

# STATE PUBLIC HEALTH ACTIONS (1305)

## Closeout Performance Measures Snapshot



Four distinct CDC chronic disease prevention programs are working together to strengthen state actions to address health risk behaviors, environments, and systems associated with diabetes, heart disease, obesity, and school health.

Improve communities to support healthy choices & behaviors.



Improve prevention and control of chronic health conditions in schools.



Improve care to facilitate prevention, early diagnosis, and quality management of heart disease, stroke, and diabetes.



Increase access to community-based diabetes prevention and self-management education programs.



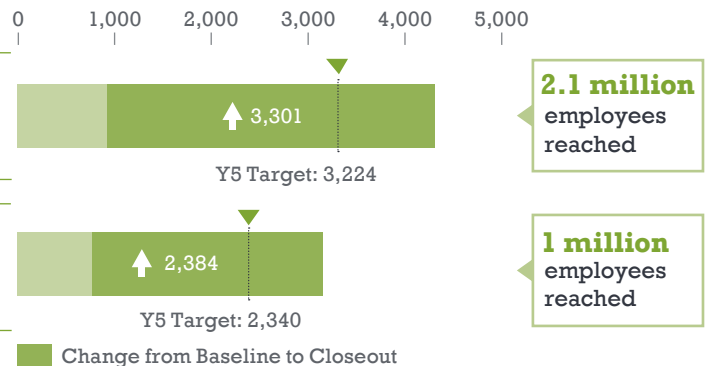
The following is a snapshot of select performance measures reported by the 1305 grantees in the closeout year of the program.



States worked within different community settings—including worksites—to improve nutrition and physical activity



<b>Physical Activity (PA) Policies</b>	4,273 worksites have adopted PA policies
<b>Nutrition guidelines</b>	3,165 worksites have adopted nutrition guidelines



States worked with local education agencies (LEAs) to improve nutrition, physical education, and the management of chronic conditions in schools



9,632 LEAs with over 35.2 million students were supported in creating healthy school nutrition environments (Y5 Target: 7,812 LEAs, 30.5 million students).



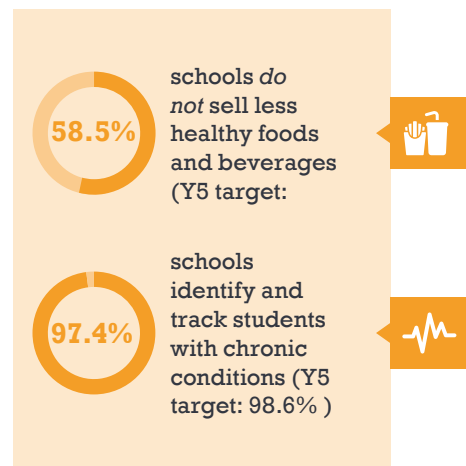
5,019 LEAs with over 25.6 million students were supported in creating physical education policies (Y5 Target: 4,452 LEAs, 21.2 million students).



247 LEAs with over 1.8 million students were supported in establishing, implementing, and evaluating CSPAP (Y5 Target: 258 LEAs, 1.9 million students).



94 LEAs supported in assessment, counseling, and referrals to community-based medical care providers for students on activity, diet, and weight-related chronic conditions (Y5 Target: 107 LEAs).

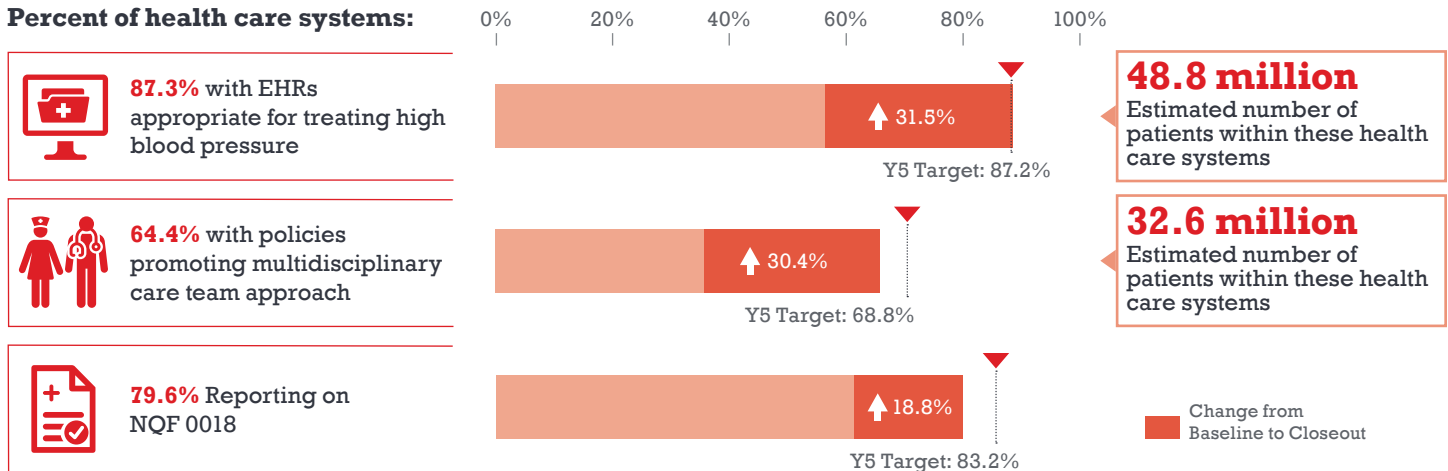


Note: Based on grantee reported data from the closeout report (2019); the number of grantees reporting differs for each measure



## Improved diagnosis and prevention of heart disease & stroke within health care systems

Effective use of electronic health record (EHR) systems and promotion of quality improvement and population reporting of patients aged 18 to 85 years who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90 mmHg) during the measurement period (National Quality Forum (NQF) Measure 0018), improves identification and monitoring of diagnosed and undiagnosed patients with uncontrolled high blood pressure. Use of multidisciplinary team care improves the quality of care provided to patients with hypertension.



**61.1% of adults with known high blood pressure have achieved blood pressure control (5.8% improvement from baseline)**

Note: The number of grantees reporting and data source types differ for each measure.



## Increased use of community-based diabetes prevention and self-management education programs

**National Diabetes Prevention Program (DPP)** supports a structured, year-long lifestyle change program that is offered in-person and online to prevent or delay the onset of type 2 diabetes among those at high risk. States are working to increase prediabetes awareness, increase referrals to CDC-recognized diabetes prevention programs, and secure the program as a covered benefit for state or public employees and Medicaid beneficiaries.

### Improved referral policies

**44%** of health care systems have policies to refer persons at high risk for type 2 diabetes to a CDC-recognized diabetes prevention program (increase of 27.1% from baseline).

### Improved Medicaid coverage

**1.4 million** Medicaid recipients at high risk for type 2 diabetes now have access to a CDC-recognized diabetes prevention program as a covered benefit (Increase of 1.3 million beneficiaries from baseline).

### Increased use

**156,354** people with prediabetes or at high risk for type 2 diabetes enrolled in a CDC-recognized diabetes prevention program.

**49.5%** of participants were referred by a health care provider.



### Diabetes Self-Management Education (DSME)

is the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care to improve clinical outcomes, health status, and quality of life. The 1305 grantees are working to increase use of DSME by increasing referrals to, coverage for, and availability of programs.

### Increased availability

**3,650** DSME programs were offered across 61.5% of counties in 42 states (increase of 511 programs from baseline).

### Improved Medicaid coverage

**3.4 million** Medicaid recipients with diabetes now have DSME as a covered benefit (increase of 1.3 million from baseline).

### Increased use

**1 million** people with diabetes participated in an American Diabetes Association (ADA)-recognized or American Association of Diabetes Educators (AADE)-accredited DSME program in targeted settings (increase of 172,858 from baseline).



**National DPP participants experienced an average weight loss of 4.4%.**



Note: Based on grantee reported data from the closeout report (2019); the number of grantees reporting differs for each measure