ODHDSP Year 3 Strategies/Activities for Local Health Departments

Strategy 1.1: Implement nutrition and beverage standards including sodium standards (e.g., food service guidelines for cafeterias and vending) in public institutions, worksites, and other key locations such as hospitals by completing the following activities:
1. Recruit at least two new worksites and two new faith-based organizations to implement nutrition and beverage standards.
2. Enroll and assess selected worksites using CDC's Worksite Health Scorecard and provide technical assistance to address gaps in worksites' food and beverage standards (including both cafeterias and vending).
3. Implement the Faithful Families program in at least two faith-based organizations. The Faithful Families program supports healthy eating and physical activity in communities of faith. Resources for the program include a 9-session curriculum and the Eating Smart and Moving More Planning Guide for Faith Communities.
Strategy 1.2: Strengthen healthier food access and sales in retail venues and community venues through increased availability, improved pricing, placement, and promotion by completing the following activities:
1. Recruit at least two small food retail venues/corner stores to promote healthier food access within their stores.
2. Identify and assess selected retail venues using the guidance and tools provided by DPH.
Strategy 1.3: Strengthen community promotion of physical activity through signage, worksite policies, social support, and joint use agreements in communities and jurisdictions by completing the following activities:
1. Recruit at least two worksites and two faith-based organizations to promote physical activity through signage, social support and joint use/shared use policies.
2. Enroll and assess selected worksites using CDC's Worksite Health Scorecard and provide technical assistance to address gaps in worksites' promotion of physical activity.
3. Implement the Faithful Families program in at least two faith-based organizations. The Faithful Families program supports healthy eating and physical activity in communities of faith. Resources for the program include a 9-session curriculum and the Eating Smart and Moving More Planning Guide for Faith Communities.
Strategy 1.5: Plan and execute strategic data-driven actions through a network of partners and local organizations to build support for lifestyle change by completing the following activities:
1. Continue to meet with a diabetes prevention coalition to advise the local health department on developing a plan to build capacity to deliver Diabetes Prevention Programs (DPPs) and assist with program implementation.
a. Develop a plan to meet with Accountable Care Organizations (ACOs), large hospitals, or local medical societies to present referral to DPPs, while continuing to increase the availability of DPPs in the areas where burden is high and the program is non-existent.
b. Conduct a self-assessment of the coalition.
2. Meet with at least two medical groups (ACOs, large hospitals, or local medical societies) to promote referral to DPP.

Strategy 1.6: Implement evidence-based engagement strategies (e.g., tailored communications) to build support for lifestyle change by completing the following activities:
1. Provide DPP scholarships (registration fee paid for DPP class) to at least 20 Medicaid-eligible persons.
2. Facilitate DPP lifestyle coach training sessions for at least two organizations.
a. Require all sites that are considering training to complete the DPP assessment form provided by DPH.
b. Require all trained sites to apply for CDC recognition prior to attending the training (application instructions provided by DPH).
3. Offer a training to lifestyle coaches focused on patient engagement.
4. Fund a data management subscription for DPP sites with recognized or pending recognition status that are working on this project.
5. Hold at least one focus group with healthcare providers to determine barriers to DPP referral.
6. Hold at least one focus group with potential DPP participants who are Medicaid eligible to determine barriers to participation.
Strategy 1.7: Increase coverage for evidence-based supports for lifestyle change by working with network partners by completing the following activity:
1. Provide technical assistance to employers who choose prediabetes after completing CDC's Worksite Health Scorecard to include:
a. Share DiabetesFreeNC.com weblink.
b. Present return on investment data that shows how covering DPP is a cost saving measure.
c. Provide a resource list of DPP classes and provide other information such as the link to www.diabetesatwork.org for posters, brochures and other ideas about how to support people with prediabetes.
d. Encourage employers to offer DPP at the worksite.
Strategy 2.1: Increase electronic health records (EHRs) adoption and the use of health information technology (HIT) to improve performance by completing the following activities:
1. Recruit at least two practices that are willing to amend their electronic health record to prompt for prediabetes screening (DPH will recommend some sites, but the Community Health Systems Coordinator may choose to work with other partners as long as they provide chronic disease care to an adult population).
2. Promote participation in webinars that are related to the DPH and also provide information on the use of HIT, national reporting of quality measures, using electronic health records to assess population health, Centers of Medicare and Medicaid payment methods, medication adherence and reconciliation, self-monitoring of blood pressure and referral to DPPs.
3. In a clinical setting, promote adoption and use of tools such as:
a. ABCs brochures (ABCS of Cardiovascular Disease Prevention).
b. Walking campaign materials developed by DPH.
c. Sodium reduction brochures developed by DPH.
d. Mediterranean Diet information developed by DPH.

Strategy 2.2: Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider level by completing the following activities:
1. Recruit one to three safety net providers (could be a continuation from a previous year or the new sites that are participating in other strategies) to participate in a disparities learning collaborative and conduct three meetings.
a. First meeting: share the disparities curriculum and determine which disparity will be addressed in each region.
b. Second meeting: share collected data and determine strategies that will be implemented to address identified disparity.
c. Third meeting: share success stories and lessons learned.
2. Recruit 40 participates for a two-day training to help participants understand institutional and structural racism which will enhance staff's ability to consider the history, context, and culture of priority populations in the selection and implementation of evidence-based strategies.
Strategy 2.3: Increase engagement of non-physician team members (e.g., nurses, pharmacists, and nutritionists, physical therapists, and patient navigators/community health workers) in hypertension management in community health care systems by completing the following activities:
1. Attend at least one COMprehensive Post Acute Stroke Services (COMPASS) board meeting if one of the participating hospitals is in your region.
2. Customize the COMPASS toolkit (provided by DPH) to your region and provide to each hospital participating in COMPASS and monitor referrals.
3. Promote Team Up Pressure Down materials with local pharmacies (print for them).
4. Share Team Up Pressure Down materials with WISEWOMAN providers if they are located in your region.
5. Work with your recruited clinical practices to have them adopt a system to encourage a multi-disciplinary team approach to blood pressure control.
Strategy 2.4: Increase use of self-measured blood pressure monitoring tied with clinical support by completing the following activities:
1. Work with your clinical sites to adopt a blood pressure policy that includes providing blood pressure monitors to patients with uncontrolled blood pressure or directing them to publicly available blood pressure stations.
2. Work with partners to obtain a supply of blood pressure monitors.
3. Work with partneres to make bloodpressure machines more available in public places like libraries.
4. Encourage two to three worksites that have completed CDC's Worksite Health Scorecard and indicate an interest in learning more about hypertension to adopt the sample policy for self-monitoring of blood pressure.
5. Encourage two to three faith communities that have completed the faith community assessment and indicate an interest in learning more about hypertension to adopt the sample policy for self-monitoring of blood pressure.

Strategy 2.5: Implement systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes by completing the following activity:
1. Work with at least two clinical sites (preferably those recruited by DPH), to find the undiagnosed hypertensives by running a list of current adult patients diagnosed with hypertension, working with DPH staff to review the list, and if necessary agree on a follow-up plan to get those with undiagnosed hypertension to become diagnosed and begin treatment.
Strategy 2.6: Increase engagement of Community Health Workers (CHWs) to promote linkages between health systems and community resources for adults with high blood pressures and adults with prediabetes or at risk for type 2 diabetes by completing the following activities:
1. Recruit eight to ten CHWs to learn the Check Change Control curriculum and serve as hypertension coaches for those newly diagnosed or who are struggling with hypertension control. This should be done in conjunction with faith communities that are interested in working on cardiovascular disease, diabetes, prediabetes, or obesity as identified from the faith community assessment and senior centers, pharmacies, and regional safety net providers.
2. Train CHWs on the Check Change Control curriculum and use of the data collection tool.
3. Train CHWs on ways to promote healthy eating, including sodium reduction and how to increase physical activity.
4. Train CHWs on HIPPA compliance when dealing with patient privacy issues.
Strategy 2.7: Increase engagement of community pharmacists in the provision of medication/self-management for adults with high blood pressure by completing the following activities:
1. Meet with pharmacies in your region that are participating in the Community Care of North Carolina (CCNC) Innovation grant and share materials provided by DPH and provide ongoing technical assistance.
2. Recruit two to five additional pharmacies in your region, share materials and provide ongoing technical assistance (list of pharmacies and materials provided by DPH).
3. Follow up with safety net providers that indicated an interest in working with pharmacies and connect them with Innovation pharmacies in their network.
Strategy 2.8: Implement systems and increase partnerships to facilitate bi-directional referral between community resources and health systems, including lifestyle change programs by completing the following activity:
1. Recruit two to five community sites that offer Chronic Disease programs (CDSMP, DPP, DSME, etc.) and who are willing to receive referrals electronically.
2. Assist the sites with purchasing tools that will allow for secure bi-directional messaging.
3. Support the 211 system for DPP screening and referral to chronic disease programs from the Quitline.