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| **COMMUNITY HEALTH IMPROVEMENT PLAN**  **STRATEGIES TO ADDRESS CHRONIC CONDITIONS**  **(Heart Diseases, Diabetes, Chronic Kidney Disease, Cancer, and Obesity)** |
| **Desired Outcome:** Using a multifaceted approach to prevent and manage chronic conditions such as heart diseases, diabetes, chronic kidney disease, cancer, and obesity. |
| **Goals:** *(These goals are very general. Organizations are encouraged to change them as needed to meet their unique needs).*   1. Reduce the obesity in both adults and children by a certain percent in each geographic area by a specific timeframe. 2. Increase percent of individuals reporting improved physical activity per the Behavioral Risk Factor Surveillance System (BRFSS). 3. Increase the number of patients screened for chronic diseases such as heart diseases, diabetes, cancer, etc. 4. Decrease chronic diseases-related hospital visits and ED utilization. |
| **Strategy: Awareness, Education/Training, Screening and Outreach** |

| **Activity or Action** | **Internal/External Partners** | **Key Process Measures** | **Timeline** |
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| Offer free blood pressure screenings in the community to identify potential risk factors and determine the appropriate best practice approaches to prevent and manage chronic conditions such as heart diseases, diabetes, cancer, and obesity. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Statewide organizations * Regional/Community-based organizations | * Number of events held * Number of individuals screened | TBD |
| Implement diet and exercise opportunities aimed at decreasing preventable chronic diseases such as diabetes, heart disease, cancer among others. These strategies will be key in helping people manage their weight. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of diet and exercise opportunities offered * Number of participants | TBD |
| Consider utilizing the mobile mammography screenings using a bus or van in the community. (*This is specific to cancer and is contingent upon availability of the necessary resources.*) | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of screenings completed * Number of patients utilizing the mobile mammography | TBD |
| Offer extended hours outside the normal times for chronic diseases screening, i.e., mammograms imaging center, to provide the needed flexibility for patients who may be busy working when they are open during the normal hours. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of individuals accessing screening services during the extended hours | TBD |
| Implement the Chronic Care Management Program CCM. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of patients identified as eligible to participate * Number of patients recruited and actively participating in the program | TBD |
| Implement a Chronic Disease Self- Management Program that addresses self- management of chronic diseases, i.e., cardiopulmonary, cardiac nutrition.  [https://www.ncoa.org/healthy-aging/chronic-](https://www.ncoa.org/article/evidence-based-chronic-disease-self-management-education-programs)  [disease/chronic-disease-self-management-](https://www.ncoa.org/article/evidence-based-chronic-disease-self-management-education-programs)  [programs/](https://www.ncoa.org/article/evidence-based-chronic-disease-self-management-education-programs) | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of patients participating in the program | TBD |
| Promote self-management tools in patient portal to assist patients with recording self-care results such as blood pressure, blood sugar and weight. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of patients utilizing the patient portal | TBD |
| Implement Self-Measured Blood Pressure Monitoring (SMBP).<https://millionhearts.hhs.gov/files/MH_SMBP_Clinicians.pdf> | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of patients utilizing the SMBP technology | TBD |
| Work closely with organizations offering transportation services in the community to provide individuals in need of the service to and from their appointments. | * Provider organizations such as:   + Hospitals/ health systems   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of fully executed contracts with partners offering the service * Number of individuals utilizing the transportation services | TBD |
| Offer patients and families education to improve CKD awareness, prevention, and management, including organ transplant.   * Address the social determinants of health that conspire to influence progression to late-stage chronic disease, including ESRD. | * Provider organizations such as:   + Hospitals/ health systems   + Health departments   + Community health centers | * Number of patients and families offered education on CKD | TBD |
| Employ free community-based CKD screening in conjunction with other chronic disease (BP and A1C) screenings to identify individuals who may be at risk or already have kidney disease. | * Provider organizations such as:   + Hospitals/ health systems   + Health departments   + Community health centers | * Number of events held * Number of people screened for BP, A1C | TBD |
| Equip health care providers with the needed knowledge and understanding of CKD care and management guidelines through didactic education and training opportunities.   * Expand engagement of Community Health Workers and pharmacists in CKD screening and education among at-risk populations. | * Provider organizations such as:   + Hospitals/ health systems   + Health departments   + Community health centers | * Number of didactic education & training opportunities offered * Number of providers attending the sessions offered | TBD |
| Integrate CKD educational resources into primary care workflows and provide the support essential for patients with Chronic Kidney Disease. | * Provider organizations such as:   + Hospitals/ health systems   + Health departments   + Community health centers | * Number of resources shared * Number of patients provided with the necessary resources | TBD |
| Implement and promote Take Charge of Your Kidney Health, a CKD-specific Chronic Disease Self-Management Program (CDSMP), to facilitate support groups for patients with CKD. | * Provider organizations such as:   + Hospitals/ health systems   + Health departments   + Community health centers | * Successful implementation of CKD program | TBD |
| Promote the CKD ECHO series to increase provider engagement across the state. | * Provider organizations such as:   + Hospitals/ health systems   + Health departments   + Community health centers   + National Kidney Foundation   + Missouri Kidney Foundation | * Number of CKD ECHO sessions offered * Number of providers participating in the sessions | TBD |
| Evaluate patterns in CKD testing, diagnosis, and management to interpret and translate the data into actionable next steps for quality improvement.   * Properly risk stratify hypertensive and diabetic patients to assess undiagnosed CKD in at-risk populations. | * Provider organizations such as:   + Hospitals/ health systems   + Health departments   + Community health centers   + National Kidney Foundation   + Missouri Kidney Foundation | * Number of CKD testing and diagnosis | TBD |
| Implement the Kidney Profile to order the tests needs to properly detect and diagnosis kidney disease in assessing both eGFR and ACR. | * Provider organizations such as:   + Hospitals/ health systems   + Health departments   + Community health centers   + National Kidney Foundation   + Missouri Kidney Foundation | * Number of times the kidney profile to order is completed including an assessment of the eGFR and ACR | TBD |
| Identify and implement process changes, workflows, and other clinical decision support tools to increase testing, diagnosis, and management of CKD. | * Provider organizations such as:   + Hospitals/ health systems   + Health departments   + Community health centers   + National Kidney Foundation   + Missouri Kidney Foundation | * Number of CKD testing, diagnosis and management following the implementation of streamlined process | TBD |
| Ensure that providers are reminding their patients about recommended screenings for chronic diseases. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of times providers remind patients about their recommended screenings. This can also be measures as a percent of the total reminded versus total patients seen. | TBD |
| Health and wellness meetings and assessments within businesses which creates opportunities to screen more people at their convenience. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of meetings held in businesses * Number of individuals screened | TBD |
| Monthly newsletters dissemination – specifically covering information about chronic disease prevention and management. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of newsletters disseminated monthly | TBD |
| Submit grant applications to target chronic conditions such as diabetes, heart disease, cancer, obesity, among others. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of grant applications submitted * Number of grants receiving funding to address chronic conditions | TBD |
| Expansion of bike trails, sidewalks and other amenities that create a provide safe places for people to exercise. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Length of new bike trail expansion (measurement in miles) | TBD |
| Implement a comprehensive plan for exercise opportunities. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * One comprehensive plan to be completed | TBD |
| Implement a standardized tool to track non-medical social determinants of health. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of patients screened for social determinants of health | TBD |
| Implement a closed loop social referral platform in collaboration with community partners to help connect individuals with the resources sought. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of organizations participating and utilizing the same social referral platform * Number of individuals screened positive and connected with the resources sought | TBD |
| Increase physician engagement opportunities on chronic conditions. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of physicians participating in events/trainings | TBD |
| Increase marketing opportunities on chronic conditions such as diabetes, heart disease, cancer, among others | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of times resources on chronic conditions are marketed | TBD |
| Collaborate with local partners to host community wellness/fitness events and activities such as walking, running and biking for youth, adults and families at large. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of collaborating partners * Number of attendees participating in the events * Number of events held | TBD |
| Offer low-cost or free community education classes and materials on the importance of diet and exercise to prevent chronic diseases such as cancer, diabetes, heart disease, among others | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of educational events held * Number of individual participants * Number of resources shared | TBD |
| Recruit employers to offer wellness screening programs for their employees to promote health and wellness | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of employers recruited * Number of employees participating | TBD |
| Create resource guide with information about the different activities/programs in the community that address chronic diseases such as diabetes, heart disease, cancer, among others | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers   Other community-based organizations as needed | * One comprehensive and updated resource guide to be completed or updated annually | TBD |
| Create educational material content for social media campaign to bring awareness on chronic diseases such as diabetes, heart disease, cancer, among others | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of educational materials created on chronic diseases | TBD |
| Create resource cards with “quick” information about specific chronic diseases with QR code that links to more information about disease. Disseminate them strategically in different settings of care. These cards may include topics such as diabetes signs and symptoms, exercise at desk, tips for deep breathing, smoking cessation strategies, cancer screenings, among others | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of resource cards disseminated * Number of locations where the resources developed are disseminated | TBD |
| Bring awareness to issues about vaping to schools and local businesses; possibly do presentations at schools and local businesses. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of presentations offered * Number of attendees at the sessions | TBD |
| Collaborate and participate in community health fairs, coalitions, stakeholders and partnerships that are targeted towards chronic conditions. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of individuals attending the fairs * Number of individuals screened * Number of resources disseminated * Number of partners collaborating | TBD |
| Disseminate chronic disease prevention information on radio or other readily available channels. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of times information is shared on radio or other channels * Number of listeners during the session | TBD |
| Incorporate practices that promote health equity into planning and execution of strategies under chronic disease priority. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of health equity practices incorporated into the organization’s strategy * Number of metrics on health disparities, social determinants of health, etc. | TBD |
| Provide diversity and cultural competency training to providers and staff that increases awareness of health disparities in the region. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of trainings offered * Number of providers and staff participating in the training events | TBD |
| Active participation in innovative programs and pilots on chronic conditions to help reduce avoidable utilization and avoidable readmissions. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of readmissions during the baseline and intervention phases * Number of avoidable utilizations during the baseline and intervention phases * Number of pilots the organization is participating in at any given time | TBD |
| Implement and promote the CDC Diabetes Prevention Program (DPP), Diabetes Self-Management Program (DSMP) and other evidence-based programs. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of individuals participating in the DPP and DSMP program * Number of community organizations certified to offer the DPP/DSMP programs | TBD |
| Provide and enroll individuals with prediabetes in Diabetes Self-Management Education Program (DSME). <https://www.cdc.gov/learnmorefeelbetter/programs/diabetes.htm> | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of individuals enrolled in DSME programs | TBD |
| Provide and enroll individuals with prediabetes in Diabetes Empowerment Education Program (DEEP). <https://www.mhanet.com/mhaimages/sqi/chna/Diabetes%20Empowerment%20Education.pdf> | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of individuals enrolled in DEEP | TBD |
| Active participation in the state, regional or community Diabetes Shared Learning Network. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of meetings attended | TBD |
| Active participation in the Missouri Million Hearts Program. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of meetings attended | TBD |
| Evaluate becoming a Million Hearts® partner by aligning with their priority action guides and protocols. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Progress towards aligning goals to Million Hearts | TBD |
| Implement Million Hearts 2027 priorities of **building healthy communities** by working with local agencies and community-based organizations to decrease tobacco use, physical inactivity, and particulate pollution exposure | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Rate of tobacco use compared to baseline * Rate of physical inactivity compared to the baseline * Rate of particulate pollution exposure compared to the baseline | TBD |
| Implement Million Hearts 2027 priorities of **optimizing care** by addressing the following:   * Improve appropriate aspirin or anticoagulant use * Improve blood pressure control * Improve cholesterol management * Improve smoking cessation * Increase the use of cardiac rehab | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of individuals receiving aspirin or anticoagulant as required * Number of patients showing improved blood pressure control readings * Number of individuals showing improved cholesterol readings * Number of individuals quitting smoking * Number of additional patients utilizing cardiac rehab | TBD |
| Active participation in the state, regional or community cancer stakeholder group. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of meetings attended | TBD |
| Heart disease screening events that include evidence-based tobacco cessation education and screening. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of screening opportunities offered * Number of individuals participating * Number of collaborating organizations | TBD |
| Support the implementation of the “MOST Teens Don’t Campaign” in school settings. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of schools implementing the program | TBD |
| Develop and offer standardized smoking cessation education and/or facilitate referral to cessation program. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of individuals participating in the sessions | TBD |
| Develop “Worksite Health Promotion Program” based on CDC Worksite Health Scorecard to prevent heart disease, stroke, diabetes and related health conditions. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of employees participating in the program | TBD |
| Provide tools and resources to support screening and for patients and families in need of services for prevention/lifestyle management. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of tools and resources disseminated * Number of patients making use of the tools and resources shared | TBD |
| Identify methods to reach Latino and African Americans (e.g., churches) and convert screening and educational materials to Latino and African Americans appeal as needed to improve cultural competency. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of organizations supporting minorities that are engaged in community health activites | TBD |
| Advocate and adopt tobacco-free school policies specifically in the ZIP codes identified to have the highest rates of smoking in the region through education and promotional campaign. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of schools adopting tobacco-free policies | TBD |
| Advocate for the implementation of school-based curriculum on tobacco prevention through education and promotional campaigns. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of schools implementing curriculum focused on tobacco prevention | TBD |
| Advocate and provide education to encourage adoption of smoke free policies and local tobacco-free ordinances across the counties in this region, e.g., Tobacco 21, point-of-sale initiatives. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of local organizations adopting smoke-free policies | TBD |
| Develop senior health program including ongoing (at least quarterly) community and minority health screening program for key CVD risk factors such as blood pressure, cholesterol and BMI. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of events held per year * Number of seniors screened | TBD |
| Host annual community health screening event on “Know Your Numbers” to include CVD profile screenings and facilitate referral or evidence- based interventions when screening positive for risk factor(s) or disease process. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of individuals participating in the annual event * Number of collaborating organizations * Number of referrals made during the exercise | TBD |
| Assess hospitals utilizing CDC Worksite Health Scorecard and develop action plan including onsite screening event. <https://www.cdc.gov/dhdsp/pubs/docs/HSC_Manual.pdf> | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of hospitals utilizing the CDC scorecard | TBD |
| Increase Medicare annual wellness exams and develop appropriate plan of care for CVD and hypertension. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of annual wellness exams completed | TBD |
| Promote Community-Based Non-Physician or Self-Screenings performed by other stakeholders. <https://academic.oup.com/ajh/article/28/11/1316/2743206> | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of non-physician or self-screenings performed by other stakeholders | TBD |
| Identify patients without a primary care provider through a variety of channels such as employers, community events, health fairs. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of patients without providers identified and connected to one | TBD |
| Explore and implement telemedicine program (Includes remote monitoring) options to improve access to specialists. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of patients utilizing telemedicine technology * Number of specialists utilizing telemedicine technology | TBD |
| Increase patient portal access to promote patient communication with care providers, patient access to test results, and patient ability to schedule appointments electronically. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of patients utilizing the patient portal | TBD |
| Evaluate utilization of Community Health Workers to improve health equity and better serve those with CVD, diabetes, cancer, among other chronic conditions. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of organizations utilizing community health workers in different settings of care | TBD |
| Coordinate and manage care across the continuum by tracking patients from hospital to post-acute care setting (home, SNF/nursing home, rehab, or palliative). | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of patients tracked for appropriateness across the continuum of care | TBD |
| Continue to implement evidence-based protocols through EHR to manage care across the continuum related to key metrics of  cholesterol, lipids and blood pressure, blood glucose (using CDC guidelines). | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of protocols implemented and followed as required of the process | TBD |
| Apply for the Patient Centered Medical Home Level III Recognition and implement it to help the hospital/health system focus efforts on clinical performance, proper utilization, cost management and customer experience. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Fully implemented and recognized Patient Centered Medical Home Level III | TBD |
| Continue to host or collaborate to provide support groups: stroke, mended hearts, diabetes, cancer, among others. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of chronic diseases support groups implemented * Number of patients utilizing support groups | TBD |
| Consider implementing evidence-based heart disease programs such as the Bootheel Heart Health Project and [Missouri Cardiovascular Health (CVH)](https://www.micalhoun.org/promisepractice/index/view?pid=545) Program. <https://cdc.thehcn.net/promisepractice/index/view?pid=3442>; <https://www.micalhoun.org/promisepractice/index/view?pid=545> | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of partners implementing evidence-based heart disease programs | TBD |
| Educate providers about the eligibility requirements for WISEWOMAN screenings and referrals. <https://health.mo.gov/living/healthcondiseases/chronic/wisewoman/> | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of providers educated about the WISEWOMAN eligibility requirements | TBD |
| Improve MIPS Quality Scores for hemoglobin A1c, lipids, blood pressure, neuropathy, fasting plasma glucose testing to identify patients with prediabetes and maintain control of clinical indicators for existing patients with diabetes. | * Provider organizations such as:   + Hospitals   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of patients showing improvement in key metrics such as hemoglobin A1c, lipids, blood pressure and fasting plasma glucose testing, etc. | TBD |
| Implement technologies such as the [HabitNu](https://www.habitnu.com/) platform to deliver services and solutions to help people lose weight and prevent chronic illnesses. This innovative technology seeks to deliver services such as the Diabetes Prevention Program (DPP), Diabetes Self-Management and Education/Support (DSMES), Hypertension (BPSM/SMBP), Behavioral Weight Loss, and other SDOH-related conditions. HabitNu provides both direct DPP services as well as a license of the full-featured platform to some of the largest health systems in the country.  HabitNu includes the following modules.   * **Enrollment**: Participant onboarding occurs through both self-enrollment and provider referrals. Participants simply complete the eligibility and enrollment survey, which can be accessed via the participant onboarding portal, the provider’s website, as well as through a link embedded in email or text messages. Eligibility and enrollment surveys are customized to each partner’s requirements. * **Digital Health App**: The HabitNu App provides an easy-to-use tool (accessible via smartphone and browser) through which participants/patients:   + track their food consumption   + track health data (e.g., weight, exercise, BP, HbA1c)   + receive learning materials (e.g., educational videos, nutrition PDFs)   + attend online meetings with their coaches, educators and fellow participants/patients   + establish health goals and track progress toward achieving them * **Billing**: HabitNu can bill for National DPP, DSMES, BPSM and other disease management programs for which payers reimburse. * **IT Capacity**: End-to-end platform for the delivery of the National DPP. The setup and table build process is typically completed in two to three weeks. * **UHAs**: HabitNu is a CDC-designated Umbrella Hub that mentors dozens of nascent National DPP providers around the country, helping them deliver National DPP and bill for services rendered without the typical 18- to 24-month recognition period. * **Integration**: The HabitNu Integration Module supports FHIR and HL-7 based bidirectional referrals from/to electronic health records (EHRs) and SDOH platforms.   To find out more, please visit [www.habitNu.com](http://www.habitNu.com). | * Provider organizations such as:   + Hospitals   + Health systems   + Health departments   + Community health centers * Other community-based organizations as needed | * Number of referrals to the platform * Number of patients showing weight loss * Number of enrollments to the program | TBD |