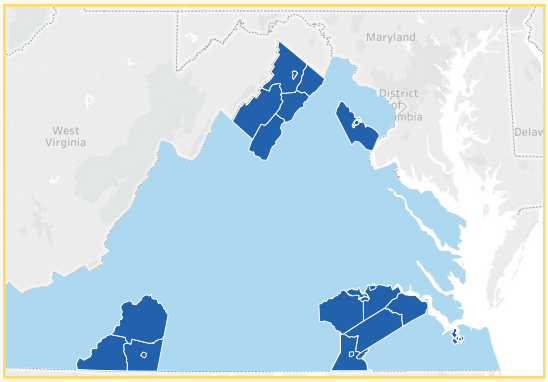
State and Local Public Health Actions 1422 Program

Virginia | PROGRAM PROFILE

The Virginia 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
$2,664,121

AMOUNT TO SUBAWARDEES
$2,095,000

PERCENTAGE OF AWARD TO SUBAWARDEES
78.6%

SUBAWARDEES

The Health Districts of:

- Crater
- Lord Fairfax
- Portsmouth
- Prince William
- West Piedmont

TYPES OF PARTNERS (NO.)

- Other local government entity (16)
- Private business (15)
- Health system/healthcare-provider (7)
- Coalition/collaborative (6)
- Community-based organization (6)
- University/academic institution (4)
- Nonprofit organization (3)
- Faith-based institution (2)
- County/city health department (1)

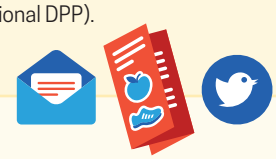
TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
Counties: Clarke, Dinwiddie, Franklin, Frederick, Greensville, Henry, Page, Patrick, Prince George, Prince William, Shenandoah, Surry, Sussex, and Warren Cities: Emporia, Hopewell, Manassas City, Manassas Park, Martinsville, Petersburgh, Portsmouth, and Winchester	Low income population with chronic health conditions including hypertension, prediabetes, type 2 diabetes, obesity, heart disease and stroke	• 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 community promotion of physical activity though signage, worksite policies, social support, and joint use agreements	Implement evidence-based engagement strategies to build support for lifestyle change	Increase engagement of community health workers (CHWs) to promote linkages between health systems and community resources for adults
GENERAL POPULATION	**GENERAL POPULATION**	**GENERAL POPULATION**
Provide technical assistance and problem-solving methods to overcome obstacles to joint use agreement acceptance and implementation.	Implement evidence-based engagement strategies (e.g., tailored communications, incentives, etc.) to build support for the National Diabetes Prevention Program (National DPP).	Increase engagement of CHWs to promote linkages between healthcare providers and community resources for adults with high blood pressure and/or with prediabetes or at high risk for type 2 diabetes.
		
Conduct assessments to determine the number and type of joint use agreements presently in effect and identify challenges.	Utilize appropriate messaging and CHWs to educate and remove barriers to participation in lifestyle change programs for high risk groups to help reduce type 2 diabetes risk and manage uncontrolled hypertension.	Establish and test CHW-centered bi-directional referral and communication systems linking patients with chronic conditions to community resources.
PRIORITY POPULATION	**PRIORITY POPULATION**	**PRIORITY POPULATION**

SUCCESS STORIES

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

In West Piedmont Health District, people with diabetes and/or hypertension face challenges managing their conditions (low health insurance coverage, high unemployment, few community resources, difficult terrain, etc.). To address challenges, community health advocates (CHAs), housed at local Federally Qualified Health Centers, connect at-risk patients to medical homes and work with patients to overcome barriers. Between June 2016 and July 2017, CHAs provided care management to over 630 patients, and enrolled 370 patients into **care management at a medical home**. Of 234 patients enrolled in care management with diabetes, 74% reduced their A1C levels. Of 225 patients with hypertension (> 140/90), 78% achieved readings lower than 140/90.

7 monthly community engagement and speaker sessions held during the first 8 months of the Manassas Walking Group.

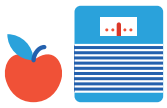
79 of 277 patients linked to community resources by West Piedmont Health District CHAs

73 patients linked to MedAssist to help cover the cost of medication.

Manassas City trails most Northern Virginia jurisdictions in terms of obesity rates, hospitalizations due to diabetes and hypertension, and stroke deaths. To improve outcomes, Prince William Health District partnered with a local mall and Novant Health University of Virginia Health System to form the **Manassas Mall Walkers Group**. The majority of participants are age 65 and older, and the group meets three times a week. Walkers have their body mass index, fasting glucose, and blood pressure measured. Monthly guest speakers provide information to walkers on a variety of topics. Since December 2016, more than 51 people have joined the group and 162 have been screened for chronic disease.

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

10 key community locations are implementing nutrition and beverage standards.

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

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

238,959 adults have access to community venues promoting physical activity.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

128,862 patients are participating in healthcare systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control.

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

DIVISION OF DIABETES TRANSLATION

23,596 adults have been reached through evidence-based engagement strategies.

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

86,389 patients are within healthcare systems with policies or systems to facilitate identification of people with prediabetes.

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