

**Current Activities under FOA 1305:**

**Domain 2 Basic**

Strategy	Activity
<b>Strategy 1 Activities: <i>Promote the adoption of food service guidelines/nutrition standards, which include sodium</i></b>	Train school food service (SFS) on implementation of new meal requirements through summer workshops. Host a webinar for SFS on implementation.
	Implement culinary skills institute for schools that focuses on food preparation and healthy food options.
	Develop online training on local wellness policies and competitive foods in partnership with the Missouri School Board Association (MSBA).
	Develop Eat Smart in Parks (ESIP) outreach/promotional materials to be used with partner organizations, such as WIC.
	Convene workgroup from Strive for Wellness Ambassadors to develop food service guidelines for Missouri's state agencies.
<b>Strategy 2: <i>Promote the adoption of physical education/physical activity (PE/PA) in schools</i></b> <b>Note: <i>for purposes of 1422, we will not be targeting schools as demonstrated in this strategy.</i></b>	Promote resources available to schools to improve the quality of PE programs.
	Develop online training materials on comprehensive physical education/physical activity programs in partnership with the MSBA.
	Develop resource lists of evidence-based programs to increase PA in school settings.
	Partner with Missouri Association of Health, Physical Education, Recreation and Dance (MOAPHERD) to provide regional trainings on the Physical Education Curriculum Analysis Tool (PECAT).
<b>Strategy 3: <i>Promote the adoption of physical activity (PA) in early care and education (ECE) and worksites</i></b>	Promote adoption of MObve Smart Guidelines through partner communications. Develop online training and resource materials to support adoption of guidelines.
	Identify and establish baseline data for workplace PA programs. Develop week-long worksite PA intervention designed to promote adoption of PA and pilot the intervention and establish partnership with Society of Human Resource Managers and other stakeholders that support worksite wellness.

**Current Activities under FOA 1305:**

**Domain 3 and 4 Basic**

<b>Strategy</b>	<b>Activity</b>
<b><i>Strategy 4: Promote reporting of blood pressure and A1C measures; and, as able, initiate activities that promote clinical innovations, team-based care, and self-monitoring of blood pressure</i></b>	Collect statewide registry data through a data warehouse for CHCs including NQF18 and NQF59. And to conduct quality improvement projects based on the registry data.
	Collaborate with Million Hearts state partners to implement registry based quality improvement aimed at improving ABCs including NQF18 and NQF59. Key strategy is utilization of physician champions to use ABCs and promote their use with their peers. They are required to implement clinical decision support software to monitor ABCs.
	Develop a scope of work for a contract for a 1) compendium of resources and tools, 2) a template for training for team care members, and 3) pilot with a target audience to assist in the implementation of PCMH at local clinics with the Heart Disease Partnership. Contract to be awarded for year two. In future years these tools will be used by practices and implementation teams to help them become PCMH.
<b><i>Strategy 5: Promote awareness of high blood pressure among patients</i></b>	Work with rural health clinics associated with health systems to embed clinical guidelines for managing high blood pressure into the delivery system in order to avoid missed opportunities to accurately diagnose, treat and follow-up with patients with high blood pressure through use of health information technology
<b><i>Strategy 6: Promote awareness of prediabetes among people at high risk for type 2 diabetes</i></b>	Convene current partners and recruit new partners to establish a committee through the Missouri Diabetes Council to address prediabetes.
<b><i>Strategy 7: Promote participation in ADA-recognized, AADE-accredited, state-accredited/certified, and/or Stanford licensed diabetes self-management education (DSME) programs</i></b>	Missouri Arthritis and Osteoporosis Program (MAOP) will establish partnerships with ten Area Agencies on Aging (AAA), through the Aging Network, and two Regional Arthritis Centers (RAC) regions and public/private insurers to deliver and/or make referrals to Diabetes Self-Management Program (DSMP). MAOP will ensure partnership with ADA and/or AADE to maximize outcome.

**Current Activities under FOA 1305:**

**Domain 2 Enhanced**

<b>Strategy</b>	<b>Activity</b>
<p><b>Strategy 1: Increase Access to healthy foods and beverages</b></p> <p><i>Intervention: Provide access to healthier food retail</i></p>	<p>Host webinar to disseminate findings of rural grocery survey and identify needs for additional TA among communities/stakeholders.</p>
	<p>Develop implementation tools and training materials for healthier retail interventions.</p>
<p><b>Strategy 2: Implement food service guidelines/nutrition standards where foods and beverages are available. Guidelines and standards should address sodium.</b></p>	<p>Develop contract to support UME Eat Smart in Parks implementation in at least three park systems.</p>
	<p>Identify at least three park systems for targeted training and TA. Provide training and technical assistance to targeted park concessionaires.</p>
	<p>Develop point of purchase materials and other marketing items.</p>
<p><b>Strategy 3: Create supportive nutrition environments in schools</b></p>	
<p><b>Strategy 4: Increase physical activity access and outreach</b></p> <p><i>Intervention: Design streets and communities for physical activity</i></p>	<p>Complete invitation for bid to identify contractor to conduct training and TA for RPCs.</p>
	<p>Develop and conduct training for RPCs.</p>
	<p>Identify data sources and establish baseline measures for transportation master plans.</p>
<p><b>Strategy 5: Implement physical activity in early care and education</b></p>	<p>Plan and deliver training of trainers for I am Moving, I am Learning (IMIL) and conduct IMIL training for child care providers.</p>
	<p>Pilot onsite coaching program for four child care providers to achieve MOve Smart status.</p>
	<p>Develop peer to peer mentoring network of trained IMIL centers including regular communication via emails, newsletters and conference calls.</p>
<p><b>Strategy 6: Implement quality physical education and physical activity in K-12 schools</b></p>	<p>Complete orientation training with target LEAs.</p>

	Conduct School Health Index (SHI) and develop action plan with targeted schools. Provide training and TA based on plans.
	Develop and disseminate a fact sheet on the status of physical activity/physical education in MO schools.
	Review available youth advocacy program models focused on PA/nutrition and develop implementation plan for year two.
<b>Strategy 7: Increase access to breastfeeding friendly environments</b>  <b>Intervention: Ensure workplace compliance with federal lactation accommodation law</b>	Identify data source and baseline data--Conduct a statewide assessment of workplace lactation support practices and develop breastfeeding friendly workplace award.
	Offer stipends to 40 employers to make accommodations for breastfeeding employees.
	Conduct outreach to local health educators about the use of award materials.
	Identify data source and baseline data--Conduct a statewide assessment of workplace lactation support practices.

### Current Activities under FOA 1305:

#### Domain 3 Enhanced

Strategy	Activity
<b>Strategy 1: Increase implementation of quality improvement processes in health systems</b>  <b>Intervention: Increase electronic health record (EHR) adoption and the use of health information technology (HIT) to improve performance</b>	Contract with MPCA by November 1, 2013. To collect statewide registry data through a data warehouse for CHCs including NQF18 and NQF59. Conduct quality improvement projects based on the registry data.
	Provide technical assistance at site visits with CHC contractors working on quality improvement projects related to NQF18 and NQF59.
	Collaborate with Million Hearts state partners to implement registry based quality improvement aimed at improving ABCs including NQF18 and NQF59. Key strategy is utilization of physician champions to use ABCs and promote their use with their peers. They are required to implement clinical decision support software to monitor ABCs.

<p><b>Strategy 2: Increase implementation of quality improvement processes in health systems</b>  <b>Intervention: Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider and system level</b></p>	<p>Collaborate with Million Hearts state partners to create a template to implement registry based quality improvement aimed at improving ABCs at small practices including NQF18 and NQF59. Key strategy is utilization of physician champions to use ABCs and promote their use with their peers. They are required to implement clinical decision support software to monitor ABCs.</p>
<p><b>Strategy 3: Increase use of team-based care in health systems</b>  <b>Intervention: Increase engagement of non-physician team members (i.e., nurses, pharmacists and patient navigators) in hypertension (HTN) and diabetes management in health care systems</b></p>	<p>Develop a Pharmacy Pilot to add a pharmacist as a part of the care team at the CHC. During the first grant year ending June 2014, MAP will collaborate with MPCA, interested CHCs, and DHSS evaluation staff to develop a plan for a new pharmacy pilot project. The project is designed to enhance the CHC team-based patient care approach by including pharmacists on the care teams focused on improving blood pressure and A1C control. The first grant year is the planning stage. The planning stage will consist of a collaboration using email, conference calls and face-to-face meetings focused on identifying FQHC pilot participants, pilot goals, guidance and expectations.</p>
	<p>Develop a scope of work for a contract for a 1) compendium of resources and tools, 2) a template for training for team care members, and 3) pilot with a target audience to assist in the implementation of PCMH at local clinics with the Heart Disease Partnership. Contract to be awarded for year two. In future years these tools will be used by practices and implementation teams to help them become PCMH.</p>

**Current Activities under FOA 1305:**

**Domain 4 Enhanced**

Strategy	Activity
<p><b>Strategy 2: Increase use of lifestyle intervention programs in community settings for the primary prevention of type 2 diabetes</b></p>	<p>Contact MCHCP to facilitate consideration of adding coverage for CDC-Recognized Diabetes Prevention Programs (RDPP) as a health insurance benefit for state workers.</p>
	<p>Work with health insurance providers to obtain coverage for CDC-RDPP.</p>
	<p>Partner with existing RDPPs to connect them with new health insurance providers.</p>
	<p>Use the State's social media tools to raise awareness about diabetes prevention, sites offering RDPPs, and guidance on enrollment.</p>
	<p>Set meetings with RDPPs and health insurance providers and health care providers to increase RDPP referrals from health care providers.</p>
	<p>Conduct Radio and Billboard media campaign to promote RDPPs to public as a solution for those at-risk for diabetes.</p>

<p><b>Strategy 3: Increase use of health care extenders in the community in support of self-management of high blood pressure and diabetes</b></p> <p><b>Intervention: Increase the engagement of community health workers (CHWs) in the provision of self-management programs and on-going support to adults with diabetes</b></p>	<p>Educate health care providers through their respective associations on the impact CHWs may have on the improvement of patient outcomes as a connector between DSME programs and health systems.</p>
	<p>Conduct an assessment to determine location, number and roles of CHWs involved in client education for high blood pressure management and DSME for diabetic clients. Based on the assessment, MAP will identify communities to be pilot projects for CHWs engaged in the provision of self-management programs and on-going support for adults with diabetes.</p>
	<p>CHWs will be provided tools and resources to educate clients who are non-diabetic but have been diagnosed hypertensive about the importance of self-management and steps to take to reduce high blood pressure. CHWs will be provided information on the Road to Health Toolkit developed by the National Diabetes Education Program as well as CDC and American Heart Association resources on high blood pressure and diabetes.</p>
	<p>CHWs will provide education to participants on the impact of healthy eating and exercise education will be provided for self-management of high blood pressure. CHWs will also be trained on how to provide support to the target population they work with to overcome economic, environmental and social barriers that can make lasting behavior change difficult.</p>
	<p>Conduct an assessment to determine location, number and roles of CHWs involved in client education for high blood pressure management and DSME for diabetic clients. Based on the assessment, MAP will identify communities to be pilot projects for CHWS engaged in the provision of self-management programs and on-going support for adults with diabetes.</p>
<p><b>Strategy 4: Increase use of chronic disease self-management programs in community settings</b></p>	<p>Missouri Arthritis and Osteoporosis Program (MAOP) will establish partnerships with ten Area Agencies on Aging (AAA), through the Aging Network, and two Regional Arthritis Centers (RAC) regions and public/private insurers. The partnerships will be used to deliver and/or make referrals to Chronic Disease Self-Management Program (CDSMP).</p>
<p><b>Strategy 5: Implement policies, processes and protocols in schools to meet the management and care needs of students with chronic conditions</b></p>	<p>Identify up to 15 LEA for intervention. Same schools as Enhanced D2-S6.</p>

<p><b><i>Intervention: Identifying and tracking students with chronic conditions that may require daily or emergency management, e.g. asthma and food allergies</i></b></p>	
	<p>Draft Letter of Agreement for LEA. Outline training, TA, and support to schools. Include expectations including time for professional development and data collection.</p>
	<p>Enhance existing tracking tools on School Health1 to include additional MAP data. Train health services staff to use tracking tool.</p>
<p><b><i>Strategy 5: Implement policies, processes and protocols in schools to meet the management and care needs of students with chronic conditions</i></b></p> <p><b><i>Intervention: Developing protocols that students identified with a chronic condition that may require daily or emergency management are enrolled in private, state or federal funded insurance programs if eligible</i></b></p>	<p>Assure that targeted schools are using a health inventory form for all students that include a health condition list as well as current insurance information.</p>
<p><b><i>Strategy 5: Implement policies, processes, and protocols in schools to meet the management and care needs of students with chronic conditions</i></b></p> <p><b><i>Intervention: Providing assessment, counseling and referrals to community-based medical care providers for students on activity, diet, and weight-related chronic conditions</i></b></p>	<p>Provide TA/Consultation to School Health Advisory Committees (SHAC) to identify community based providers for referrals related to activity, diet and weight related chronic conditions.</p>