Summary Information:

- **Project Purpose:** The project will support innovative and sustainable state heart disease and stroke prevention projects which focus on improving hypertension through equitable change.
- **Eligibility:** Open to all states, with priority for applications that prioritize a jurisdiction with a high burden of hypertension and significant social and economic need.
- **Maximum Funding Amount:** $35,000 per state (up to 4 states)
- **Intent to Apply:** Email ASTHO contacts (Amandeep Kaur and Talyah Sands) of your intent to apply by November 13, 2020.
- **Proposal Due Date and Time:** December 2, 2020, 11:59 PM ET
- **Selection Announcement Date:** December 16, 2020
- **Estimated Period of Performance and Final Report Date:** January 4, 2021 to July 31, 2021
- **ASTHO Point of Contact:** Amandeep Kaur, Analyst, Health Improvement (akaur@astho.org) and Talyah Sands, Director, Health Improvement (tsands@astho.org).

Objectives:

In FY2021, the ASTHO/CDC Heart Disease and Stroke Prevention (HDSP) Learning Collaborative (LC) is building on its initiative to support jurisdictions in implementing innovative strategies to prevent heart disease and stroke through the following objectives:

1. Improve hypertension control and prevention through equitable strategies that will increase the percentage of patients 35-64 years of age who had hypertension diagnosis and control during the measurement period.
2. Develop evidence-based policy, systems, or environmental change strategies that are sustainable for long-term impact.
3. Prepare to sustain the project beyond the project period to actively eliminate health inequities and improve heart disease and stroke outcomes.

Importance of Hypertension Control:

The HDSP LC is focused on improving hypertension outcomes because hypertension is one of the three key risk factors for heart disease. Heart disease is the leading cause of death in Americans.

- Black and African American individuals are 50% more likely to have hypertension and a higher heart disease mortality rates than whites.
- Disparities in hypertension treatment and control can be observed for other communities as well, such as Mexican-Americans and Asian-Americans.

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1. CDC. “High Blood pressure.” Available at https://www.cdc.gov/bloodpressure/index.htm
General’s Call to Action to Control Hypertension further elevates the importance of eliminating disparities in the treatment and control of hypertension by adapting a multilevel strategy.

Support from ASTHO:
ASTHO will support participating states by providing technical assistance through virtual planning meetings, learning sessions, and one-on-one technical assistance. States will receive support to develop, implement, and evaluate their jurisdiction’s project. In addition to providing support for the HTN program, ASTHO will also provide an additional learning opportunity focused specifically on cholesterol treatment and management to build knowledge and capacity to this related area of cardiovascular disease prevention.

Required Proposal Content:
Proposal Content: Please include the following elements in your submission. The project narrative may not exceed 3 pages in length. Appendices are not required but may be submitted as appropriate and will not count towards the page limit.

- **Cover Letter (5 points):** Letter from the health official expressing interest and support of participation in the LC. Please include the names and contact information (address, e-mail, and telephone number) of the primary project lead, secondary project lead, and financial/contract lead. The cover letter will not count towards the page limit.

- **Project Narrative (30 points):** Summary of your proposed strategies and action items to address the objectives outlined above. Please address the following in your proposal:
  - **Focus on an Outcome (4 points):** Strategies focused on improving hypertension of patients aged 35-64 years through HDSP LC’s logic model outcomes (see Appendix A). Applicants must select one outcome to focus on from the logic model. Outcomes and state examples are also listed in Table 1.
  - **Focus on an Essential Policy (4 points):** Strategies focused on improving hypertension through evidence-based policy, systems, or environmental (PSE) change. Applicants must choose one PSE change of focus from the Essential Policies for Chronic Disease Prevention and Control in Appendix D. Applicants are advised to develop activities that are sustainable beyond the project period.
  - **Integration of Health Equity (6 points):** Strategies to address hypertension should holistically address health inequities to prevent heart disease and stroke. Through this project, equitable change to prevent and control hypertension will be re-emphasized. Applicants must include strategies to achieve health equity. With the rise of telehealth during the COVID-19 pandemic, access to mass media and emerging technology becomes a priority. Applicants are encouraged to use the different conditions of social determinants of health as a reference. Applicants are encouraged to design activities that are transformational as defined in Table 2 and reference the Surgeon General’s Call to Action to Control Hypertension framework for multilevel influences on hypertension disparities on page 17 of the report/in Appendix C.
  - **Select a Jurisdiction to Focus (4 points):** As noted in the Surgeon General’s Call to Action to Control Hypertension, “the primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social.” Therefore, applicants are encouraged to select a jurisdiction with a high burden of
hypertension and significant social and economic need using CDC’s Interactive Atlas of Heart Disease and Stroke. Steps to generate county level data for your state are included in Appendix B.

- **Outline a High-Level Workplan (4 points):** Applicants must clearly list project goals, activities, partners, and timeline.

- **Collaboration (4 points):** Applicants must work across boundaries or sectors to establish cohesive partnerships with key entities that serve the same population. Applicants must describe partners they will collaborate with for the project. The outcome selected from Table 1 and social determinants of health focus area could help to identify partners.

- **Team Capacity (4 points):** Include information about the project team’s capacity to perform the tasks required within the specified timeframe. Please share project team’s needs to meet anticipated challenges and for virtual engagement (i.e., Zoom membership for partner meetings, etc.).

- **Budget & Budget Narrative (5 points):** Applicants must provide a budget that details plan to spend the total award amount of $35,000. A budget template is attached below and will not count towards the page limit.

**Application Review:**
Each application will be reviewed and rated by ASTHO and CDC staff. Proposals will be rated based on the inclusion of required proposal content.

**HDSP LC FY2021 Priorities:**
Past collaboratives have focused on outcomes highlighted in the HDSP LC logic model, which can be found in Appendix A. The key outcomes are listed below with examples of how states have implemented projects to achieve their selected outcome. The key outcomes will increase the proportion of adults with controlled hypertension.

**Table 1: Examples of state projects focusing on HDSP LC Logic Model outcomes**

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Increased protocols for identification of patients with high blood pressure | **Michigan State Snapshot:** Integrated follow-up protocols, high blood pressure management through community health workers.  
**Minnesota State Snapshot:** Used electronic health record systems to identify patients |
| Increased clinical linkages with lifestyle change programs | **Nevada Public Health Collaborative to Improve Cardiovascular Health:** Supported behavioral changes to improve diet and provider visits. |
Increased curricula and training for community-led resources and initiative  
Virginia State Snapshot: Linked patients to pharmacists and community support.

Expand payment mechanism for community-led initiatives  
Oklahoma State Snapshot: Tested a pay-for-performance model and calculating return on investment.

Other examples of state projects that focused on HDSP LC logic model outcomes are available on ASHTO’s Tools for Change.

ASTHO is committed to supporting states to design and implement system level change that will create sustainable health improvement. ASTHO developed a compendium of priority policies for State and Territorial Health Officials to prevent and control chronic disease. The full Essential Policies guide can be found in Appendix C.

Social Determinants of Health:  
ASTHO is committed to supporting state health agencies in their work to address health disparities and advance health equity. This commitment is evident in ASTHO’s vision statement and 2018-2021 Strategic Map and will be the central theme of the HDSP LC.

The American Psychological Association recognizes the physiological demand on the body caused by stress. This includes perceived discrimination, neighborhood stress, environmental stress, economic determinants, education, lower-quality care, inability to navigate the system, and provider ignorance, bias, or stress. These stressors may explain health disparities that currently exist. Through this project, project teams will identify and develop system-level strategies which will address health disparities.

Applicants are encouraged to incorporate transformational approaches when addressing health equity in their project proposals.

**Table 2: Transactional and transformative approaches**

<table>
<thead>
<tr>
<th></th>
<th>Transactional Approach</th>
<th>Transformative Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Issue-based efforts that help individuals negotiate existing structures. These solutions transact with institutions to get a short-term gain for communities but leave the existing structure in place.</td>
<td>Initiatives that cross multiple institutions that shift efforts towards proactive solutions. These solutions alter the ways institutions operate thereby shifting cultural values and political will to create equity.</td>
</tr>
<tr>
<td><strong>Approach</strong></td>
<td>Routine solutions using skills and experience readily available.</td>
<td>Require changes in values, beliefs, roles, relationships, and approaches towards work.</td>
</tr>
<tr>
<td><strong>People responsible</strong></td>
<td>Often solved by an authority or Expert.</td>
<td>Solved by the people with the problem.</td>
</tr>
<tr>
<td><strong>Changes required</strong></td>
<td>Require change in just one or a few places; often contained within organizational boundaries.</td>
<td>Requires change in numerous places; usually cross organizational boundaries.</td>
</tr>
</tbody>
</table>
Receptivity | People are generally receptive to technical solutions. | People try to avoid the work of “solving” the adaptive challenge.
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Timeframe | Can be implemented quickly—even by edict. | “Solutions” can take a long time to implement and require experiments and new discoveries; they cannot be implemented by edict.

**Source:**
Health Impact Partners: HealthEquityGuide.org. ASTHO Health Equity Workshop Presentation. October 30, 2019; Arlington, VA.

**Monetary Assistance Available:**
A total award amount of up to $35,000 will be provided to the participating health agency in this project. Contract funds may be used to support costs associated with participation in this project, including personnel, supplies, data collection, meeting expenses, and in-jurisdiction travel as consistent with the project outlined in the health agency’s workplan.

**Expectations for Participation:**
Participating states will be required to participate in the activities listed under the LC Activities and Timeline section. By agreeing to participate in the LC, state teams are also committing to responding to ASTHO’s communication outreach within two business days.

**LC Activities and Timeline:**
The following is a draft timeline and is subject to change. Dates will be determined based on participant availability.

<table>
<thead>
<tr>
<th>Month</th>
<th>Activities</th>
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</table>
| January 2021 | • Project period starts and contract initiated  
• Kick-off call  
• Invoice due |
| February 2021 | • Cohort virtual planning meeting  
• Individual state planning meeting: Completed action plan worksheet due one week from the meeting.  
• Baseline data due  
• Invoice due |
| March 2021   | • Check-in call 1  
• Invoice due |
| April 2021   | • Virtual learning session 1, submit Plan, Do, Study, Act (PDSA) cycle findings prior to each learning session.  
• Midpoint data due  
• Invoice due |
| May 2021               | • Check-in Call 2  
|                       | • Invoice due  
| June 2021            | • Virtual learning session 2, submit PDSA cycle findings prior to each learning session.  
|                       | • Cholesterol treatment and management learning opportunity  
|                       | • Invoice due  
| July 2021            | • Check-in call 3  
|                       | • Final report due: Highlighting overall successes, challenges, outcomes, and sustainability strategies.  
|                       |   • Documentation of processes, best practices, tools, and resources developed through this project, which may be shared via ASTHO’s Tools for Change resource library.  
|                       | • Endpoint data due  
|                       | • Invoice due  

**Scheduling State Kick-off Call:**
ASTHO will host a state kick-off call in January 2021. In the email submission with your proposal, please include your project team’s availability for the following days:
- January 12 to 14  
- January 19 to 21  
- January 26 to 28  

**Submission Information:**
ASTHO must receive the application by 11:59 PM ET on December 2, 2020. Please submit an electronic copy of the application to Amandeep Kaur, Analyst, Health Improvement (akaur@astho.org) and Talyah Sands, Director, Health Improvement (tsands@astho.org).
APPENDIX A

ASTHO/CDC Heart Disease and Stroke Prevention Learning Collaborative (LC) Logic Model

**Inputs**
- 2013-2018 DSP Learning Collaborative
- CDC/ASTHO leadership, guidance, and support
- S/T/HA partnerships with external stakeholders (e.g., community, employers, clinicians, NGOs, peers)
- Jurisdiction governance structure
- S/T/HA proposal workplan

**Activities**
- Virtual and in-person stakeholder convenings (e.g., ASTHO Learning Opportunities)
- Technical Assistance to S/T/HA teams
- S/T/HA continuous quality improvement and the use of data
- S/T/HA application of new information from capacity building resources (e.g., ASTHOWG, ASTHO/pacemakers)
- ASTHO and S/T/HA dissemination/communication among external stakeholders

**Outputs**
- Partnerships formalized (e.g., MOUs, contracts)
- Data collection and sharing
- Clinical/communtiy linkages
- Team-based care
- Financing and reimbursement (VRX)

**PDSA Cycles**
- Increased number of formalized partnerships across sectors
- Increased use of systems for information exchange
- Increased protocols for identification of patients with high blood pressure
- Increased clinical linkages with lifestyle change programs
- Increased care and training for community-based resources and initiatives
- Expanded payment mechanisms for community-led initiatives
- Increased use of CHWs

**Outcomes**
- Short Term
  - Increased identification (screening and diagnosis) of hypertension
  - Increased medical management and control of hypertension
  - Increased use of, and adherence to, evidence-based lifestyle change programs
- Intermediate
  - Transformed capacity of public health workers to facilitate community-led initiatives
  - Increased proportion of adults with hypertension with blood pressure under control
- Long Term
  - Decreased prevalence of adults with hypertension
APPENDIX B


**Directions to accessing social and economic data:**
- Open CDC’s *Interactive Atlas of Heart Disease and Stroke*
- Select *state report with county data. Select your state.*
- Under Report Data, click *social and economic data.*
- Choose one of the following to focus: *social environment, demographics, physical environment, or urban-rural status.*
  - Then select a subsection of the social and economic data.
- Click *show results.*

**Directions to accessing Hypertension data:**
- Open CDC’s *Interactive Atlas of Heart Disease and Stroke*
- Select *state report with county data. Select your state.*
- Under Report Data, click *health indicators.*
- Under *diagnosis categories*, choose *hypertension.*
- Select *death* as the *health indicator*
- Click *show results.*
- To access county data, click *county statistics.*

APPENDIX C


Information follows on next two pages.
Strategy C. Eliminate disparities in the treatment and control of hypertension.

Early and consistent access to health care can reduce or prevent hospitalizations and poor outcomes related to hypertension. However, as noted in Section 7, disparities exist in hypertension control, the adoption of healthy behaviors, and the presence of risk factors. As noted by Geoffrey Rose in his book *The Strategy of Preventive Medicine*, “the primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social.” Factors that influence these disparities include inequalities in the distribution of social, economic, and environmental conditions needed for health. Collectively, these factors are referred to as social determinants of health, or “conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.” These factors can be the primary drivers of health because they affect biology, physiology, health behaviors, health factors, clinical management, clinical outcomes, and community health.

Multiple factors contribute to disparities in hypertension, and these factors are influenced at multiple levels, including by individual patient factors, family and social support, health care providers and clinical teams, health care organization and practice settings, local communities, and state and national health policies (Figure 4).

Reducing disparities in hypertension control likely requires greater commitment to eliminating differences in access to quality health care while also addressing a variety of social factors that influence overall health. Culturally competent best practices that support individuals, their families, and clinicians

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Figure 4. Multilevel Influences on Disparities in Hypertension Prevention and Control

within unique communities are needed. A substantial gap exists between our knowledge of what works and what is actually being done to improve hypertension control across diverse communities, although promising examples of effective interventions exist. For example, interventions that incorporate addressing social determinants of health have been shown to help individuals improve both their systolic and diastolic blood pressure. However, limited data are available, and additional research is needed to understand how these factors can be integrated effectively into interventions.

One way to close the gap between knowledge and action is to ensure that the needs of individuals and specific populations drive translation research and that this research systematically evaluates which interventions work for which populations and in which settings and whether they are culturally relevant and sensitive. Affected individuals, clinicians, and communities should be brought into the process early and often to help assess the implementation and adaptation of best practices. Ideally, these partners can help researchers prioritize funding and identify champions that are already using emerging and promising practices in communities facing disparities. We need to re-envision how and where care is provided, particularly in areas where people get health care from a variety of sources, and remove barriers. This approach will require action where people live, work, and play, with a focus on achieving health equity and eliminating disparities.

APPENDIX D

Essential Policies for Chronic Disease Prevention and Control: Priorities for State and Territorial Health Officials.

Information follows on next page.
<table>
<thead>
<tr>
<th>Essential Policies for Chronic Disease Prevention and Control</th>
<th>Authority</th>
<th>Influence</th>
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<tbody>
<tr>
<td><strong>Tobacco</strong></td>
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<tr>
<td>1. Increase taxes on all tobacco products</td>
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<tr>
<td>2. Create &amp; enforce comprehensive tobacco-free air policies</td>
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<td>3. Restrict all forms of tobacco product advertising</td>
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<tr>
<td>4. Restrict all tobacco product flavors, including menthol</td>
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<tr>
<td>5. Protect local authority to enact tobacco control policies</td>
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<tr>
<td>6. Promote policies that increase access to tobacco cessation programs</td>
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<tr>
<td><strong>Nutrition</strong></td>
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<td></td>
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<tr>
<td>1. Implement multicomponent policies that reduce sugar consumption</td>
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<td>2. Implement policies that promote breastfeeding</td>
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<tr>
<td>3. Implement procurement, contracting and retail policies that increase access to healthy foods</td>
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<tr>
<td>4. Implement nutrition policies in early child care facilities</td>
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<tr>
<td>5. Enhance access to, utilization of, and nutritional quality of school meals</td>
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<tr>
<td><strong>Physical Activity</strong></td>
<td></td>
<td></td>
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<tr>
<td>1. Increase support and resources for physical activity in community settings</td>
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<td></td>
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<tr>
<td>2. Support built environment policies that promote physical activity</td>
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<tr>
<td>3. Enhance physical education and recess standards in schools</td>
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<tr>
<td>4. Implement policies to increase physical activity and reduce screen time in early childhood education settings</td>
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<tr>
<td><strong>Chronic Disease Control</strong></td>
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<tr>
<td>1. Create policies and structures to establish community health workers in the public health workforce</td>
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<tr>
<td>2. Prohibit tanning bed use among minors under the age of 18</td>
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<tr>
<td>3. Introduce policies that increase access to Diabetes Prevention Programs</td>
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<tr>
<td>4. Support policies that improve prescribing of, and adherence to hypertensive treatment plans including blood pressure self monitoring</td>
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<tr>
<td>5. Support policies that incentivize the early detection and diagnosis of cognitive impairment and dementia in healthcare settings</td>
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