

Workplan – September 30, 2014 – September 29, 2015

| Expected Outcome(s) for the Project Period | | | | |
|---|--|--|---|------------------------|
| <ul style="list-style-type: none"> • Reduce death and disability due to diabetes, heart disease and stroke in implementation area • Reduce the prevalence of obesity in implementation area | | | | |
| WORKPLAN -- COMPONENT 1: Environmental strategies to promote health and support and reinforce healthful behaviors | | | | |
| Program Strategies | Performance Measures | Data Source | Target | Timeframe |
| 1. Implement food and beverage guidelines including sodium standards in public institutions, worksites and other key locations such as hospitals | <ul style="list-style-type: none"> • # of community locations that implement nutrition/beverage standards • # of adults with access to community locations that implement nutrition/beverage standards • Consumption of fruits, vegetables, healthy beverages | <ul style="list-style-type: none"> • Subawardee Quarterly Program Reports (SQPR), CDC modified Retail Food Environment Index (mRFEI), USDA Food Atlas • SQPR • Purchase data for participating venues from SQPR | <ul style="list-style-type: none"> • 20% ↑ in locations implementing standards • 20% ↑ in adults with access to community locations • 2% ↑ in fruit, vegetable, & healthy beverage consumption | Q1-Q4 |
| Activities | | | Person Responsible | Completion Date |
| Join “Building Healthy Academic Communities” collaborative and engage in implementing healthy food and beverage guidelines in the university setting (state and subawards) | | | Ashley Davis | Q3 |
| Expand collaboration with Ohio Hospital Association’s (OHA) Foundation for Healthy Communities to implement Good4You food and beverage standards in hospitals across the state (state and subawards) | | | Ashley Davis | Q4 |
| Expand collaboration with YMCAs to implement food and beverage guidelines, specifically Water First for Thirst messaging and guidelines (state and subawards) | | | Nutrition and Food Access Coordinator (NFAC) | Q4 |
| Work with local libraries, parks and recreation, city and county buildings to implement healthy food and beverage guidelines, specifically Water First for Thirst messaging and guidelines (subawards) | | | NFAC | Q4 |
| Program Strategies | Performance Measures | Data Source | Target | Timeframe |
| 2. Strengthen healthier food | • # retail venues that promote | • SQPR, mRFEI, USDA | • ↑ of 1 retailer in | Q1-Q4 |

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| <p>access and sales in retail venues and community venues through increased availability, improved pricing, placement, and promotion</p> | <p>healthier food access</p> <ul style="list-style-type: none"> • # community venues that promote healthier food access • # adults with access to retail venues that promote healthier food access • # adults with access to community venues that promote healthier food access • Consumption of fruits and vegetables | <p>Food Atlas</p> <ul style="list-style-type: none"> • SQPR, mRFEI, USDA Food Atlas • SQPR • SQPR • Purchase data for participating venues from SQPR | <p>each subaward community that promote healthier food access</p> <ul style="list-style-type: none"> • 20% ↑ in community venues that promote healthier food access • 20% ↑ in adults with retail access that promote healthier food access • 20% ↑ in adults with community access that promote healthier food access • 2% ↑ in fruit and vegetable consumption | |
| Activities | | | Person Responsible | Completion Date |
| Develop relationships with regional foodbanks and create an action plan to develop a “Healthy Food Bank Hub” system in Ohio (state) | | | Ashley Davis | Q3 |
| Provide technical assistance and marketing materials with the Ohio healthy corner store “brand” to implement healthy corner stores using the behavioral economics model (state and subawards) | | | NFAC | Q3 |
| Expand opportunities with established partners such as The Finance Fund to create a healthy food financing fund in Ohio (state) | | | Ashley Davis | Q4 |
| Implement healthy checkout lanes (retail venue) using behavioral economics strategies | | | NFAC | Q4 |

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| (subawards) | | | | |
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| Implement healthy Client Choice Food Pantries (community venue) through placement and promotion of healthy foods (subawards) | | | NFAC | Q4 |
| Program Strategies | Performance Measures | Data Source | Target | Timeframe |
| 3. Strengthen community promotion of physical activity (PA) through signage, worksite policies, social support, and joint-use agreements in communities and jurisdictions | <ul style="list-style-type: none"> • # and type of community venues that promote PA through signage, worksite policies and shared-use/joint use agreements • # of adults who have access to community venues that promote PA • # of adults who meet PA guidelines | <ul style="list-style-type: none"> • SQPR • SQPR • BRFS | <ul style="list-style-type: none"> • ↑ in 1 community venue promoting PA in each sub-awarded community • 20% ↑ in adults with access to community venues that promote PA • 2% ↑ in adults meeting PA guidelines | Q1-Q4 |
| Activities | | | Person Responsible | Completion Date |
| Expand collaboration with the Health Policy Institute of Ohio (HPIO) to implement joint use with hospitals and leverage hospital community benefit requirements (state) | | | Caitlin Harley | Q2 |
| Provide technical assistance on and implement joint use agreements, specifically between school districts and their respective communities/cities/counties (state and subawards) | | | Caitlin Harley | Q3 |
| Implement walking groups for social support linking walking to culture (e.g., art walks, walk with a doc, etc.) (subawards) | | | Caitlin Harley | Q3 |
| Implement free group fitness classes at parks, farmers' markets and other public spaces (subawards) | | | Caitlin Harley | Q3 |
| Develop, educate and implement worksite PA policies specific to active commuting such as bike and walk-to-work infrastructure support (state and subawards) | | | Caitlin Harley Linda Scovern | Q3 |
| Post stair prompt signage at worksites, and other point of decision signage promoting walking in parks (state and subawards) | | | Caitlin Harley Linda Scovern | Q4 |
| Provide Work@Health trainings to Healthy Ohio Business Council (HOBC) members that includes | | | Linda Scovern | Q4 |

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| CDC's Worksite Health Scorecard to assess pre- and post-worksite wellness programs (state and subawards) | | | | |
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| Program Strategies | Performance Measures | Data Source | Target | Timeframe |
| 4. Develop and/or implement transportation and community plans that promote walking | <ul style="list-style-type: none"> • # of communities that develop and/or implement a transportation plan that promotes walking • # of adults who have access to communities that develop and/or implement plans to promote walking • # of adults who meet PA guidelines | <ul style="list-style-type: none"> • SQPR, Complete Streets Policy Inventory • SQPR • BRFSS | <ul style="list-style-type: none"> • ↑ from 12 to 15 the # of communities with Complete Streets policies • 20% ↑ in adults with access • 2% ↑ in adults meeting PA guidelines | Q1-Q4 |
| Activities | | | Person Responsible | Completion Date |
| Work with Municipal Planning Organizations (MPO), Safe Routes to School National Partnership-Ohio Network (SRTS) and city/county planning departments to provide technical assistance on adoption and implementation of Complete Streets policies in high need areas (state and subawards) | | | Caitlin Harley | Q4 |
| Work with local MPOs and city/county planning to provide technical assistance on adoption and implementation of inclusion of bike and pedestrian infrastructure into master transportation plans (state and subawards) | | | Caitlin Harley | Q4 |
| COMPONENT 1: Strategies to build support for lifestyle change, particularly for those at high risk, to support diabetes and heart disease and stroke prevention efforts | | | | |
| Program Strategies | Performance Measures | Data Source | Target | Timeframe |
| 5. Plan and execute strategic data-driven actions through a network of partners and local organizations to build support for lifestyle change. | <ul style="list-style-type: none"> • # of unique sectors represented in the network • Annual participation/response rate of network partners in network self-assessments • # of persons with prediabetes or | <ul style="list-style-type: none"> • SQPR • Lifestyle Change Network (LCN) assessment results • CDC Diabetes Prevention | <ul style="list-style-type: none"> • ↑ to 5 unique sectors represented • ↑ to 75% the rate of partners participating in self-assessment | Q1-Q4 |

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| | at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program | Recognition Program (DPRP) reports | • 5% ↑ in Diabetes Prevention Program (DPP) enrollment | |
| Activities | | | Person Responsible | Completion Date |
| Recruit and convene a statewide Lifestyle Change Network (LCN) of unique partners to build support for DPP (state) | | | Linda Scovern | Q2 |
| Engage the LCN to create a plan to increase referrals and build support for DPP (state) | | | Linda Scovern | Q3 |
| Use tools from “Coalitions Work!” to conduct an assessment of the LCN (state) | | | Linda Scovern | Q3 |
| Identify community stakeholders and partners to connect lifestyle change programs to healthcare systems and engage community members (subawards) | | | Linda Scovern | Q3 |
| Promote awareness of and enrollment in DPP through insurance companies, AAAs, parks and recreation, senior centers, and faith-based organizations (subawards) | | | Linda Scovern | Q4 |
| Program Strategies | Performance Measures | Data Source | Target | Timeframe |
| 6. Implement evidence-based engagement strategies to build support for lifestyle change | <ul style="list-style-type: none"> • # of people reached through evidence-based engagement strategies • # of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program | <ul style="list-style-type: none"> • SQPR • CDC DRPR reports | <ul style="list-style-type: none"> • ↑ to 5,000 # of people reached • 5%↑ in DPP enrollment | Q1-Q4 |
| Activities | | | Person Responsible | Completion Date |
| Work with the state employees wellness program provider, Healthways, to develop targeted communications and an incentive program for state employees with prediabetes to direct them to DPP (state) | | | Linda Scovern, Eric Greene | Q2 |
| Provide technical assistance on utilization of evidence-based engagement strategies to enroll priority populations in DPP using social marketing principles and tools (state and subawards) | | | Eric Greene | Q3 |
| Work with benefit providers/employers to develop targeted communications to high-risk employees using engagement strategies, such as utilizing social media to direct employees to DPP (subawards) | | | Linda Scovern, Eric Greene | Q4 |

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| Program Strategies | Performance Measures | Data Source | Target | Timeframe |
|---|---|--|--|-----------------|
| 7. Increase coverage for evidence-based supports for lifestyle change by working with network partners | <ul style="list-style-type: none"> • # of employees with prediabetes or at high risk for type 2 diabetes who have access to evidence-based lifestyle change programs as a covered benefit • # of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program | <ul style="list-style-type: none"> • Benefit provider data • CDC DRPR reports | <ul style="list-style-type: none"> • Maintain # of employees with access • 5%↑ in DPP enrollment | Q1-Q4 |
| Activities | | | Person Responsible | Completion Date |
| Develop and present education to employers through the 7 regional HOBcs about the return on investment of DPP as a covered benefit (state and subawards) | | | Linda Scovern | Q4 |
| Work with the Ohio Department of Administrative Services (DAS) to extend coverage for DPP to state employees covered through Medical Mutual insurance (state) | | | Linda Scovern | Q4 |
| Work with the Ohio Department of Aging (ODA) to gain reimbursement of DPP for Ohio Public Employee Retirement System members with non-Medicare coverage (state) | | | Linda Scovern | Q4 |
| WORKPLAN: COMPONENT 2: Health System Interventions to Improve the Quality of Health Care Delivery to Populations with the Highest Hypertension and Prediabetes Disparities | | | | |
| Program Strategies | Performance Measures | Data Source | Target | Timeframe |
| 1. Increase electronic health records (EHR) adoption and the use of health information technology (HIT) to improve performance | <ul style="list-style-type: none"> • % patients within healthcare systems with EHR appropriate for treating patients with high blood pressure (HBP) • Proportion of adults with HBP in adherence to medication regimens | <ul style="list-style-type: none"> • Ohio Health Systems Survey (OHSS) • BRFSS | <ul style="list-style-type: none"> • 1% ↑ in # of patients within systems that have EHR appropriate for treating HBP • 2% ↑ in adults in adherence | Q1-Q4 |
| Activities | | | Person Responsible | Completion Date |

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| Work with partners to identify Patient-Centered Medical Home (PCMH) and large family medicine practices in subaward communities that have Certified Electronic Health Record Technology (CEHRT) (state) | | | Clinical Systems Coordinator (CSC) | Q2 |
|---|---|--|--|-----------------|
| Develop and administer the OHSS to identified practices to determine information including brand of CEHRT, registry capability, and if practices are reporting at Meaningful Use Stage 1 or 2 (state) | | | Chronic Disease (CD) Epidemiologist | Q2 |
| Analyze the OHSS to identify practices with CEHRT capable of HBP management (state) | | | CD Epidemiologist | Q3 |
| Use OHSS results to recruit practices to establish local HTN Collaboratives (subawards) | | | CSC | Q4 |
| Work with Ohio Quality Improvement Network (QIN) to provide training to identified practices on creating patient registries for HBP (state and subawards) | | | CSC | Q4 |
| Program Strategies | Performance Measures | Data Source | Target | Timeframe |
| 2. Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider level | <ul style="list-style-type: none"> • % of persons within healthcare systems with systems to report standardized clinical quality measures for the management and treatment of patients with HBP • Proportion of adults with HBP in adherence to medication regimens | <ul style="list-style-type: none"> • OHSS • BRFS | <ul style="list-style-type: none"> • 1% ↑ in persons within systems that have EHR appropriate for reporting HBP quality measures • 2% ↑ in adults in adherence | Q1-Q4 |
| Activities | | | Person Responsible | Completion Date |
| Collaborate with the Ohio Academy of Family Physicians (OAFP) to develop and conduct a <i>Team Training Day</i> for PCMH and family medicine practices participating in the HTN Collaboratives in 1422 subaward communities (state and subawards) | | | CSC | Q3 |
| Work with Ohio QIN to provide technical assistance to providers on creating patient registries to identify African American patients in their practices with undiagnosed/uncontrolled HBP (state and subawards) | | | CSC | Q3 |
| Provide technical assistance to subawards on cultural sensitivity, and dissemination and implementation of <i>Check it. Change it. Control it. Your Heart Depends on It.</i> Toolkit for African | | | Community Systems Coordinator (CoSC) | Q4 |

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| Americans (state) | | | | |
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| Program Strategies | Performance Measures | Data Source | Target | Timeframe |
| 3. Increase engagement of non-physician team members in HTN management in community healthcare systems | <ul style="list-style-type: none"> • % of patients within healthcare systems with policies or systems to encourage a multi-disciplinary team approach to blood pressure control • Proportion of adults with HBP in adherence to medication regimens | <ul style="list-style-type: none"> • OHSS • BRFSS | <ul style="list-style-type: none"> • 1% ↑ in patients within systems that encourage a multi-disciplinary team approach to HBP control • 2% ↑ in adults in adherence | Q1-Q4 |
| Activities | | | Person Responsible | Completion Date |
| Analyze the OHSS to determine where Community Health Workers (CHW) are employed in 1422 subaward communities and their level of integration into the healthcare team (state) | | | CD Epidemiologist | Q2 |
| Establish a collaborative consisting of representatives from the Ohio CHW Association (OCHWA) and the six certified CHW training programs (state and subawards) | | | Heart Disease & Diabetes Prevention Manager | Q3 |
| Assess curriculums of CHW training programs and existing reimbursement mechanisms to determine the need for and availability of training for new and existing CHWs in HBP and prediabetes/diabetes management (state) | | | CoSC | Q3 |
| Develop a sustainability plan for expanding CHW utilization in HBP and prediabetes/diabetes management (state) | | | CoSC | Q4 |
| Develop online training modules to integrate CHWs into community-based efforts to prevent and manage HBP and prediabetes/diabetes in 1422 communities (state) | | | CoSC | Q4 |
| Program Strategies | Performance Measures | Data Source | Target | Timeframe |
| 4. Increase use of self-measured blood pressure (SMBP) monitoring tied with clinical support | <ul style="list-style-type: none"> • % of patients within healthcare systems with policies or systems to encourage SMBP • Proportion of patients with HBP that have a self-management plan | <ul style="list-style-type: none"> • OHSS • BRFSS | <ul style="list-style-type: none"> • 1% ↑ in patients within systems that have SMBP policies/systems • 2% ↑ in adults with HBP that have a | Q1-Q4 |

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| | | | self-management plan | |
| Activities | | | Person Responsible | Completion Date |
| Work with the Ohio BRFSS to add SMBP questions to the 2015 BRFSS questionnaire to determine prevalence (state) | | | CD Epidemiologist | Q1 |
| Analyze the OHSS to determine the policies or systems that encourage SMBP (state) | | | CD Epidemiologist | Q2 |
| Assess Medicaid Managed Care plans for blood pressure equipment reimbursement policies (state) | | | CSC | Q2 |
| Develop messages and identify dissemination channels to promote SMBP to providers and patients in subaward communities (state and subawards) | | | Eric Greene | Q3 |
| Compile and disseminate resources (e.g. American Heart Association’s <i>HEART 360, Check it. Change it.</i> smartphone app for recording blood pressure readings, etc.) to healthcare providers that support and encourage SMBP (state and subawards) | | | CSC | Q4 |
| Program Strategies | Performance Measures | Data Source | Target | Timeframe |
| 5. Implement systems to facilitate identification of patients with undiagnosed HTN and people with prediabetes | <ul style="list-style-type: none"> • % of patients within health-care systems with policies or systems to facilitate identification of patients with undiagnosed HTN and people with prediabetes • Proportion of adults with HBP in adherence to medication regimens • # of persons with prediabetes or at high risk of type 2 diabetes who enroll in a CDC-recognized lifestyle change program | <ul style="list-style-type: none"> • OHSS • BRFSS • CDC DPRP reports | <ul style="list-style-type: none"> • 1% ↑ in patients within systems that have policies/systems to identify undiagnosed HTN and prediabetes • 2% ↑ in adults in adherence • 5%↑ in persons enrolled in DPP | Q1-Q4 |
| Activities | | | Person Responsible | Completion Date |

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| Analyze the OHSS to determine the policies and procedures practices have in place to identify patients with undiagnosed HTN and people with prediabetes (state) | CD Epidemiologist | Q2 | | |
| Work with Ohio QIN to provide technical assistance to providers on developing EHR registries to identify patients in their practices with undiagnosed HTN and prediabetes (state) | CSC | Q3 | | |
| Work with partners to develop provider resources and DPP referral protocols for patients with prediabetes (state and subawards) | CSC | Q3 | | |
| Develop messages and identify dissemination channels to inform providers and promote DPPs to patients in subaward communities (state and subawards) | Eric Greene | Q3 | | |
| Identify and recruit existing DPPs and American Association of Diabetes Educators/American Diabetes Association programs in subaward communities that are interested in becoming CDC-recognized DPPs (state and subawards) | CoSC | Q4 | | |
| COMPONENT 2: Community Clinical Linkage Strategies to Support Heart Disease and Stroke and Diabetes Prevention Efforts | | | | |
| Program Strategies | Performance Measures | Data Source | Target | Timeframe |
| 6. Increase engagement of CHWs to promote linkages between health systems and community resources for adults with HBP and adults with prediabetes or at high risk for type 2 diabetes | <ul style="list-style-type: none"> • # of health systems that engage CHWs to link patients to community resources that promote self-management of HBP and prevention of type 2 diabetes • Proportion of adults with HBP in adherence to medication regimens • Proportion of patients with HBP that have a self-management plan • # of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program | <ul style="list-style-type: none"> • OHSS • BRFSS • BRFSS • CDC DPRP reports | <ul style="list-style-type: none"> • 1% ↑ in # of health systems that link patients to community resources • 2% ↑ in adults in adherence • 2% ↑ in adults with HBP self-management plan • 5% ↑ in persons enrolled in DPP | Q1-Q4 |
| Activities | | Person Responsible | Completion | |

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| | | | Date | |
|---|--|--|--|-----------|
| Analyze the OHSS to identify health care systems with CHWs (state) | | CD Epidemiologist | Q2 | |
| Contact community-based agencies in the subaward communities that currently employ CHWs to determine populations reached and health conditions addressed (subawards) | | CoSC | Q3 | |
| Identify community resources available for people with HTN, prediabetes and those at risk of type 2 diabetes (subawards) | | CoSC | Q3 | |
| Establish quarterly meetings with CHWs in subaward communities to strengthen relationships, establish care coordination and referral processes to existing community resources (subawards) | | CoSC | Q4 | |
| Provide training and technical assistance to CHWs, including resources such as the CDC <i>Community Health Workers Sourcebook</i> , to build capacity for addressing HTN and prediabetes in high-need populations (state and subawards) | | CoSC | Q4 | |
| Program Strategies | Performance Measures | Data Source | Target | Timeframe |
| 7. Increase engagement of community pharmacists in the provision of medication-/self-management for adults with HBP | <ul style="list-style-type: none"> • # community pharmacists that promote medication/self-management • Proportion of adults with HBP in adherence to medication regimens • Proportion of patients with HBP that have a self-management plan | <ul style="list-style-type: none"> • Ohio Pharmacists Association (OPA) • BRFSS • BRFSS | <ul style="list-style-type: none"> • 5% ↑ of pharmacists that promote medication/self-management • 2% ↑ in adults in adherence • 2% ↑ in adults with HBP self-management plan | Q1-Q4 |
| Activities | | Person Responsible | Completion Date | |
| Work with OPA to determine number and location of community pharmacies currently engaged in medication therapy management (MTM) for HBP in 1422 subaward communities (state) | | CSC | Q1 | |
| Identify community pharmacies in 1422 subaward communities who are not engaged in MTM for HBP (state) | | CD Epidemiologist | Q1 | |
| Through a competitive RFP process, fund two Ohio Colleges of Pharmacy to provide technical assistance and clinical oversight to establish MTM programs with pharmacists and healthcare systems in 1422 subaward communities (state) | | CSC | Q2 | |

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| Provide technical assistance to subawards on approaches to engage local pharmacists in MTM (state and subawards) | | | CSC | Q3 |
|---|--|--|--|-----------------|
| Recruit community pharmacies to participate in MTM that includes HBP and SMBP (subawards) | | | CSC | Q4 |
| Program Strategies | Performance Measures | Data Source | Target | Timeframe |
| 8. 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.) | <ul style="list-style-type: none"> • # health systems with an implemented community referral system for evidence-based lifestyle change programs • # persons with HBP who enroll in an evidence-based lifestyle change program • # persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program | <ul style="list-style-type: none"> • OHSS • CDC DPRP reports • CDC DPRP reports | <ul style="list-style-type: none"> • ↑ by 1 the # of systems with referral systems in each subaward community • 5% ↑ in persons with HBP enrolled • 5% ↑ in persons with prediabetes/at risk type 2 diabetes enrolled | Q1-Q4 |
| Activities | | | Person Responsible | Completion Date |
| Determine if bi-directional referral systems exist for lifestyle change programs in 1422 subaward communities (subawards) | | | CoSC | Q2 |
| Provide technical assistance to 1422 subaward communities on establishing bi-directional referral systems for lifestyle change programs (state) | | | CoSC | Q2 |
| Establish care coordination protocols and processes that community agencies and providers can use to refer patients to lifestyle change programs (subawards) | | | CoSC | Q3 |
| Provide 2-1-1 systems serving 1422 subaward communities information on lifestyle change programs in their area and establish a bi-directional referral system (subawards) | | | CoSC | Q3 |
| Develop social marketing strategies to identify messages and dissemination channels to increase awareness of prediabetes among patients and providers (state) | | | Eric Greene | Q4 |