

# Partnerships to Improve Community Health FY 2014 Program Highlights



Partnerships to Improve Community Health (PICH) is a 3-year initiative of the Centers for Disease Control and Prevention (CDC) that began in FY 2014. It is designed to improve the health of all Americans and to reduce chronic diseases and related risk factors in communities. The PICH initiative encourages multisector partners to work together to use strategies that have been proven to work in the places where people live, learn, work, and play.

In September 2014, CDC gave about \$49.3 million to 39 PICH awardees in 13 large cities and urban counties (with populations of 500,000 or more), 20 small cities and counties (with populations of 50,000 to 499,999), and 6 American Indian tribes or tribal organizations.

PICH awardees will use these funds to address the following risk factors:

- **Tobacco Use and Exposure:** Reducing exposure to secondhand smoke in multiunit housing complexes, on school campuses, and at public gatherings promotes good health where people live, learn, work, and play.
- **Physical Inactivity:** Improving physical activity opportunities in schools and workplaces encourages exercising and promotes healthy lifestyles.
- **Poor Nutrition:** Providing access to healthy foods and drinks in schools, child care settings, workplaces, government facilities, and senior centers helps to improve our nation's health.
- **Lack of Access to Opportunities for Chronic Disease Prevention, Risk Reduction, and Disease Management:** Expanding access to clinical and community services through multidisciplinary teams and information technology helps people manage chronic diseases.

## Tobacco Use and Exposure

### *Lucas County, Ohio*

**The Challenge:** In Lucas County, nearly 22% of adults and 42% of low-income residents reported smoking in their homes in the past month.

**The Goal:** By September 2017, about 18,000 low-income Lucas County residents who live in multiunit housing are expected to have access to smoke-free environments.

**Proposed Activity:** The Hospital Council of Northwest Ohio (HCNO) is partnering with a multisector coalition to expand smoke-free protections to 10 multiunit housing complexes in low-income communities. This new policy will reduce exposure to secondhand smoke for thousands of county residents. The HCNO will also partner with local public housing authorities to teach residents about the benefits of smoke-free housing policies.

## Physical Inactivity

### *Pawnee County, Oklahoma*

**The Challenge:** About 35% of adults in Pawnee County said they were not physically active during their leisure time in 2005-2010. County residents were less active than adults across Oklahoma and the United States.

**The Goal:** By September 2017, about 3,400 Pawnee County residents will have more options for physical activity.

**Proposed Activity:** The Pawnee Nation of Oklahoma is working to reduce risk factors for chronic diseases in Pawnee County. A multisector coalition that includes the Pawnee Indian Health Center plans to set up worksite wellness programs for Pawnee Nation staff; give residents more ways to be physically active through biking, walking, and running programs; and improve community designs to make streets safe for pedestrians.

### *Mississippi River Region, Mississippi*

**The Challenge:** In 2013, nearly 35% of adults in Central-Southwest Mississippi River Region were obese, compared with 26.9% of adults nationwide. About 61% of residents in the Central-Southwest Mississippi River Region reported that they were not physically active for at least 30 minutes on at least 5 days a week.

**The Goal:** By September 2017, about 24,200 residents living in the Central-Southwest Mississippi River Region will have more access to physical activity opportunities.

**Proposed Activity:** My Brother's Keeper, Inc., a nonprofit organization that works to improve the health and well-being of minority groups, is partnering with a multisector coalition of community organizations, health departments, and academic institutions to increase access to physical activity opportunities at schools and parks. At least five schools in low-income communities will allow residents to use school property after school for physical activity. Local parks and recreational facilities will also be improved to give residents safe places to walk and bike.

## Poor Nutrition

### *New Castle County, Delaware*

**The Challenge:** In 2011, nearly 33% of adults in New Castle County had been diagnosed with high blood pressure and 26% were obese. Percentages were higher among minority groups living in low-income communities in the county.

**The Goal:** By September 2017, about 76,500 county residents are expected to have more access to healthy food and drink options in their communities.

**Proposed Activity:** Nemours/Alfred I. duPont Hospital for Children is working with a coalition that includes government agencies, schools, child care centers, health care systems, communities, and other groups to reduce behaviors that contribute to high chronic disease prevalence and poor nutrition. The coalition is working with local farmers' markets and corner stores to get affordable fruits, vegetables, and whole grains into low-income communities. They also will work with Delaware employers to set up worksite wellness programs that encourage healthy eating and physical activity.

### *Seattle-King County, Washington*

**The Challenge:** On average, Seattle-King County residents ate only one fruit and fewer than two vegetables a day in 2013. The county also has higher numbers of people who are overweight or obese than the overall United States.

**The Goal:** By September 2017, about 2 million Seattle-King County residents are expected to have better access to healthy food and drink options in their communities.

**Proposed Activity:** Seattle-King County is partnering with a community coalition to expand incentive programs that offer people who get Supplemental Nutrition Assistance Program (SNAP) benefits more options for healthy foods and drinks at two new farmers' markets. The county will also work to increase access to nutritious foods that meet federal guidelines in early child care settings and to improve wellness policies at K-12 schools and in early child care settings. These efforts will help make sure that children in communities with high rates of chronic diseases and health inequities have better access to healthy food and drink options.

## Lack of Access to Opportunities for Chronic Disease Prevention, Risk Reduction, and Disease Management

### *Schenectady County, New York*

**The Challenge:** In 2009, about 9.4% of Schenectady County residents had diabetes, which is the highest rate among any community in upstate New York. Nearly 66.6% of county residents were overweight or obese.

**The Goal:** By September 2017, about 55,000 Schenectady County residents will have better access to links between clinical and community services that improve diabetes management.

**Proposed Activity:** Schenectady County is working with a multisector coalition to improve the quality of care for people with prediabetes and diabetes. The coalition will set up a disease registry to collect data on people with prediabetes and diabetes. The goal is to identify people early, which can help reduce the risk of complications and improve self-management. Registry data can also be used to improve the quality of patient care and make sure that people at high risk get the preventive screenings and treatments they need. The county will also work with community- and faith-based organizations to set up a referral system for medical care and diabetes self-management education.

### *Solano County, California*

**The Challenge:** In 2011, about 11% of adults in Solano County had diabetes and 27% were obese. Diabetes and obesity rates were higher in the county than they were at state and national levels.

**The Goal:** By September 2017, about 300,000 Solano County residents are expected to have more opportunities for chronic disease prevention, risk reduction, or disease management through systems that link residents to clinical and community services (e.g. tobacco quit lines, diabetes management programs).

**Proposed Activity:** Building on previous community health programs, Solano County is collaborating with a multisector coalition of health care, academic, social service, and community groups and local government agencies to set up clinical referral systems for patients with or at risk for high blood pressure and diabetes. These efforts are designed to increase the number of health care providers who refer patients to programs such as the Chronic Disease Self-Management Program, National Diabetes Prevention Program, or Weight Watchers. These efforts are also expected to help improve treatment and care for chronic diseases in California.



For more information about PICH, visit  
<http://www.cdc.gov/nccdphp/dch/programs/partnershipstoimprovecommunityhealth/index.html>