Heart Disease Prevention & Management Request for Proposals

"The National Cardiovascular Health Program"

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH, CHRONIC DISEASE PREVENTION AND CONTROL PROGRAM
Contact Information: DHHS.CDPCprogram@nebraska.gov

Introduction and Overview:

The purpose of this request for proposals (RFP) is to solicit applications from qualified Clinics and Health Systems invested in planning and implementing sustainable policy and systems change(s) around cardiovascular health through a partnership with the Nebraska Department of Health & Human Services (DHHS) Chronic Disease Prevention & Control Program (CDPCP).

This opportunity focuses on improving clinical detection and management of adult patients (ages 18-85) that have undiagnosed and/or unmanaged high blood pressure. This award supports awardees in identifying gaps in care and then planning and implementing focused interventions in four strategies, Social Determinants of Health (SDOH), Electronic Health Record (EHR) utilization, Team-Based care (TBC), and Self-Measured Blood Pressure (SMBP) with Clinical Support.

Heart disease was the leading cause of death in both Nebraska and in the United States in 2021[1]. High blood pressure and high blood cholesterol are major risk factors for heart disease and strokes. In 2021, approximately 31.7% of adults in Nebraska reported having high blood pressure and 31.7% reported having high blood cholesterol[2]. Individuals with cardiovascular and metabolic diseases face an increased susceptibility to novel viruses and suffer poorer outcomes when infected. Clinical efforts to support patients in managing cardiovascular health were stalled during the pandemic. Now, more than ever, clinical entities need the opportunity to engage in focused interventions that will lead to positive cardiovascular health outcomes in their patient population.

Purpose

The purpose of this award is to support qualified clinics and health systems in the design, implementation, and evaluation of evidence-based interventions aimed at improving the prevention and management of cardiovascular diseases.

[1] Centers for Disease Control and Prevention (CDC). CDC Wonder. National Vital Statistics System Data, 2021.
[2] Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data, 2019.

Evidence-Based Interventions

This award supports clinics and health systems in the design, implementation, and evaluation of the following interventions for adults:

1. Social Determinants of Health: Social determinants of health are defined as "nonmedical factors that influence health outcomes." They are factors such as access to nutritious food, adequate housing, transportation, financial ability to pay for medications, utilities, and basic household items, childcare, freedom from racial discrimination, abuse of any kind, or any other nonmedical factor that may inhibit their ability to remain healthy. *Current data shows that 47% of a person's health is attributed to social determinants of health*, while health behaviors account for 35%, 16% is attributed to clinical care, and 3% to physical environment[3]. Clinics should aim to start screening all patients through a standardized process, send referrals to appropriate community organizations, and track outcomes of these referrals. For guidance in advancing SDOH, please refer to the "Resources" section of this RFP.

2. EHR Utilization: Utilizing EHR systems to their full capacity promotes efficient team-based care and improves outcomes. The EHR should serve as the main information hub for the care team. Participants should work on evidence-based practice changes around the way they use electronic documentation for gather demographic data, social determinants of health needs, tracking referrals, and facilitating team-based care.

3. Team-Based Care (TBC): TBC is a multi-disciplinary approach to patient care that utilizes the expertise of the patient, the primary care provider, and other non-physician team members such as nurses, pharmacists, dieticians, social workers, patient navigators, and/or community health workers to achieve coordinated, high-quality care. Principles of TBC include: (1) shared goals; (2) clear roles; (3) mutual trust; (4) effective communication; and (5) measurable processes and outcomes. Non-physician team members augment the work of the primary care provider in the form of process support and shared responsibilities of care in areas such as: medication adherence, support, and education; medication management; patient follow up and adherence; self-management support and education; community resources connections; dietary, physical activity, and weight loss counseling; and diagnosis and disease processes education. Awardees will develop policies and systems and explore innovative activities to enhance TBC for patients with high blood pressure. For guidance in advancing TBC, please refer to the "Resources" section of this RFP.

4. Self-Measured Blood Pressure Monitoring (SMBP) with Clinical Support: SMBP is a patient's regular use of a personal blood pressure monitoring device to assess and record blood pressure across different points in time outside of a clinical setting, typically at home. When combined with clinical support (e.g., one-on-one counseling, web-based or telephonic support tools, education), this intervention can enhance the quality and accessibility of care for people with high blood pressure and improve blood pressure control[4]. Awardees will develop and implement a SMBP with clinical support program or improve an already-existing

[3] Assistant Secretary for Planning and Evaluation (ASPE), Office of Health Policy, Addressing Social Determinants of health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts, 2022.

[4] Centers for Disease Control and Prevention. *Best Practices for Cardiovascular Disease Prevention Programs: A Guide to Effective Health Care System Interventions and Community Programs Linked to Clinical Services*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2017.

program by creating policies or systems that integrate SMBP into the care of patients with high blood pressure. For guidance in advancing SMBP with Clinical Support, please refer to the "Resources" section of this RFP.

> "People get too caught up in the need to change the world, but what you're trying to accomplish is making small changes- we're giving patients blood pressure cuffs to use at home. It's a small concept. It takes a lot of planning, but it's effective and clinics need to keep in mind the big picture on what they are trying to accomplish and look at those small steps."
>
> -Previous Clinic Awardee

Who May Participate

The following entities located in Nebraska are eligible to submit an application in accordance with this RFP:

- For profit or nonprofit independent primary care clinics
- For profit or nonprofit health systems with one or more primary care clinics.

  DHHS defines health system as an overarching entity comprised of an integrated organization of providers, institutions and resources that deliver health care services. A health system may include:

  - Community Health Centers
  - Accountable Care Organizations
  - Clinically Integrated Networks
  - Physician Organizations
  - Community Health Centers
  - Governmental entities that provide oversight to entities providing direct patient primary care
  - Local Health Departments

  If multiple clinics within one health system apply, each must have separate and unique patient populations and health care providers. The activities for this award are to be conducted at the individual clinic level and DHHS will communicate directly with each clinic. The health system will support the work of the individual clinics.

  Previous awardees who completed all work are eligible to reapply; however, they must show that there is a need for further funding through data, and they must describe how the work would change to continue to improve blood pressure control and blood cholesterol management rates. DHHS will give preference for this award to applicants who have not yet participated.

Ineligible Entities

- Awardees who currently receive funding from DHHS through the 2304 cooperative agreements with CDC.

Benefits of Participation

While the focus of this award is to improve cardiovascular health outcomes as part of DHHS's cooperative agreement with CDC, an awardee may experience many additional benefits through participating. An awardee may:

- Improve blood pressure control rates among their patient population.
- Improve the results of healthcare interventions for individuals with chronic diseases and conditions.
- Increase value-based pay and chronic disease care management reimbursement.
- Increase patient engagement and satisfaction.
- Receive supportive guidance, expertise, resources, funding, and technical assistance, from DHHS and other partners.
- Share and promote successes to CDC, Nebraska medical professional associations, health systems, and clinics through CDPCP reporting.
- Collect data that demonstrates clinical improvement efforts and supports application for the American Heart Association's Target BP program recognition.
- Learn from other awardees through a Community of Practice (CoP) formed by current and past awardees.

Award Information

Estimated Total Funding: $204,000

Project Period: ~1 year

Maximum Award Amount per Clinic: $25,500

Anticipated Total Number of Awards: 8 clinics

This is an outcomes-driven award. Awardees must implement evidence-based interventions and demonstrate action towards sustained organization-level change around high blood pressure control and high blood cholesterol management. DHHS will monitor progress through:

- Regular check-in meetings conducted by phone or virtually.
- Progress reports for each work period.
- Completion of the post-Scan and Plan assessment.
- Participation in evaluation activities.

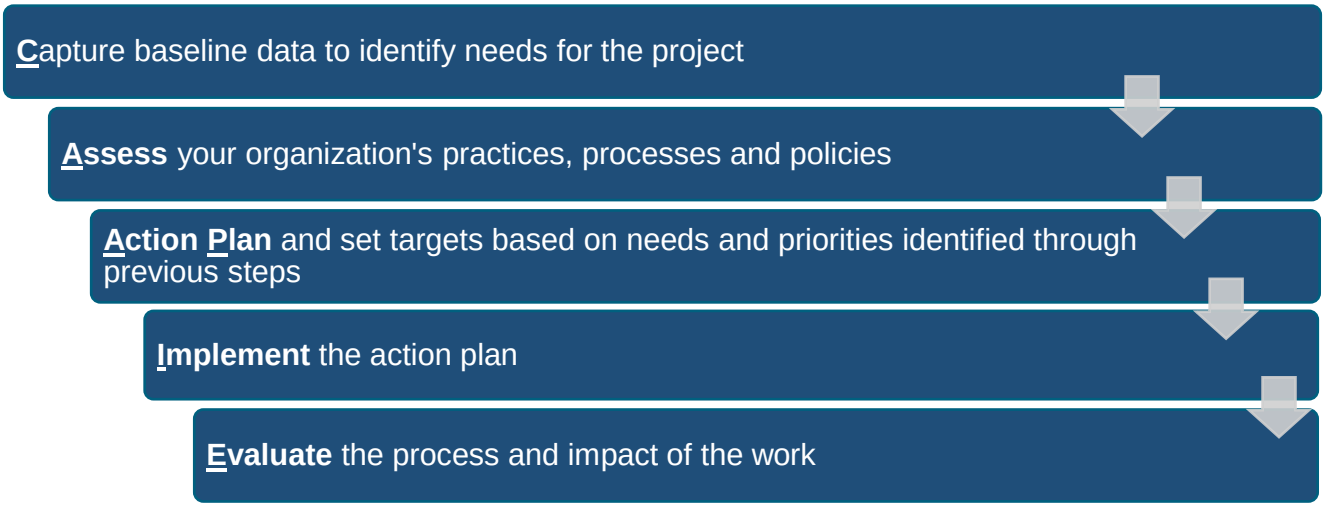
DHHS will award payments based on (1) the completion of all required deliverables and (2) the demonstration that work is positively contributing to the advancement of the awardee's action plan and the expected outcome measures of the award.

DHHS staff will monitor awards and assure that all awardees comply with federal and state statutes/regulations/policies. If an awardee (1) fails to comply with federal and state statutes/regulations/policies and/or (2) fails to perform its obligations of the award in a timely or proper manner, DHHS has the right to temporarily withhold payments pending the correction of any deficiency; disallow all or part of the cost of an activity or action not in compliance; wholly or partly suspend or terminate the award; or take any other remedies that may be legally available and necessary.

For an estimated payment summary, please refer to the "Funding Summary for One Clinic" section below.

Scope of Work

To provide a seamless approach to the award work and to assist awardees in achieving the intended outcomes, DHHS developed a framework called CAAPIE. CAAPIE stands for **C**apture, **A**ssess, **A**ction **P**lan, **I**mplement and **E**valuate. Applicants will complete the Capture, Assess, and Action Plan phases of the CAAPIE framework as part of the application, then complete the Implement and Evaluate phases if selected for the award.



Awardees will progress through each phase of CAAPIE and comprehensively and consistently document progress and data through progress reports and the Scan and Plan Tool (see Attachment C). The Scan and Plan Tool is an Excel file created by DHHS to guide awardees through pre- and post-award data collection and through using pre-award data to develop an action plan for the award work. The Scan and Plan Tool includes instructions to aid in its completion. DHHS has provided a sample Scan and Plan Tool (see Attachment D) for reference.

The information below more specifically outlines the CAAPIE framework as it relates to the Scan and Plan Tool and the award:

Application Phases

1. Capture baseline data
   Applicants will complete two tabs (General Info and outcomes) in the Scan and Plan Tool. These tabs collect information about 1) general clinic information, 2) demographic information for the applicant's patient population and 3) baseline data that will contribute to

high blood pressure control and high blood cholesterol management calculations. Applicants will use this baseline data to track intervention success.

The CDPCP encourages applicants who cannot pull, and report data requested to submit their application package with the missing data and provide a brief explanation of the barriers to this data collection here in the application (Attachment A). These application packages will still be considered for funding. If selected, the CDPCP will work with the clinic to overcome data collection barriers.

2. Assessment
   Applicants will complete four tabs, one for each intervention (EHR Data use, SDOH Screening, Team Based Care (TBC), and Self-Monitored Blood Pressure (SMBP)), in the Scan and Plan Tool. Each intervention tab includes 1) a self-assessment of current policies, systems, and practices, 2) open-ended questions about perceived strengths and potential areas for improvement, and 3) a section to develop action steps that will be completed during the project period in order to achieve the intended intervention outcomes and established targets (set on the Action Planning tab).

3. Action Planning
   The action steps listed on each of the intervention tabs will pre-populate into the Scan and Plan's Action Planning tab. On the Action Planning tab, applicants 1) establish data targets for the expected outcomes and 2) for each action step indicate a time frame for activity completion and the personnel responsible. These interventions should be evidence-based practice, please refer to the resources below for suggest resources or reach out to your Grant Coordinator.

Award Phases

4. Implementation
   Selected awardees will implement the work outlined in the action plan. Check-in meetings with the CDPCP to monitor progress on the action plan will occur every 4-6 weeks or as determined necessary. Awardees will submit four progress reports throughout the award period documenting the work completed and progress made on activities.

5. Evaluation
   Awardees will report data for the expected outcomes at the mid-project and the end of the project periods. At the end of the project, awardees will 1) repeat the Scan and Plan self-assessment for each intervention, 2) write a final success statement for each intervention, and 3) participate in any additional evaluation activities requested by DHHS. These additional activities may include, but are not limited to, formal documentation, surveys, and focused conversations with the DHHS.

Work Timeline Summary

Application	Period 1	Period 2	Period 3	Period 4
Capture · Assess · Action Plan	Implement ~3 months	Implement ~3 months	Implement ~3 months	Implement ~3 months
○ Complete the Application Documents. ○ Confirm acceptance of funding opportunity ○ Scan and Plan will be sent after receiving original application and must be completed and returned before the first period begins.	○ Implement action plan activities ○ Check in meetings with DHHS every 4-6 weeks (or as requested) ○ Submit one progress report.	○ Implement action plan activities ○ Check in meetings with DHHS every 4-6 weeks (or as requested) ○ Submit one progress report with mid-project data.	○ Implement action plan activities ○ Check in meetings with DHHS every 4-6 weeks (or as requested) ○ Submit one progress report.	○ Implement action plan activities ○ Check in meetings with DHHS every 4-6 weeks (or as requested) ○ Submit one progress report with project-end data and final success statements. ○ Complete the post-Scan and Plan Assessment

Evaluation: Periods 1-4

Participate in evaluation activities requested by DHHS. Activities may include, but are not limited to, formal documentation, surveys, and focused conversations.

Funding Summary for One Clinic

CAAPIE Framework Phase	Deliverable/ Documentation	Deliverable Frequency and Timeline	Payment
Capture	General Info and Outcomes tabs of the Scan and Plan Tool	One time during the application period	*$0.00 or N/A* **This is part of the required application process*
Assess			
• **Pre-Assessment**	SDOH, EHR Utilization, TBC, and SMBP tabs of the Scan and Plan Tool	One time during the application period	*$0.00 or N/A* **This is part of the required application process*
• **Post-Assessment**	Re-assessment of the criteria on the SDOH, EHR Utilization, TBC, and SMBP tabs of the Scan and Plan Tool	One time following the completion of all four project periods	One payment of $2,000
Action Plan	Action Planning tab of the Scan and Plan Tool	One time during the application period	*$0.00 or N/A* **This is part of the required application process*
Implement	Check-in Meetings and Four Progress Reports: 1. Progress reports for each project period that provide a description/reflection of progress towards Action Plan activities for each of the four interventions: SDOH, EHR Utilization, TBC, and SMBP. The reports may also include requested data and other supporting documentation such as awardee-created workflows, policies, and patient education materials. 2. Participation in check in meetings with DHHS.	1. Submitted at the end of each of the four project periods. 2. Every 4-6 weeks (or as requested)	Required Interventions: • EHR Utilization: • SDOH: • TBC: • SMBP: Per Progress Report Total: $5,000 Four payments of $5,000 for a total of $20,000 *Please note that if progress is not noted on each intervention participant may receive a pro-rated payment.
Evaluate	Evaluation Activities: 1. Participate in any evaluation activities requested by DHHS, including a 30 min. meeting in which the awardee evaluates DHHS's facilitation of this award opportunity. 2. Write a minimum of one final success statement per intervention.	1. As requested by DHHS 2. One time in Progress Report 4	Two payments of $1,750 (one following Periods 1 and 2 and one following Periods 3 and 4) for a total of $3,500.

TOTAL AVAILABLE FUNDING $25,500

Award Requirements and Expectations

This is an outcomes-driven award. Awardees must implement evidence-based interventions and demonstrate action towards sustained organization-level change around high blood pressure control and high blood cholesterol management. To support the work, awardees will:

- Designate a staff member to serve as the point of contact to DHHS (for Health System applicants, each Clinic must designate a staff member).
- Create a team of staff dedicated to completing the award work.
- Maintain clear and timely communication with DHHS.
- Participate in check-in meetings with DHHS every 4-6 weeks or as requested.
- Submit timely and robust deliverables that demonstrate continued progress with each intervention.
    - At its discretion, CDPCP may change reporting and submission requirements in order to support outcome achievement.
- Use required reporting templates and tools provided by DHHS.
- Share information about partnerships and innovative practices with DHHS.
- As needed, accept technical assistance from DHHS or partner organizations.
- Participate in all evaluation activities that DHHS requests. Activities may include, but are not limited to, formal documentation, surveys, and focused conversations.

As part of the application process, applicants will sign and return the “Participation Commitment” expressing agreement to the above requirements and expectations. For health system applicants, the health system will sign a “Participation Commitment” and each clinic will sign a “Participation Commitment.” In the application package, Health systems must provide a brief description of their role versus the role of the individual clinics in completing the award work.

If selected for this award opportunity, the awardee is required to sign the legal subaward and agree to the Terms and Assurances, which will be provided after notification of award.

Attachments

Applicants will submit the following attachments with the application. Please reference the attachments for further instructions.

For Single Clinic Applicants	For Health System Applicants
A. Clinic Application Documents	A. Clinic Application Documents
C. Scan and Plan Tool	B. Health System Application Documents
	C. Scan and Plan Tool

Additional reference attachments:

D. Sample Scan and Plan Tool

RFP Timeline:

05/08/2024	Request for Proposals released	
	During this period, please reach out to the Grant coordinator at Sara.lawless@nebraska.gov for assistance. We would be happy to schedule calls with our team to assist you in filling out the scan and plan as needed.	
06/10/2024	Initial Application Due (Clinic application and pre-award questionnaire).	
06/14/2024	Final notification of applicant decisions and release of Scan and Plan tool to selected applicants.	
07/25/2024	Scan and plan tool due to DHHS, email to sara.lawless@nebraska.gov. Please send as soon as it is completed.	
08/01/2024	Award starts. Selected applicants will begin action plan work	

Contact Information

For any questions, please contact DHHS at the following email address:
DHHS.CDPCprogram@nebraska.gov

Acknowledgement

This request for proposals is supported by Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award (CDC-RFA-DP-23-0004) totaling $899,275 with 100 percent funded by CDC/HHS. The contents are those of the Nebraska Department of Health & Human Services Chronic Disease Prevention and Control Program and do not necessarily represent the official views of, nor an endorsement by, CDC/HHS or the U.S. Government.

Appendix A:

Key Terminology

Action Plan: A detailed plan outlining action steps needed to reach one or more goals.

Action Step: The specific activity(s) an organization performs to achieve one or more goals.

Adults

Patients for Blood Pressure Control: Ages 18-85
Patients for Blood Cholesterol Management: Ages 20+

Atherosclerotic Cardiovascular Disease (ASCVD): Includes acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke or transient ischemic attack (TIA), and peripheral arterial disease of atherosclerotic origin (CMS, 2019). Find the American College of Cardiology's ASCVD Risk Estimator here.

Community of Practice (CoP): A group of people who share a common concern, a set of problems, or an interest in a topic and who come together to fulfill both individual and group goals.

Controlled Blood Pressure: Systolic blood pressure below 140 mm Hg and diastolic blood pressure below 90 mm Hg among patients ages 18-85 with diagnosed hypertension. If multiple readings were taken in one visit, the average of all readings should be used to obtain the final blood pressure value. Exclusions may include all patients: 1) with evidence of end-stage renal disease on or prior to the end of the measurement year; 2) with a diagnosis of a pregnancy during the measurement year; or 3) who had an admission to a non-acute inpatient setting during the measurement year.

Disparate Population: A sub-group of the overall patient population, identified by a demographic variable such as age, gender, race/ethnicity, or insurance type that is experiencing a health disparity (see health disparity definition). They are disproportionately affected by a chronic health condition.

Dyslipidemia: Elevated total or low-density lipoprotein (LDL) cholesterol levels, or low levels of high-density lipoprotein (HDL) cholesterol (ICD-10: E78.00, E78.01, E78.2, E78.4, E78.5, and E78.6).

Health Disparity: A particular type of preventable health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion (Healthy People, 2020).

High Blood Cholesterol/Hyperlipidemia: Total cholesterol greater than 200 mg/dL with an LDL greater than 100 mg/dL (National Cholesterol Education Program, 2001) with a diagnosis of dyslipidemia (ICD-10 codes E78.00, E78.1, E78.2, E78.4, E78.5 or E78.6) or with a high risk of cardiovascular events (based on CMS criteria) among patients ages 21+.

High Blood Pressure (HBP)/Hypertension: Systolic blood pressure (SBP) of 140 mmHg or higher or diastolic blood pressure (DBP) of 90 mm Hg or higher with a diagnosis of hypertension (ICD 10 codes I.10 - I15.8) among patients ages 18-85.

Managed Blood Cholesterol: High blood cholesterol among patients ages 21+ treated with statin medications.

Priority Population: A disparate (see disparate population definition) population for whom interventions will be targeted.

Self-Measured Blood Pressure (SMBP) with Clinical Support: A patient's regular use of personal blood pressure monitoring devices to assess and record blood pressure across different points in time outside of a clinical, community, or public setting, typically at home. When combined with clinical support (e.g., one-on-one counseling, web-based or telephonic support tools, education), this intervention can enhance the quality and accessibility of care for people with high blood pressure and improve blood pressure control.

Team-Based Care (TBC): A multi-disciplinary approach to patient care that utilizes the expertise of the patient, of the primary care provider, and of other non-physician team members such as nurses, pharmacists, dieticians, social workers, patient navigators, and/or community health workers to achieve coordinated, high-quality care. Principles of TBC include: (1) Shared goals; (2) Clear roles; (3) Mutual trust; (4) Effective communication; (5) Measurable processes and outcomes. Non-physician team members augment the work of the primary care provider in the form of process support and shared responsibilities of care in areas such as: medication adherence, support, and education; medication management; patient follow up and adherence; self-management support and education; community resources connections; dietary, physical activity, and weight loss counseling; and diagnosis and disease processes education.

Appendix B

Resources

Please take some time to explore the resources below as they are intended to assist applicants in understanding the interventions and in formulating action steps and work plans for this award.

Blood Pressure and Cholesterol Patient Education

What is High Blood Pressure?

Available in English and Spanish

Source: Target: BP

2 page overview of blood pressure and how to understand a blood pressure reading.

How Do I Manage My Medicines?

Source: Target: BP

2 page guide with tips for adherence and a sample form to use for at-home documentation.

Make the most of your appointment with a health care professional

Source: American Medical Association/American Heart Association

1 page template for patients to review and document their current health habits and most recent blood pressure in preparation for discussion with their provider.

What is High Blood Pressure Medicine?

Source: Target: BP

2 page overview of common medications and their side effects and tips for adherence.

Heart Guide

Source: Mended Hearts

105 page guide developed by patients for patients with cardiovascular disease and their caregivers.

7 Steps to a Healthy Heart

Source: Association of Black Cardiologists

32 page guide designed to teach patients how to choose a healthy lifestyle to prevent chronic disease. This guide can be grouped with the Heart and Soul cookbook. The cookbook comes in a magazine-like format and contains simple, delicious, plant-based recipes. Click here to order a free box of 25 of these cookbooks.

Hypertension Control Tools for Clinical Staff

Hypertension Control Change Package

Source: Centers for Disease Control and Prevention/Million Hearts

This is an excellent resource for brainstorming your clinics action steps. The guide includes change concepts, change ideas, and evidence- or practice-based tools and resources.

BP Connect: Improving Follow-up After High Blood Pressures Toolkit

Source: HIPxChange

BP Connect is a protocol where nurses or medical assistants during vitals assessment are prompted by EHR alerts to provide patient counseling and to create a follow-up order. This toolkit provides multiple resources that guide implementation of this protocol and that guide education to staff about the protocol. Among these resources is a step-by-step guide for building the protocol into the EHR. Users will need to create a free account with HIPxChange to access this resource.

Medication Adherence

Source: Preventative Cardiovascular Nurses Association

4 page guide on methods for improving medication adherence. The guide also includes a sample medication tracking form.

MAP BP

Source: American Medical Association

A free evidence-based quality improvement program named for its three key elements: Measure accurately, Act rapidly, Partner with patients. The AMA provides expert coaching and support with developing blood pressure dashboards for those who request the program.

Team-Based Care (TBC)

Team-Based Care to Improve Blood Pressure Control
Source: Centers for Disease Control and Prevention

Webpage that defines TBC and provides guidance for its implementation.

Technical Package for Cardiovascular Disease Management in Primary Health Care: Team-Based Care
Source: World Health Organization

36-page guide that overviews the advantages and disadvantages of TBC, steps for implementing TBC, and sample workflows. There are tables starting on page 15 that provide ideas for tasks that can be assigned to different members of the care team.

Creating Patient-Centered Team-Based Primary Care
Source: Agency for Healthcare Research and Quality

Article that discusses the need for team-based care and outlines strategies for its implementation

Cardiovascular Disease: Team-Based Care to Improve Blood Pressure Control
Source: The Community Guide

Webpage that compiles supporting research for the use of TBC in high blood pressure control as well as guidelines and resources for implementing TBC.

Effectiveness and Cost-Effectiveness of Team-Based Care for Hypertension: A Meta-Analysis and Simulation Study
Source: American Heart Association Journals

A study examining the effectiveness and cost savings of team based care with non-physician titration.

Self-measured Blood Pressure (SMBP)

7-step SMBP Quick Guide
Source: American Medical Association

5 page guide on developing an SMBP program. Includes CPT codes and validated device resources.

Ambulatory and Home Blood Pressure Monitoring
Source: National Association of Community Health Centers/Million Hearts

9 page guide for providers and for patients about implementing ambulatory or home blood pressure monitoring.

An Economic Case for SMBP Monitoring
Source: Centers for Disease Control and Prevention/Million Hearts

1 page brief that outlines the case for reimbursement of SMBP education and device purchases. Incudes CPT codes.

SMBP Patient Training Checklist
Source: Target: BP

YouTube Video: SMBP Patient Training
Source: American Medical Association

3 mins 45 secs

Home Blood Pressure Recording Log
Source: Stride BP

Validated SMBP Devices Guidance

US Blood Pressure Validated Device Listing

Stride BP Validated Blood Pressure Monitors Listing

Target BP Purchasing and Managing Devices Recommendations
Includes a sample loaner device agreement form and device inventory form.

SMBP Device Accuracy Test
Source: Target: BP

1 page checklist for verifying that and SMBP device accurately measures blood pressure.

Choosing a Home Blood Pressure Monitor for Your Practice At-A-Glance-Comparison
Source: National Association of Community Health Centers

1 page chart that compares SMBP devices by cost, validation status, device features, and data/technology features.

Health Disparities Resources

Evaluating Strategies for Reducing Health Disparities By Addressing The Social Determinants Of Health
Source: Health Affairs

This article address how treatment recommendations and education might change to address certain health disparities.

Social Determinants of Cardiovascular Disease
Source: American Heart Association Journals

An article examining health inequities.

** Please reach out to the Heart Disease and Stroke Program Coordinator for full list of SDOH screening tools

Hypertension Control and Cholesterol Management Achievement Recognition Programs

Target: BP
The Target: BP Recognition Program celebrates physician practices and health systems who achieve blood pressure control rates at or above 70 percent within the populations they serve.

Million Hearts
The Million Hearts® Hospitals & Health Systems Recognition Program acknowledges institutions working to systematically improve the cardiovascular health of the population and communities they serve.

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2 page overview of blood pressure and how to understand a blood pressure reading.

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EMR Integration Resources

Electronic Alerts to Improve Heart Failure Therapy in Outpatient Practice: A Cluster Randomized Trial
Source: Journal of the American College of Cardiology

Additional Resources

10-year ASCVD Risk Calculator
Source: American College of Cardiology/American Heart Association

Journal Article: Improving hypertension control and cardiovascular health: An urgent call to action for nursing
Source: Worldviews on Evidence-Based Nursing Journal

Article published on Feb. 8, 2022 that poses actions for each nursing role (e.g. RN vs. APRN vs. QI/Population Health) to take in order to control hypertension and prevent CVD.

Improving Chronic Disease Self-Management Cardiovascular Disease Change Package
Source: Quality Innovation Network

14 page guide for community coalitions working to improve cardiovascular disease self-management. The guide includes a thorough explanation of Plan-Do-Study-Act (PDSA) cycle design and it includes an extensive list of additional resources.

American Heart Association (AHA) NE Chapter

The AHA offers one-on-one assistance to clinics who are working to improve hypertension control and cholesterol management and to clinics who are developing or improving their SMBP program. It also assists clinics with completing the American Heart Association's Target BP, Check. Change. Control. Cholesterol. and Target: Type 2 Diabetes programs and receiving recognition for the completion of those programs.

Infographics and CE courses for Staff

Free CME Course: Advancing Quality Care for Patients with Hypercholesterolemia
Source: Prime Continuing Medical Education

51 mins

Infographic: In-Office Blood Pressure Measurement
Source: Target: BP

Available in English and Spanish

Infographic that demonstrates 7 steps for getting an accurate blood pressure reading. Target BP encourages providers to display it in a public place. Providers may hang the infographic on bulletin boards, frame it in exam rooms, make it a computer screensaver, and laminate and hang it on the blood pressure pump stand. It is available in a poster size or as a folded 6x9 card.

Video: How to Check Blood Pressure Manually
Source: RegisteredNurseRN.com

5 minute 16 second YouTube video that reviews how to check blood pressure with a manual cuff.

Technique Quick Check
Source: Target: BP

Checklist for determining if a medical professional accurately and consistently measures blood pressure.

Free CME Course: Measuring Blood Pressure Accurately
Source: Target: BP

65 mins

Free eLearning Course: Taking an Accurate Blood Pressure Reading
Source: Metastar

35 mins

Free CME Course: How to Improve Hypertension Control Through Team-Based Care
Source: Target: BP

60 mins

Free eLearning Course: Patient Self-Measurement of Blood Pressure
Source: Metastar

35 mins

Free CME Course: Partnering with Patients Using Self-Measured Blood Pressure and Collaborative Communication
Source: Target: BP

58 mins

Free CME Course: Health Equity and Hypertension Treatment