The Virginia 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**
- Counties: Clarke, Dinwiddie, Franklin, Frederick, Greensville, Henry, Page, Patrick, Prince George, Prince William, Shenandoah, Surry, Sussex, and Warren
- Cities: Emporia, Hopewell, Manassas City, Manassas Park, Martinsville, Petersburg, Portsmouth, and Winchester

**PRIORITIZED POPULATION**
- Low income population with chronic health conditions including hypertension, prediabetes, type 2 diabetes, obesity, heart disease and stroke

**SELECTION CRITERIA**
- 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.

**AWARD**
- $2,664,121

**AMOUNT TO SUBAWARDEES**
- $2,095,000

**PERCENTAGE OF AWARD TO SUBAWARDEES**
- 78.6%

**SUBAWARDEES**
- The Health Districts of:
  - Crater
  - Lord Fairfax
  - Portsmouth
  - Prince William
  - West Piedmont

**TYPES OF PARTNERS (NO.)**
- Other local government entity (16)
- Private business (15)
- Health system/healthcare-provider (7)
- Coalition/collaborative (6)
- Community-based organization (6)
- University/academic institution (4)
- Nonprofit organization (3)
- Faith-based institution (2)
- County/city health department (1)

**DUAL APPROACH**

**GENERAL POPULATION**
- Provide technical assistance and problem-solving methods to overcome obstacles to joint use agreement acceptance and implementation.

**GENERAL POPULATION**
- Implement evidence-based engagement strategies (e.g., tailored communications, incentives, etc.) to build support for the National Diabetes Prevention Program (National DPP).

**GENERAL POPULATION**
- Increase engagement of CHWs to promote linkages between healthcare providers and community resources for adults with high blood pressure and/or with prediabetes or at high risk for type 2 diabetes.

**PRIORITY POPULATION**
- Conduct assessments to determine the number and type of joint use agreements presently in effect and identify challenges.

**PRIORITY POPULATION**
- Utilize appropriate messaging and CHWs to educate and remove barriers to participation in lifestyle change programs for high risk groups to help reduce type 2 diabetes risk and manage uncontrolled hypertension.

**PRIORITY POPULATION**
- Establish and test CHW-centered bi-directional referral and communication systems linking patients with chronic conditions to community resources.
SUCCESS STORIES

**Many communities in Virginia are experiencing increasing rates of obesity, type 2 diabetes, and hypertension diagnoses.** To address chronic disease, the state and its partners implemented 15 mutually reinforcing strategies. Below are two examples of these strategies at work.

In West Piedmont Health District, people with diabetes and/or hypertension face challenges managing their conditions (low health insurance coverage, high unemployment, few community resources, difficult terrain, etc.). To address challenges, community health advocates (CHAs), housed at local Federally Qualified Health Centers, connect at-risk patients to medical homes and work with patients to overcome barriers. Between June 2016 and July 2017, CHAs provided care management to over 630 patients, and enrolled 370 patients into care management at a medical home. Of 234 patients enrolled in care management with diabetes, 74% reduced their A1C levels. Of 225 patients with hypertension (> 140/90), 78% achieved readings lower than 140/90.

Manassas City trails most Northern Virginia jurisdictions in terms of obesity rates, hospitalizations due to diabetes and hypertension, and stroke deaths. To improve outcomes, Prince William Health District partnered with a local mall and Novant Health University of Virginia Health System to form the Manassas Mall Walkers Group. The majority of participants are age 65 and older, and the group meets three times a week. Walkers have their body mass index, fasting glucose, and blood pressure measured. Monthly guest speakers provide information to walkers on a variety of topics. Since December 2016, more than 51 people have joined the group and 162 have been screened for chronic disease.

**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**

- **10** key community locations are implementing nutrition and beverage standards.
- **24** retail and community venues are increasing availability, affordability, placement, and/or promotion of healthy foods.
- **243** community venues are promoting physical activity through signage, joint use agreements, and/or worksite policies.
- **238,959** adults have access to community venues promoting physical activity.

**DIVISION FOR HEART DISEASE AND STROKE PREVENTION**

- **128,862** patients are participating in healthcare systems with policies or systems to encourage a multidisciplinary team approach to blood pressure control.
- **8** healthcare systems are implementing a community referral system to evidence-based lifestyle change programs for people with hypertension.
- **23,596** adults have been reached through evidence-based engagement strategies.
- **980** adults at high risk for type 2 diabetes are enrolled in CDC-recognized diabetes prevention programs.
- **86,389** patients are within healthcare systems with policies or systems to facilitate identification of people with prediabetes.

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.

LAST UPDATED 1/31/2018