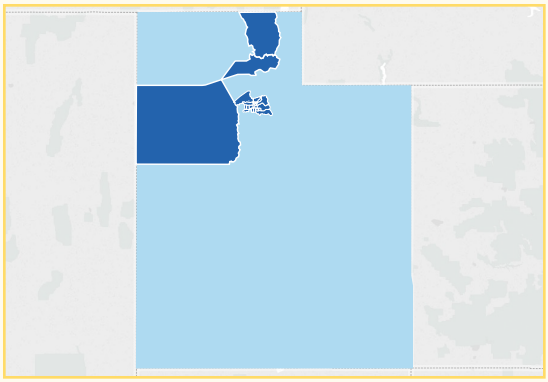
State and Local Public Health Actions 1422 Program

Utah | PROGRAM PROFILE

The Utah 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
$3,519,999

AMOUNT TO SUBAWARDEES
$1,760,000

PERCENTAGE OF AWARD TO SUBAWARDEES
50%

SUBAWARDEES

The Health Departments of:

- Bear River
- Salt Lake County
- Tooele County
- Weber Morgan

TYPES OF PARTNERS (NO.)

- Other local government entity (10)
- Health system/healthcare-provider (8)
- Coalition/collaborative (5)
- Private business (5)
- Community-based organization (2)
- Nonprofit organization (2)
- Other (1)
- University/academic institution (1)

TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
Selected areas in Cache, Tooele, Weber, and Salt Lake counties	Low-income populations with a high risk and/or high burden of diabetes or uncontrolled hypertension	▪ Community capacity/ infrastructure ▪ Disease burden ▪ Population size ▪ 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 healthier food access and sales in retail venues and community venues through increased availability of healthy foods, improved pricing, placement, and promotion	Implement evidence-based engagement strategies to build support for lifestyle change	Increase use of self-measured blood pressure monitoring tied with clinical support
GENERAL POPULATION	**GENERAL POPULATION**	**GENERAL POPULATION**
Partner with statewide retail food stores to promote healthy food donations to the Utah Food Bank and food pantries through signage, donation bins, and product placement.	Implement a comprehensive communications and marketing plan including tailored social media to build support for the National Diabetes Prevention Program (National DPP).	Develop a follow-up assessment/ application infrastructure for Excellence in Blood Pressure Management recognition.
Assess policies of food pantries and other food assistance programs and provide technical assistance to encourage healthier food access and donations.	Implement a comprehensive communications and marketing plan tailored to build support for the National DPP among low-income/ low-access populations.	Provide technical assistance to clinics that participated in the Utah Million Hearts Phase 1 Assessment and are working towards Excellence in Blood Pressure Management recognition.
PRIORITY POPULATION	**PRIORITY POPULATION**	**PRIORITY POPULATION**

SUCCESS STORIES

Many communities in Utah are experiencing increasing rates of obesity, type 2 diabetes, and hypertension. To address chronic disease, the state and its partners implemented 15 mutually reinforcing strategies. Below are two examples of these strategies.

In Weber County, approximately 28% of residents have been diagnosed with high blood pressure. Ogden Clinic and the Weber-Morgan Health Department reached 84,115 adults through the **Hear the Beat, Track the Measure** program. The program includes a four-step protocol: (1) identify patients with high blood pressure, (2) provide education and a loaner blood pressure cuff, (3) evaluate the progress of the patient, and (4) graduate the patient from the program once blood pressure is stable. The goal of the integrative care process was to engage all members involved on the team to provide comprehensive and quality care to individuals in our community. The project is still in progress, but staff feedback is promising, indicating efficient and effective communication across the health system.

8 clinics implemented the Hear the Beat, Track the Measure program.

159 employers completed the CHW organizational survey.

Statewide, Utah is working to better understand how employers utilize **community health workers (CHWs)**. In fall 2016, the state and local health departments conducted a survey of employers working to address social determinants of health to identify CHW roles and training needs. A total of 159 employers reported using CHWs or had staff who assumed a similar role. The CHW workforce is diverse, having multiple titles and roles. Employers expressed a need for more CHW resources, conferences, and online trainings for management of both hypertension and type 2 diabetes. The State used the findings to facilitate conversations on opportunities for community-clinical linkages and to provide technical assistance and resources to organizations that use CHWs.

SUBAWARDEE PERFORMANCE MEASURE HIGHLIGHTS

The Centers for Disease Control and Prevention (CDC'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

15 key community locations are implementing nutrition and beverage standards.

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

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

329, 090 adults have access to community venues promoting physical activity.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

287,085 patients are participating in healthcare systems[1] with electronic health records appropriate for treating patients with high blood pressure.

350,655 patients are participating in healthcare systems[1] with policies or systems to encourage a multidisciplinary team approach to blood pressure control.

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

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

DIVISION OF DIABETES TRANSLATION

902,241 adults have been reached through evidence-based engagement strategies.

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

350,085 patients are within healthcare systems with policies or systems to facilitate identification of people with prediabetes.

1 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.

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