

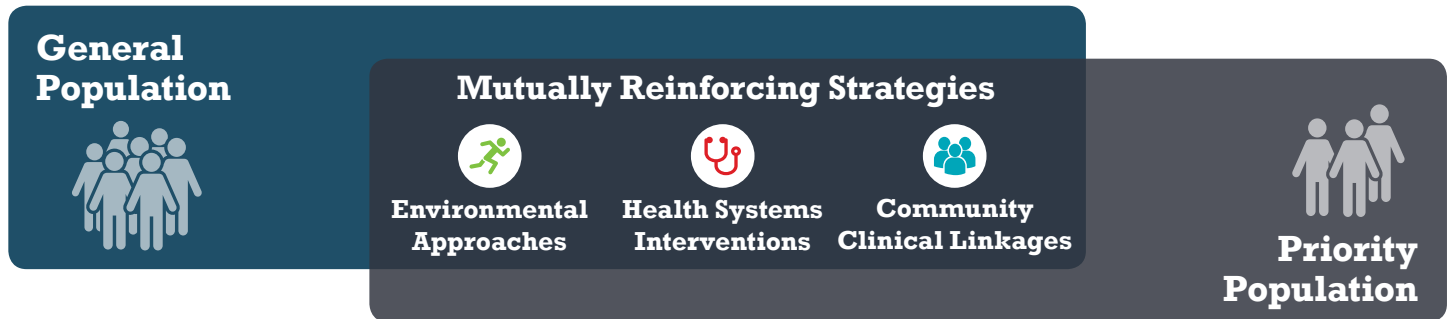
STATE AND LOCAL PUBLIC HEALTH ACTIONS (1422)

Year 2 Performance Measures Snapshot



CDC funded 17 states and 4 large cities to address multiple risk factors for chronic diseases using the dual approach and mutually reinforcing strategies to implement environmental, health systems, and community-clinical linkage strategies. This snapshot reflects year 2 performance measure data that were reported at the general population level. Priority population data will be available in year 3 of this cooperative agreement.

Dual Approach



Environmental Approaches

Environmental approaches—such as increasing access to healthy food and physical activity—support healthy behaviors and are likely to have a lasting effect on population health.

- 448** community locations implemented nutrition and beverage standards (*increase of 183 locations from baseline*).
- 1,230** retail venues promote healthier food access through increased availability, and improved pricing (*increase of 439 venues from baseline*).
- 1,099** community venues promoted physical activity through signage, worksite policies and shared-use agreements (*increase of 321 venues from baseline*).
- 176** communities developed and/or implemented a transportation plan that promotes walking (*increase of 120 communities from baseline*).

2.5 million more adults have access to retail venues and community venues that promote healthier food, compared with baseline.

18.4 million more adults have access to community venues that promote physical activity, compared with baseline.

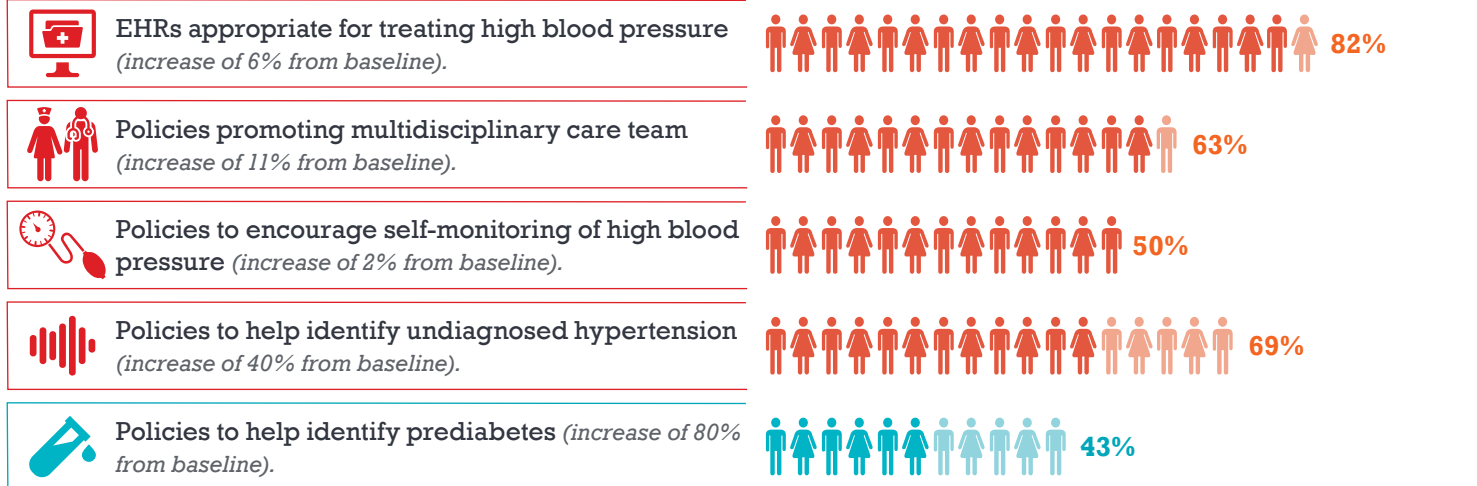
Note: The number of grantees reporting differs for each measure.
 Note: The increased percentage represents relative change from baseline to year 2.



Health System Interventions

Health system interventions enhance the quality of health care delivery to improve the diagnosis and management of chronic disease. Grantees have worked to increase the number of health systems that use electronic health record (EHR) systems, integrated care, and other approaches to improve the monitoring, management, and diagnosis of hypertension and prediabetes.

Percentage of Patients in Health Care Systems with the following:



Note: The number of health systems vary for each measure.
Note: The increased percentage represents relative change from baseline to year 2.



Community-Clinical Linkages

Community-clinical linkages increase engagement of nonclinical partners to support chronic disease prevention and management. Effective use of community resources ensures that people with or at high risk for chronic diseases have access to quality community resources to best manage their conditions or disease risk.

National Diabetes Prevention Programs (National 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 people at high risk. States, large cities, and sub-awardees worked to increase prediabetes screening, testing, and referral; enroll vulnerable, at-risk participants in CDC-recognized diabetes prevention programs; and secure the program as a covered benefit for employees.



Evidence-Based Lifestyle Change Programs help people with high blood pressure to lower and control their blood pressure through healthier diets and increasing physical activity. Grantees worked to increase use of lifestyle change programs by leveraging CHWs and increasing referrals from health care systems.



Engaging Community Health Workers (CHW)
112 health care systems engage CHWs to link patients to a CDC-recognized diabetes prevention program (increase of 161% from baseline).

Improved Referral Policies
117 health care systems have policies to refer people at high risk for type 2 diabetes to a CDC-recognized diabetes prevention program (increase of 48% from baseline).

Tailored Communication Activities
2.2 million people were reached through evidence-based engagement strategies and exposed to messages about the National DPP (increase of 794% from baseline).

Engaging Community Health Workers (CHW)
108 health care systems engage CHWs to link patients to resources to promote self-management of high blood pressure (increase of 130% from baseline).

Improved Referral Policies
130 health care systems have community referral system for people with hypertension (increase of 49% from baseline).

Increased Use

17,142 people with prediabetes or at high risk for type 2 diabetes enrolled in a CDC-recognized diabetes prevention program (increase of 86% from baseline).



Increased Use

2,162 people with high blood pressure enrolled in a lifestyle change program (increase of 127% from baseline).



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