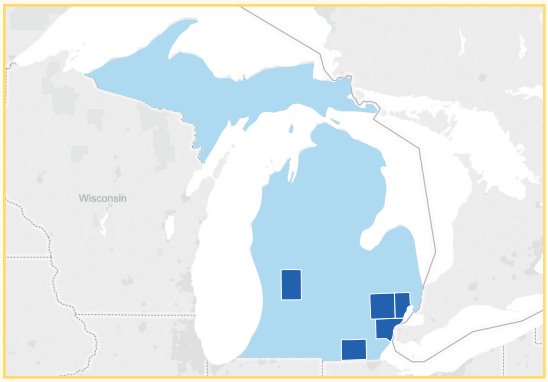
State and Local Public Health Actions 1422 Program

Michigan | PROGRAM PROFILE

The Michigan Department of Community Health (MDCH) 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
$1,760,000

PERCENTAGE OF AWARD TO SUBAWARDEES
50%

SUBAWARDEES
- Chronic Disease Coordinating Networks
- Emma L. Bixby Medical Center, Promedica
- Grand Rapids Metropolitan YMCA
- Greater Detroit Area Health Council
- National Kidney Foundation of Michigan

TYPES OF PARTNERS (NO.)
- Other local government entity (12)
- Coalition/collaborative (10)
- Nonprofit organization (10)
- Health system/healthcare provider (4)
- Private business (4)
- University /academic institution (4)
- Community-based organization (1)

TARGETED COMMUNITY*	PRIORITY POPULATION**	SELECTION CRITERIA
Kent, Lenawee, Macomb, Oakland, and Wayne counties	Low-income adults	▪ Community capacity/ infrastructure ▪ Disease burden ▪ 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

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**
Participate in state and local level physical activity committees and ensure Chronic Disease Coordinating Networks (CDCNs) are linked to key local and state partners.	Disseminate a culturally tailored media campaign for type 2 diabetes prevention in CDCN communities with a media mix to include newspaper ads, social media, and PSA's.	Launch a statewide campaign using print and electronic materials promoting the role of the CHW as a linkage between the health system and community.
Implement worksite policies and a referral process from medical facilities to walking clubs or YMCA for individuals needing to increase physical activity.	Utilize culturally tailored media to increase awareness of prediabetes and the National Diabetes Prevention Program (National DPP) by distributing press releases, social media posts, and newsletter articles.	CHWs will refer patients with prediabetes and hypertension to the National DPP, and distribute resources to increase patient knowledge and self-management efforts.
PRIORITY POPULATION	**PRIORITY POPULATION**	**PRIORITY POPULATION**

MUTUALLY REINFORCING

SUCCESS STORIES

Chronic diseases—including heart disease, stroke, diabetes, and obesity along with related risk factors, such as physical inactivity, and poor diet—are the leading causes of death and disability in Michigan. In response, the state formed chronic disease care networks to implement new initiatives.

In Lenawee County, 38% of the population is obese. Through the 1422 program, the county has increased **access to nutritious foods, physical activity, and lifestyle change programs like the National DPP Lifestyle Change program** offered by local YMCAs and other CDC-recognized organizations across Michigan. Primarily focusing on creating a healthy environment greatly impacts the county's ability to sustain programs and resources to educate residents and guide and encourage lifestyle change. Referrals are now coming in from all over the county, and Lenawee County has enrolled 124 adults in CDC-recognized diabetes prevention programs. As of June 2016, participants in Lenawee's CDC-recognized diabetes prevention programs are collectively losing more weight than the program's national average.

377 patients enrolled in CDC-recognized diabetes prevention programs

4 new CDC-recognized diabetes prevention programs established.

233 hypertensive patients identified using the new EHR algorithms

To the north in Oakland and Wayne Counties, racial/ethnic minorities are disproportionally affected by hypertension and obesity. To better identify and reach these minority communities, the National Kidney Foundation of Michigan and the Western Wayne Family Health Center reviewed and strengthened local healthcare **electronic health records (EHRs)** by creating new metrics and algorithms over a two-year period. The EHR improvements led to identification of 233 undiagnosed hypertensive individuals. Staff follow up with the undiagnosed individuals to provide hypertensive management resources.

SUBAWARDEE PERFORMANCE MEASURE HIGHLIGHTS

CDC's National Center for Chronic Disease Prevention and Health Promotion funds the 1422 SLTPHA 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.

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

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

1,022,025 adults have access to community venues promoting physical activity.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

41,570 patients are participating in healthcare systems with EHRs appropriate for treating patients with high blood pressure.

28,137 patients are participating in healthcare systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control.

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

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

DIVISION OF DIABETES TRANSLATION

614,200 adults reached through evidence-based engagement strategies.

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

36,900 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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