Nebraska Chronic Disease Prevention & Control Program

The Chronic Disease Prevention & Control Program is funded through two grants from the Centers for Disease Control & Prevention (CDC). The program focuses on healthy environments in workplaces, schools, early childhood education facilities, and in the community. It also focuses on working through health systems and communities to reduce complications from multiple chronic diseases such as diabetes, heart disease, and stroke. The goal of the program is to make healthy living easier for all Americans.

One of the CDC grants requires that the program subaward a majority of the funds to communities to contribute to the work and to enhance capacity of these agencies to carry out grant related work (excluding activities listed in red font below). The program suabawards a total of $1,800,000 to six local health departments including Douglas County Health Department, Public Health Solutions, South Heartland District Health Department, Central District Health Department, Two Rivers Public Health Department, and Panhandle Public Health District.

The program focuses work in four areas:

1. Epidemiology, surveillance, and evaluation to inform, prioritize, and monitor diseases and risk factors and the delivery of interventions.
2. Environmental strategies that reinforce healthful behaviors and expand access to healthy choices.
3. Health systems interventions to improve the delivery and use of clinical and other preventive services.
4. Clinical and community linkages to better support chronic disease self-management.

The CDC grants have three short-term goals:

1. Improve environments in worksites, schools, early childhood education services, state and local government agencies, and community settings to promote healthy behaviors. Also, to expand access to healthy choices for people of all ages related to diabetes, cardiovascular health, physical activity, healthy foods and beverages, obesity, and breastfeeding.
    1. Strategies to Accomplish this Goal
        1. Increase access to healthy foods and beverages
        2. Implement food service guidelines/nutrition standards where foods and beverages are available. Guidelines and standards should address sodium.
        3. Create supportive nutrition environments in schools
        4. Increase physical activity access and outreach
        5. Implement physical activity in early care and education
        6. Implement quality physical education and physical activity in K-12 schools
        7. Increase access to breastfeeding friendly environments

2. Improve the delivery and use of quality clinical and other health services aimed at preventing and managing high blood pressure and diabetes.
    1. Strategies to Accomplish this Goal
        1. 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.
        2. Promote awareness of high blood pressure among patients
        3. Increase implementation of quality improvement processes in health systems
            1. Increase electronic health records (EHR) adoption and the use of health information technology (HIT) to improve performance
            2. Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider and systems level
        4. Increase use of team-based care in health systems
            1. Increase the engagement of non-physician team members (i.e. nurses, pharmacists, and patient navigators) in hypertension (HTN) and diabetes management in health care systems
            2. Increase the use of self-measured blood pressure monitoring tied with clinical support

3. Increase links between community and clinical organizations to support prevention, self-management and control of diabetes, high blood pressure, and obesity.
    1. Strategies to Accomplish this Goal
        1. Increase access, referrals, and reimbursement for AADE-accredited, ADA-recognized, or Stanford-licensed DSME programs
        2. Increase referrals to, use of, and/or reimbursement for CDC recognized lifestyle change programs for the prevention of type 2 diabetes
        3. Increase use of health-care extenders in the community in support of self-management of high blood pressure and diabetes
            1. Increase engagement of community health workers (CHWs) in the provision of self-management programs and on-going support for adults with high blood pressure and adults with diabetes
            2. Increase engagement of CHWs to promote linkages between health systems and community resources for adults with high blood pressure and adults with diabetes
            3. Increase engagement of community pharmacists in the provision of medication-/self-management for adults with high blood pressure and adults with diabetes
        4. Increase access to and use of Chronic Disease Self-Management (CDSM) programs (Living Well)

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