 1422 SLTPHA communities across the state.

19,000+ employees are being reached by nutrition and/or physical activity policy, system, and environmental changes.

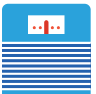
106 patients enrolled in the hypertension adherence coaching program.

71% of patients attended at least five coaching sessions.

57 class cohorts were offered by CDC-recognized diabetes prevention programs across the 1422 communities.

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

26 key community locations are implementing nutrition and beverage standards.

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

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

213,773 adults have access to community venues promoting physical activity.

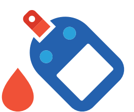
DIVISION FOR HEART DISEASE AND STROKE PREVENTION

776,939 patients are participating in healthcare systems with EHRs appropriate for treating patients with high blood pressure.

219,873 patients are participating in healthcare systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control.

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

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



DIVISION OF DIABETES TRANSLATION

15,706 adults have been reached through evidence-based engagement strategies.

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

776,939 patients are within healthcare systems with policies or systems to facilitate identification of people with prediabetes.

10 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