What Is the Dual Approach?

The goal of the funding opportunity announcement (FOA) DP14-1422, PPHF 2014: State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke is to use evidence-based approaches to prevent obesity, diabetes, and heart disease and stroke, and to reduce health disparities in both the general and priority populations. In this FOA, states, large cities, and local communities work together to develop and put into action a set of comprehensive and mutually reinforcing strategies within and across two components. This work includes Component 1 (environmental and system approaches to promote health and build support for lifestyle change) and Component 2 (health systems interventions to improve the quality of health care delivery and to strengthen community-clinical linkages). This work is designed to concurrently reach the general population at the state level and priority populations at both the state and community levels. This multilevel method is known as the Dual Approach.

Case for the 1422 Dual Approach

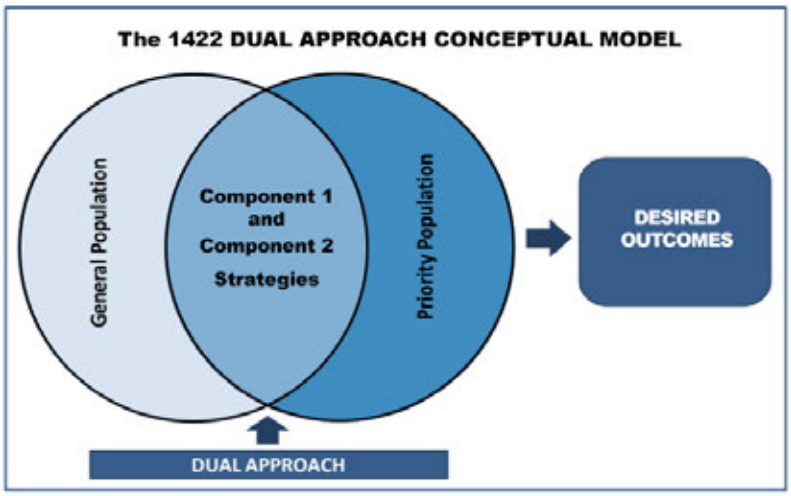
Chronic diseases are the leading cause of death and disability in the United States and account for 86% of the nation's health care costs. Reducing the nation's chronic disease burden will require "combined whole-population and individual approaches, including targeted resources and support for population subgroups with the greatest burden."[1] The Dual Approach supports improved health for the larger population while also using targeted interventions to address barriers and challenges faced by specific subgroups. The Dual Approach is based on the theory of targeted universalism, which states that reducing disparities for the most marginalized populations improves overall well-being for everyone.[2] The following table provides examples of the Dual Approach when both general population and targeted interventions are applied together.

THE DUAL APPROACH USES STRATEGIES TO ADDRESS HEALTH ISSUES IN THE GENERAL POPULATION AT A STATE LEVEL AND THE PRIORITY POPULATIONS WITHIN TARGETED COMMUNITIES.

Component	Strategy	Example of a General Population Intervention	Example of a Targeted Intervention to Address Priority Populations
Component 1—Environmental and System Approaches	Build support for lifestyle change to scale and sustain the National Diabetes Prevention Program (National DPP) and carry out environmental strategies to support and reinforce healthful behaviors.	Develop a statewide network of partners, a state strategic plan to build support for the National DPP, and carry out state-level environmental strategies to promote healthy eating and increase safe opportunities for physical activity.	Enroll priority populations that include Medicaid beneficiaries in a CDC-recognized lifestyle change program that supports participants with healthy food options and opportunities for physical activity within their community.
Component 2—Community-Clinical Linkages	Improve access to, coverage for, and use of community-based services for chronic disease prevention and disease management.	Put into action organizational strategies to increase availability of the patient-centered medical home model in health care systems.	Include safety-net providers in quality-improvement efforts to identify and increase control of high blood pressure among vulnerable and low-income populations.

Dual Approach Conceptual Framework

This conceptual model displays how general population strategies and interventions, and targeted interventions for priority populations, contribute to the Dual Approach. The primary goal is to reduce health disparities and improve health equity in the targeted areas.



Component 1, environmental and lifestyle change strategies, is put into action in the same communities and jurisdictions as Component 2, health systems and community-clinical linkage strategies. Local improvements are supported by state-level efforts funded by DP14-1422 and by DP13-1305 State Public Health Actions. The strategies in both components should be mutually reinforcing.

Key Definitions
Component 1 strategies include environmental and system approaches to promote health, support and reinforce healthful behaviors, and build support for lifestyle improvements for general populations. These populations include people with uncontrolled high blood pressure and people at high risk for developing type 2 diabetes. Populations at high risk for type 2 diabetes include those with prediabetes or those who have a sufficient number of other conditions or behaviors that put them in a high-risk category.
Component 2 strategies include health system interventions and community-clinical linkages that focus on the general and priority populations. These may promote the use of electronic health records and health information technology, carry out the use of team-based care, and facilitate the additions of community health workers and community pharmacists as integral members of the health care team to address disparities related to hypertension and diabetes.
Community-Clinical Linkages are collaborations between health care practitioners in clinical settings and programs in the community—both working to improve the health of people and the communities in which they live.
General Population includes people living in a particular area (i.e., state, county, city, town, or parish), people in a particular group (i.e., students, parents, or blue-collar workers), or individuals that have common characteristics (i.e., young adults, single women, or disabled veterans).
Priority Populations in this context are high-risk, high-burden populations with prediabetes or uncontrolled high blood pressure who experience racial/ethnic or socioeconomic health disparities. These can include inadequate access to care, poor quality of care, or low income.
Targeted Community—is defined for the purpose of this FOA as a county, a metropolitan statistical area (MSA), or a group of contiguous counties. These communities have significant disease burden and sufficient combined populations to reach significant numbers of people.
Dual Approach means the use of both general and priority population interventions simultaneously to reduce health disparities population-wide and among priority or targeted communities.
Mutually Reinforcing Strategies work together and support each other to strengthen the effectiveness and change the desired health outcomes in both the general and priority populations.

References

[1]Bauer, et al. Prevention of chronic disease in the 21st century: elimination of the leading preventable causes of premature death and disability in the USA. *Lancet*. 2014; 384:45-52.

[2]National Collaborating Centre for Determinants of Health. *Let's Talk: Universal and Targeted Approaches to Health Equity.* Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University; 2013.