The Massachusetts Department of Public 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**

- Bristol, Franklin, Hampden, and Hampshire counties

**PRIORITY POPULATION**

- Residents of low socio-economic status in all targeted communities

**SELECTION CRITERIA**

- Community capacity/infrastructure
- Disease burden
- Established partnerships
- Population size

**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.
**SUCCESS STORIES**

**Massachusetts residents are facing increasing rates of diabetes and hypertension.** To address chronic disease, the state and its partners implemented 15 mutually reinforcing strategies. Below are examples of two of the strategies at work.

In Franklin County, an increase in prevalence of type 2 diabetes has led to a partnership between Mass in Motion, the 1422 program, the YMCA in Greenfield, the Athol YMCA, Community Health Center of Franklin County, and Franklin County Council of Governments to launch an initiative to scale and sustain the National Diabetes Prevention Program (National DPP). The Community Health Center of Franklin County and other community-based organizations have connected residents to CDC-recognized diabetes prevention programs at local YMCAs where lifestyle coaches teach residents how to incorporate healthy eating, physical activity, and problem-solving/coping skills into their daily lives.

The first CDC-recognized diabetes prevention program started at the Greenfield YMCA in February 2016 and maintained a 90% participant attendance rate. Seven of 10 participants met or exceeded the program’s weight loss goal. A second class launched on July 14, 2016.

In Springfield, MA, Caring Health Center has integrated community health workers (CHWs) with an aim to improve the detection of patients with undiagnosed hypertension and to manage those with uncontrolled hypertension. Caring Health Center developed a hypertension registry; provided training for CHWs on contacting and providing community and clinic-based interventions to patients with undiagnosed hypertension; and facilitated collaboration between CHWs, pharmacists, and primary care providers to review cases and address patient social, environmental, clinical, and behavioral challenges.

**SUBAWARDEE PERFORMANCE MEASURE HIGHLIGHTS**

The Centers for Disease Control and Prevention 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**
- **3** key community locations are implementing nutrition and beverage standards.
- **25** retail and community venues are increasing availability, affordability, placement, and/or promotion of healthy foods.
- **237** community venues are promoting physical activity through signage, joint use agreements, and/or worksite policies.
- **206,205** adults have access to community venues promoting physical activity.

**DIVISION FOR HEART DISEASE AND STROKE PREVENTION**
- **48,461** patients are participating in healthcare systems with electronic health records appropriate for treating patients with high blood pressure.
- **48,461** patients are participating in healthcare systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control.
- **2,101,212** adults reached through evidence-based engagement strategies.
- **111** adults at high risk for type 2 diabetes enrolled in CDC-recognized diabetes prevention programs.
- **48,461** patients are within healthcare systems with policies or systems to facilitate identification of people with prediabetes.
- **4** 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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