1422 Example: Mutually Reinforcing Strategies—PART A

Description: The state sub-awardee is the county health department. The priority population is represented by Mr. Oliver (i.e., low socioeconomic status (SES), Medicaid beneficiary, and low-income area). Mutual reinforcing strategies work together and support each other to strengthen the desired health outcomes both in the general and priority populations. Note: Sub-awardees may also be health districts or community-based organizations.

Strategy	State Activity	Priority Population Activity
1.6—Implement evidence-based engagement strategies to build support for lifestyle programs.	Develop marketing and media campaign materials to assist the county health department and other local health care providers with support from the CDC-recognized diabetes prevention program providers and hypertension self-management programs—specifically in low-income areas.	The county health department educates local Federally Qualified Health Centers (FQHCs) and other local health care providers on how to (1) identify and refer patients with prediabetes and hypertension for enrollment in a CDC-recognized diabetes prevention program and hypertension self-management program, (2) work with one or more CDC-recognized diabetes prevention program providers to address barriers to care (e.g., transportation), and (3) increase awareness of local healthy food retail venues in low-income areas.
2.4—Increase the use of self-measured blood pressure monitoring tied with clinical support.	Provide training and technical assistance to the county health department on organizational policy development, standardized protocols, and clinic design for self-measured blood pressure. Work with the county health department to develop materials to present to Medicaid Managed Care Organizations (MCOs) to cover costs for home blood pressure monitoring.	The county health department provides technical assistance to FQHCs and other local health care providers related to self-measured blood pressure monitoring, including protocol development and workflow. In addition, the county health department works with Medicaid MCOs to cover costs for home blood pressure monitoring.
1.2—Strengthen healthier food access and sales in retail and community venues through increased availability and improved pricing, placement, and promotion.	In coordination with the state's healthy retail program, collect information to develop a database and educational materials for food banks and retail venues that accept WIC/SNAP (Women, Infants, & Children/Supplemental Nutrition Assistance Program) for dissemination to the county health department and local health care providers.	The county health department tailors educational materials and conducts workshops for local retail owners accepting WIC/SNAP in low-income areas to (1) increase participation in statewide healthy retail programs; (2) create awareness of cardiovascular disease, diabetes, and obesity in low-income areas; and (3) create awareness of CDC-recognized diabetes prevention programs and hypertension self-management programs. Local health care providers refer patients to these prevention and self-management programs and to healthy food retail venues.

1422 Example: Mutually Reinforcing Strategies—PART B

Description: Strategies 1.6, 2.4, and 1.2 work to link individuals with hypertension, prediabetes, and food insecurity issues to hypertension self-management programs, CDC-recognized diabetes prevention programs, and healthy food retail venues.

General Population

State-Level Activities

1.6: Marketing and media campaign materials to increase awareness of and enrollment in CDC-recognized diabetes prevention programs and hypertension self-management programs in low-income areas.

2.4: Training and technical assistance on organizational policy development, protocols, and clinic design for self-measured blood pressure.

1.2: Database and educational materials on healthy retail venues that accept WIC/SNAP to support activities that increase awareness in low-income areas.

1422 Strategies

- ✓ 1.6
- ✓ 2.4
- ✓ 1.2

State-level activities support local efforts

Priority Population

Local-Level Activities

1.6: Mr. Oliver, a Medicaid beneficiary, has a doctor's appointment at an FQHC near his home. He learned about this clinic from a marketing campaign at the Medicaid office in the county health department.

DIABETES & HYPERTENSION PREVENTION PROGRAMS

2.4: During his appointment, he received information on a local CDC-recognized diabetes prevention program and a self-management plan, inclusive of clinical support, for his prediabetes and high blood pressure. His plan included a home blood pressure monitor covered by Medicaid.

1.2: During his appointment, Mr. Oliver also received information about the grocery store that accepts WIC/SNAP and is located near the clinic. The grocery store is part of a healthy retail program that gives him access to more affordable, healthier foods recommended by the CDC-recognized diabetes prevention program.

Mutually reinforcing strategies

Mr. Oliver's first CDC-recognized diabetes prevention program and self-measured blood pressure follow-up are scheduled for the following week.

He now has the resources necessary to help him manage his prediabetes and hypertension and engage in a healthier lifestyle.

DESIRED OUTCOMES

DUAL APPROACH