SUCCESS STORIES

Philadelphia, one of the 10 largest U.S. cities, has some of the highest rates of hypertension, type 2 diabetes, and heart disease. In response, the Philadelphia Department of Public Health (PDPH) has developed several initiatives to battle these rising numbers. The following are examples of two of its initiatives.

To address the high rates of hypertension, the Temple University Health System, with help from the PDPH, developed a **Self-Monitoring Blood Pressure (SMBP) pilot program at one practice** aimed at assisting hypertensive patients in controlling their blood pressure. To develop and test the program, Temple assembled a team comprised of practice staff (physician, nurse practitioner, nurse navigator, and CHW) and a community pharmacist. Hypertensive patients participating in the project experienced on average a 10 mmHg drop in systolic blood pressure and a 3 mmHg drop in diastolic blood pressure over a 16-week period. Based on the success of the pilot, Temple expanded the program to two additional practices. Two SMBP pilots are also taking place within Jefferson Health System practices.

2 health systems launched SMBP initiatives.

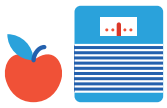
In the initial results from the Temple SMBP initiative, hypertensive patients in the program experienced an average of a 10 mmHg drop in systolic blood pressure and 3 mmHg drop in diastolic blood pressure over a 16-week period.

16 hospitals serving over 647,587 people, are promoting healthy, locally grown, sustainable food.

The PDPH also decided to focus on healthy food availability to combat chronic disease. **The Good Food, Healthy Hospitals program (GFHH)** was created to work across and within health care institutions to promote healthy, locally grown sustainable food. GFHH seeks to forge a deep connection between health care and food as the basis for improving health outcomes for staff, patients, and visitors. Since 2014, Philadelphia's hospital food environment has transformed with 16 hospitals pledging to adopt GFHH standards, which is five times the original goal. These hospitals serve over 647,587 people annually.

LARGE CITY 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

18 key community locations are implementing nutrition and beverage standards.

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

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

19,296 adults have access to community venues promoting physical activity.

DIVISION FOR HEART DISEASE AND STROKE PREVENTION

205,217 patients are participating in healthcare systems with EHRs appropriate for treating patients with high blood pressure.

201,688 patients are participating in healthcare systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control.

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

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

DIVISION OF DIABETES TRANSLATION

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

201,688 patients are within healthcare systems with policies or systems to facilitate identification of people with prediabetes.

9 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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