JCDHE 1422 Grant Strategies

Component 1.1: Environmental strategies to promote health and support and reinforce healthful behaviors

Strategy 1 - Implement nutrition and beverage standards including sodium standards (i.e., food service guidelines for cafeterias and vending) in public institutions, worksites and hospitals

Strategy 2: Strengthen healthier food access and sales in retail venues (e.g. grocery stores, supermarkets, chain restaurants and markets) and community venues (e.g. food banks) through increased availability (e.g. more fruit and vegetables and more low/no sodium options), improved pricing and placement, and promotion

Strategy 3: Strengthen community promotion and physical activity through signage, worksite policies, social support, and joint-use agreements

Strategy 4 - Develop and/or implement transportation and community plans that promote walking

Component 1.2: Strategies to build support for lifestyle change, particularly for those at high risk, to support diabetes, heart disease and stroke prevention

Strategy 5 - Plan and execute strategic data-driven actions through a network of partners and local organizations to build support for lifestyle change

Strategy 6: Implement evidence-based engagement strategies (e.g. tailored communications, incentives, etc.)

Strategy 7: Increase coverage for evidence-based supports for lifestyle change by working with network partners

Component 2.1: Health system interventions to improve quality of health care delivery to populations with the highest hypertension and prediabetes disparities

Strategy 8: Increase electronic health records (EHR) adoptions and the use of health information technology (HIT) to improve performance (e.g. implement advanced Meaningful Use data strategies to identify patient populations who experience CVD-related disparities)

Strategy 9: Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider level (e.g. use dashboard measures to monitor health care disparities and implement activities to eliminate health care disparities)

Strategy 10: Increase engagement of non-physician team members (i.e. nurses, pharmacists, nutritionists, physical therapists and patient navigators/community health workers) in hypertension management in community health care systems

Strategy 11: Increase use of self-measured blood pressure monitoring tied with clinical support

Strategy: 12 - Implement systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes

Component 2-2: Community clinical linkage (CCL) strategies to support heart disease, stroke and diabetes prevention efforts

Strategy 13: Increase engagement of community health workers to promote linkages between health systems and community resources for adults with high blood pressure and adults with prediabetes or at high risk for type 2 diabetes

Strategy 14: Increase engagement of community pharmacists in the provision of medication/self-management for adults with high blood pressure

Strategy 15: Implement systems to facilitate bi-directional referral between community resources and health systems, including lifestyle change programs (e.g. EHRs, 800 numbers, 211 referral systems. Etc.)

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