

Missouri Department of Health and Senior Services
Local Public Health Agency Capacity Assessment

For participation in Funding Opportunity Announcement (FOA) 1422: Diabetes Prevention-State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke

Background: In response to the Centers for Disease Control and Prevention (CDC) FOA 1422, four to eight communities with the capacity to implement the following proposed strategies will be identified. A community is defined as a single county or Public Health Jurisdiction, Metropolitan Statistical Area, or a group of contiguous counties or Public Health Jurisdiction.

Instructions: Please provide the information requested and return to Barbara Brendel no later than September 9, 2014 at barbara.brendel@health.mo.gov.

If you have questions about the information requested, please contact Barbara Brendel at 573-522-2840 or barbara.brendel@health.mo.gov.

Thank you for your interest in participating in this important public health project.

“Community” Name: _____

County(ies) or Public Health Jurisdiction(s) Included: _____

Lead County: _____

Contact Name: _____

Contact Email: _____

Contact Phone: _____

COMPONENT 1: Environmental strategies to promote health and support and reinforce healthful behaviors. Strategies to Build Support for Healthy Lifestyles, Particularly for Those at High Risk, to Support Diabetes and Heart Disease and Stroke Prevention Efforts.

Strategy 1.1: Implement nutrition and beverage standards including sodium standards (i.e., food service guidelines for cafeterias and vending) in public institutions, worksites and other key locations, such as hospitals

Strategy 1.2: Strengthen healthier food access and sales in retail venues

Strategy 1.3: Strengthen community promotion of physical activity through signage, worksite policies, social support, and join use agreements in communities

Strategy 1.4: Develop and/or implement transportation and community plans that promote walking

Strategy 1.5: Plan and execute strategic data-driven actions through a network of partners and local organizations to build support for lifestyle change

Strategy 1.6: Implement evidence-based engagement strategies, such as tailored communications, incentives, etc., to build support for lifestyle change

Strategy 1.7: Increase coverage for evidence-based supports for lifestyle change by working with network partners

1. Please describe your agencies’ experience in working with environmental strategies to promote health and support and reinforce healthful behaviors, such as those identified

in the proposed strategies above. Include your agencies' role and the community partners with which you worked.

2. Please describe existing staffing **and** staffing needs to effectively coordinate the planning, implementation and evaluation of the proposed strategies in your "community".
3. Please list partners with which you would work to plan, implement and evaluate the proposed strategies.

COMPONENT 2: Health System Interventions to Improve the Quality of Health Care Delivery to Populations with the Highest Hypertension and Pre-diabetes Disparities. Community Clinical Linkage Strategies to Support Heart Disease and Stroke and Diabetes Prevention Efforts.

Strategy 2.1: Increase electronic health records adoption and the use of health information technology to improve performance

Strategy 2.2: Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider level

Strategy 2.3: Increase engagement of non-physician team members

Strategy 2.4: Increase use of self-measured blood pressure monitoring tied with clinical support.

Strategy 2.5: Implement systems to facilitate identification of patients with undiagnosed hypertension and people with pre-diabetes

Strategy 2.6: Increase engagement of community health workers to promote linkages between health systems and community resources for adults with high blood pressure and adults with pre-diabetes or at high risk for type 2 diabetes

Strategy 2.7: Increase engagement of community pharmacists in the provision of medication-/self-management for adults with high blood pressure

Strategy 2.8: Implement systems and increase partnerships to facilitate bi-directional referral, such as electronic health record, 800 number or 211 referral systems, between community resources and health systems, including lifestyle change programs

1. Please describe your agencies' experience in working with health system intervention strategies to improve the quality of health care delivery to populations with the highest hypertension and prediabetes disparities, such as those identified in the proposed strategies above. Include your agencies' role and the community partners with which you worked.
2. Please describe existing staffing **and** staffing needs to effectively coordinate the planning, implementation and evaluation of the proposed strategies in your "community".
3. Please list partners with which you would work to plan, implement and evaluate the proposed strategies.