

# STATE AND LOCAL PUBLIC HEALTH ACTIONS (1422)

## Year 3 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 3 performance measure data that were reported at the general population level as well as the priority population level through the work of subawardees.

### 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.

-  **595** community locations implemented nutrition and beverage standards (*increase of 394 locations from baseline*).
-  **2,263** retail venues promoted healthier food access through increased availability, and improved pricing (*increase of 761 venues from baseline*).
-  **1,146** community venues promoted physical activity through signage, worksite policies and shared-use agreements (*increase of 782 venues from baseline*).
-  **311** communities developed and/or implemented a transportation plan that promotes walking (*increase of 244 communities from baseline*).

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

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

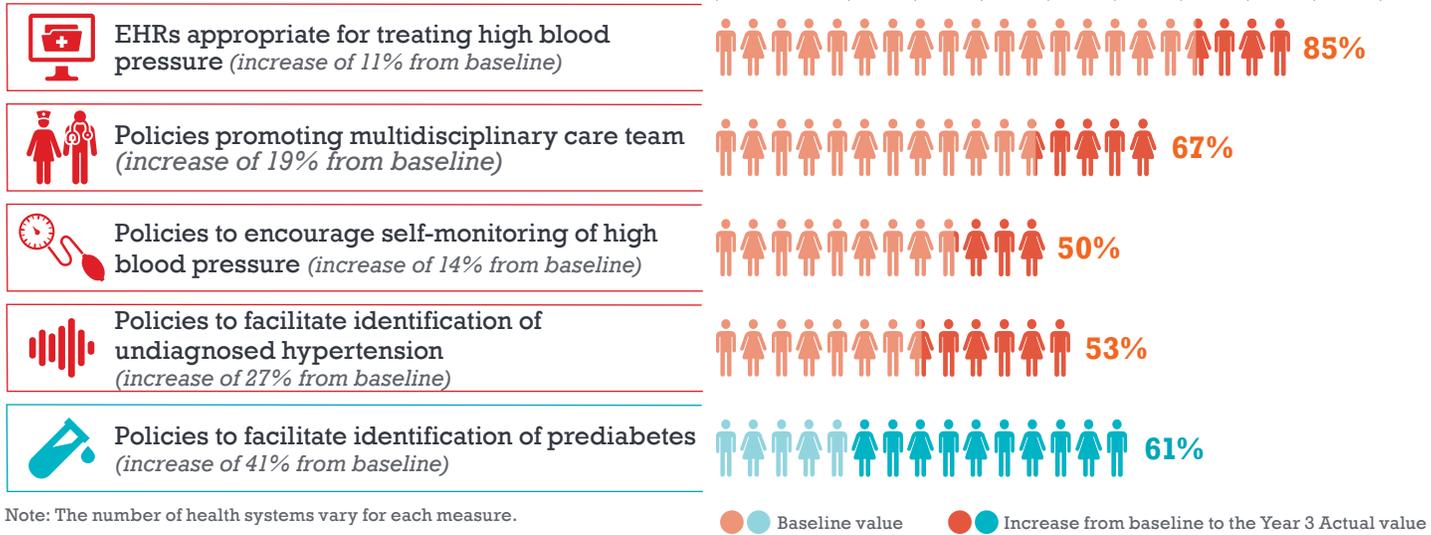
Note: Based on grantee reported data from Year 3 annual progress report (2017); the number of grantees reporting differs for each measure



## 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 are using electronic health record (EHR) systems, integrated care policies, and other policies to improve the monitoring, management, and diagnosis of hypertension and prediabetes.

### % patients in health care systems with



## Community-Clinical Linkages

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

### The National Diabetes Prevention Program

includes a structured program—in person or online—developed specifically to prevent type 2 diabetes. States, large cities, and sub-awardees worked to scale and sustain the National DPP by working through network partners, implementing evidence-based engagement strategies, and increasing coverage and referral policies.



#### Engaging community health workers (CHWs)

**187** health care systems engage CHWs to link patients to CDC-recognized diabetes prevention programs (increase of 188% from baseline)

#### Improved referral policies

**267** health care systems have policies to refer persons at high risk for type 2 diabetes to a CDC-recognized diabetes prevention program (increase of 299% from baseline)

#### Tailored communication activities

**34.8 million** people were reached through evidence-based engagement strategies focused on the National DPP (increased from 206,506 people at baseline)

#### Increased use

**3,786** people with prediabetes or at high risk for type 2 diabetes enrolled in a CDC-recognized diabetes prevention program (increased from 193 enrollees at baseline)



### Evidence-based lifestyle change programs,

help persons 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)

**180** health care systems engage CHWs to link patients to resources to promote self-management of high blood pressure (increased from 69 systems at baseline)

#### Improved referral policies

**248** health care systems have community referral system for people with hypertension (increased from 119 systems at baseline)

#### Increased use

**5,031** people with high blood pressure enrolled in a lifestyle change program (increased from 1,777 people at baseline)



Note: Based on grantee reported data from Year 3 annual progress report (2017); the number of grantees reporting differs for each measure