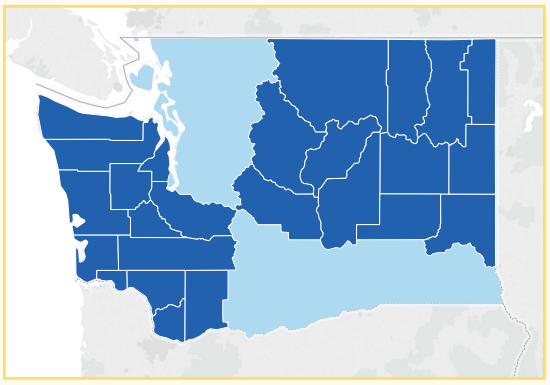
State and Local Public Health Actions 1422 Program

Washington State | PROGRAM PROFILE

The Washington 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

$3,520,000

AMOUNT TO SUBAWARDEES

$1,974,330

PERCENTAGE OF AWARD TO SUBAWARDEES

56.1%

SUBAWARDEES

- Healthy Living Collaborative Accountable Community of Health (ACH) Regions: Southwest Washington & Cascade Pacific Action Alliance
- Grant County Health District ACH Regions: North Central ACH & Greater Columbia ACH
- Kitsap County Health District Olympic Community of Health ACH
- Tacoma-Pierce County Health Department Pierce County ACH
- Spokane Regional Health District Better Health Together ACH

TYPES OF PARTNERS (NO.)

- Health system/healthcare provider (40)
- Other local government entity (15)
- Community-based organization (14)
- University/academic institution (12)
- Nonprofit organization (7)
- Coalition/collaborative (7)
- County/city health department (6)
- Private business (4)
- Tribal nation (2)
- Other (1)

TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
Adams, Chelan, Clallam Clark, Cowlitz, Douglas, Ferry, Grant, Jefferson, Kitsap, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Pierce, Skamania, Spokane, Stevens, Wahkiakum and Whitman counties	Hispanic/Latino, African American, American Indian/Alaska Native, Asian Pacific Islander, rural, low-income, Medicare and or Medicaid eligible, uninsured and under-insured, and those experiencing mental health issues	▪ 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	Increase use of self-measured blood pressure monitoring tied with clinical support	Implement systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes
GENERAL POPULATION	**GENERAL POPULATION**	**GENERAL POPULATION**
Promote use of Healthy Food Options Report to assess and support healthy food access in emergency food programs.	Develop trainings and promote resources to community health workers (CHWs), employers, providers, and pharmacists for self-monitoring of blood pressure and linkages to clinical support.	Promote use of policies, procedures, and resources to identify patients with prediabetes.
		
Target food pantries to improve promotion of and maximize access to healthy food options.	Engage CHWs, employers, providers, and pharmacists in trainings and provide resources to establish policies and procedures around self-monitoring of blood pressure.	Engage clinics, healthcare systems, and CHWs to establish policies and procedures around the identification of people with prediabetes and referral protocols.
PRIORITY POPULATION	**PRIORITY POPULATION**	**PRIORITY POPULATION**

SUCCESS STORIES

In Washington, an estimated 2 million adult residents live with prediabetes, and approximately 1.6 million adults live with hypertension. To address these chronic diseases, the state and its partners are implementing 15 mutually reinforcing strategies.

To improve blood pressure control among adults with hypertension, one evidence-based strategy is to support self-monitoring of blood pressure. Under the 1305 award, a training for CHWs was developed to support community members with high blood pressure. Through the 1422 award, collaborative partnerships formed **community lead organizations (CLOs)** which resulted in 149 CHWs and others trained to support accurate blood pressure measurement and self-monitoring. The CLOs were able to connect with community- and faith-based organizations to provide this service, which did not exist prior to the 1422 program. The state's partnership with the American Heart Association enhances this reach and work within the CLOs.

Safer routes across streets created with painted pathways, walking groups, and maps.

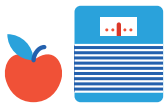
Working with the Washington Association of Community and Migrant Health Centers to reach priority populations though Federally Qualified Health Centers.

Multiple community partners working together, increased participation in and availability of CDC-recognized diabetes prevention programs.

The CLO Prevention First program is working with health care systems, businesses, nonprofits, and public health agencies to prevent type 2 diabetes. Community organizations are increasing the availability of **CDC-recognized diabetes prevention programs**. Health systems are evaluating and updating prediabetes **screening and referral processes**. Worksites are offering education and policies that provide information on and promote screening for prediabetes. Several coordinated screenings at food pantry and low-income housing locations mean even more referrals to local CDC-recognized diabetes prevention program classes. Prevention First is committed to continuing and expanding these efforts throughout the seven-county region.

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

23 key community locations are implementing nutrition and beverage standards.

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

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

62,147 adults have access to community venues promoting physical activity.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

89,233 patients are participating in healthcare systems with electronic health records appropriate for treating patients with high blood pressure.

89,269 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.

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

DIVISION OF DIABETES TRANSLATION

120,380 adults have been reached through evidence-based engagement strategies.

3,488 patients are within healthcare systems with policies or systems to facilitate identification of people with prediabetes.

6 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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