

FY2022 State Heart Disease and Stroke Prevention Learning Collaborative: Improving Hypertension Through Equitable Change REQUEST FOR PROPOSALS

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 state public health agencies, with priority for applications that prioritize a jurisdiction with a high burden of hypertension and significant social and economic need. See note below about the option to select a bona fide agent.
- **Funding Amount:** minimum of \$100,000 per state (up to 7 states), with the option to request up to \$150,000.
- **Intent to Apply:** Email chronicdisease@astho.org of your intent to apply by Jan. 28, 2022.
- **Proposal Due Date and Time:** Feb. 11, 2022, 11:59 p.m. ET.
- **Selection Announcement Date:** Feb. 23, 2022.
- **Estimated Period of Performance and Final Report Date:** Feb. 28, 2022 to July 31, 2022.
- **ASTHO Point of Contact:** chronicdisease@astho.org.

Objectives:

State and territorial health agencies (S/THAs) are key leaders in preventing heart attacks and strokes. Since 2013, ASTHO has partnered with CDC's Division for Heart Disease and Stroke Prevention to support S/THAs through a learning collaborative to address hypertension. To date, the ASTHO/CDC Heart Disease and Stroke Prevention Learning Collaborative has engaged 32 S/THAs in implementing innovative models to prevent hypertension through system changes and quality improvement processes.

In FY2022, the ASTHO/CDC Heart Disease and Stroke Prevention (HDSP) Learning Collaborative (LC) is building on its initiative to support jurisdictions in implementing innovative strategies around state heart disease and stroke prevention projects, which focus on improving hypertension through equitable change through the following objectives:

1. Through the use of equitable strategies, increase the percentage of patients 35-64 years of age who had hypertension diagnosis and achieved control during the measurement period.
2. Develop evidence-based policy, systems, or environmental change strategies that are sustainable for long-term impact.
3. Address associated risk factors, such as excess sodium consumption, tobacco use, or physical inactivity as a way to improve hypertension prevention and control.

Importance of Improving Hypertension Outcomes:

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

Technical Assistance 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.

Required Proposal Content:

Please include the following elements in your submission. The project narrative may not exceed 3 pages in length (size 11 font). Appendices are not required but may be submitted as appropriate and will not count towards the page limit.

Note: Applicants may work with an entity, whether coalitions, universities, or local entities to apply as bona fide agents on their behalf. The bona fide agent will be required to submit a letter from the state public health agency designating the entity of this status and confirming their involvement as a partner in the project.

- **Cover Letter (10 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. 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.
- **Project Narrative (30 points):** Summary of your proposed strategies and action items to address the objectives outlined above. Applicants are encouraged to address associated risk factors for hypertension through their proposed initiatives, such as but not limited to addressing excess sodium consumption as a way to improve hypertension control and prevention. Please address the following in your proposal:

ⁱ CDC. "High Blood pressure." Available at <https://www.cdc.gov/bloodpressure/index.htm>

ⁱⁱ CDC. "African American Health." Available at <https://www.cdc.gov/vitalsigns/aahealth/index.html>

ⁱⁱⁱ Al Kibria, Gulam Muhammed. "Racial/ethnic disparities in prevalence, treatment, and control of hypertension among US adults following application of the 2017 American College of Cardiology/American Heart Association guideline." Preventive medicine reports vol. 14 100850. 16 Mar. 2019, doi:10.1016/j.pmedr.2019.100850 Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6488531/>. Accessed 10-23-2020.

- **Focus on an Outcome (5 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 of the following outcomes to focus on from the logic model. Outcomes and state examples are also listed in Table 1.

Outcomes (Choose One)
Increased protocols for identification of patients with high blood pressure
Increased clinical linkages with lifestyle change programs
Increased curricula and training for community-led resources and initiatives
Expand payment mechanisms for community-led initiatives

- **Focus on an Essential Policy with the Goal Hypertension Management (5 points):** As part of a dual approach and to complement your outcome, select one evidence-based policy, systems, or environmental (PSE) change to help address risk factors associated with hypertension. ASTHO is committed to supporting states to design and implement system level change that will create sustainable health improvement, guided by relevant policies from ASTHO’s [Essential Policies for Chronic Disease Prevention and Control](#) in the table below. Applicants are advised to develop activities that are sustainable beyond the project period.

Essential Policies (Choose One)
Tobacco
Create & enforce comprehensive tobacco-free air policies
Nutrition
Implement food service guidelines, procurement, and environmental policies that increase access to healthy foods
Physical Activity
Support built environment policies that promote physical activity
Increase support and resources for physical activity in community settings

Chronic Disease
Create policies and structures to establish community health workers in the public health workforce
Introduce policies that increase access to Diabetes Prevention Programs
Support policies that improve prescribing of, and adherence to hypertensive treatment plans including blood pressure self-monitoring

- **Integration of Health Equity (20 points):** Strategies to address hypertension should holistically address health inequities to prevent heart disease and stroke. The applicant will demonstrate consideration and experience in addressing health inequities through culturally tailored community engagement. Demonstrate understanding of key concepts such as social determinants of health, health equity, systems change, collective impact, community leadership, and how those terms would be applied to this project. Through this project, equitable change to prevent and control hypertension will be re-emphasized. Proposals will be judged according to two health equity elements:
 - *Applicants must identify a focal community for their health equity efforts.* 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.” Applicants must identify a focal community with a high burden of hypertension and significant social/economic need, and describe how their proposed program will be catered to meet the needs of this community. Applicants are encouraged to use these resources to help them identify a focal community:
 - [CDC’s Interactive Atlas of Heart Disease and Stroke](#) is an online mapping tool that allows users to create and customize county-level maps of heart disease and stroke by race and ethnicity, gender, and age group across U.S. states and territories.
 - Steps to generate county level data for your state are included in Appendix B.
 - *Applicants must include strategies to achieve health equity.* Applicants are encouraged to use these resources to help them incorporate health equity strategies into their proposals:
 - ASTHO’s [Guidance for Integrating Health Equity Language Into Funding Announcements](#) is a resource for states to incorporate health equity into their operations, provides health equity terms and examples of health equity activities.
 - Healthy People 2030 defines a broad array of [social determinants of health](#); these social determinants influence health disparities and health equity.

- The [Surgeon General’s Call to Action to Control Hypertension](#) framework describes multilevel influences on hypertension disparities on page 17 of the report/in Appendix C. Applicants are encouraged to design “transformational” activities, as defined in this resource and in Table 2 below.

Consideration will be given to applicants who demonstrate successful work with historically underserved and underrepresented entities (minority-, women-, disadvantaged-, and veteran-owned businesses or “MWDVBEs” and black, indigenous, people of color or “BIPOC”) in addressing health disparities.

- **Outline a High-Level Workplan (10 points):** Applicants must clearly list project goals, activities, partners, and timeline.
 - *Collaboration:* Applicants must work across sectors to establish cohesive partnerships with key entities that serve the same population. Applicants must describe partners they will collaborate with for the project. Applicants are encouraged to identify partners that align with their chosen outcome, essential policy, and/or health equity goals.
- **Budget and Budget Narrative (10 points):** Applicants must provide a budget that details plan to spend the total award amount of a minimum of \$100,000, with the option to request up to \$150,000. A budget narrative must accompany the budget and indicate the costs associated with each proposed activity (*see tab in template*). Budgets must be submitted in Excel format even if the ASTHO template is not used. A budget template is available in Attachment A and will not count towards the page limit.
- **Response to ASTHO Contract Terms and Conditions (10 points):** **ASTHO and selected applicant(s) will enter into a fixed price agreement.** A copy of ASTHO’s general contract terms and conditions is available in **Attachment B. *Review the terms and conditions with your contracts officer or legal team and confirm that if selected, you will enter into this agreement; or identify and include any proposed changes to the terms with your proposal application.*** ASTHO reserves the right to accept or decline any proposed changes to the terms and conditions. Significant proposed changes, which could affect the agreement’s timely execution, may impact your selection as a successful applicant.

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 FY2022 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

Outcomes	Examples
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 ASTHO's [Tools for Change](#).

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

	Transactional Approach	Transformative Approach
Definition	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.	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.
Approach	Routine solutions using skills and experience readily available.	Require changes in values, beliefs, roles, relationships, and approaches towards work.
People responsible	Often solved by an authority or Expert.	Solved by the people with the problem.
Changes required	Require change in just one or a few places; often contained within organizational boundaries.	Requires change in numerous places; usually cross organizational boundaries.
Receptivity	People are generally receptive to technical solutions.	People try to avoid the work of “solving” the adaptive challenge.
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.
<p>Source: Human Impact Partners: HealthEquityGuide.org. ASTHO Health Equity Workshop Presentation. October 30, 2019; Arlington, VA. Content adapted from Ronald A. Heifetz & Donald L. Laurie, “The Work of Leadership,” Harvard Business Review, January-February 1997; and Ronald A. Heifetz & Marty Linsky, Leadership on the Line, Harvard Business School Press</p>		

Monetary Assistance Available:

A total award amount of \$100,000 minimum, with the option to request up to \$150,000, will be provided to the participating health agency in this project through a fixed-price agreement. 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.

Allowable Expenses

Funds may not be used for equipment purchases. Per HHS requirements, funds awarded under this RFP are prohibited from being used to pay the direct salary of an individual at a rate in excess of the federal Executive Schedule Level II (currently \$203,700).

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. Please provide both a first and second designated point of contact (email and phone and indicate communication type preference) that will be responsive to ASTHO staff. These contacts will be expected to respond to correspondence within four business days. This will help to ensure clear and consistent communication.

LC Activities and Timeline:

The following is a draft timeline and is subject to change. Dates will be determined based on participant availability.

Month	Activities
February-March 2022	<ul style="list-style-type: none"> • Project period starts and contract initiated • Kick-off call • Invoice due
March 2022	<ul style="list-style-type: none"> • Cohort virtual planning meeting • Individual state planning meeting: Completed action plan worksheet due one week from the meeting. • Baseline data due • Invoice due
April 2022	<ul style="list-style-type: none"> • Check-in call 1 • Virtual learning session 1, submit Plan, Do, Study, Act (PDSA) cycle findings prior to each learning session. • Midpoint data due • Invoice due
May 2022	<ul style="list-style-type: none"> • Check-in Call 2 • Invoice due
June 2022	<ul style="list-style-type: none"> • Virtual learning session 2, submit PDSA cycle findings prior to each learning session. • Cholesterol treatment and management learning opportunity • Invoice due
July 2022	<ul style="list-style-type: none"> • Closing Meeting • Final report due: Highlighting overall successes, challenges, outcomes, and sustainability strategies. <ul style="list-style-type: none"> ○ 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 February - March 2022. In the email submission with your proposal, please include your project team’s availability for the following days:

- Feb. 28 to March 2, 2022
- March 14 to 16, 2022

Submission Information:

ASTHO must receive the application by 11:59 PM ET on January 28, 2022. Please submit an electronic copy of the application to chronicdisease@astho.org

Timeline

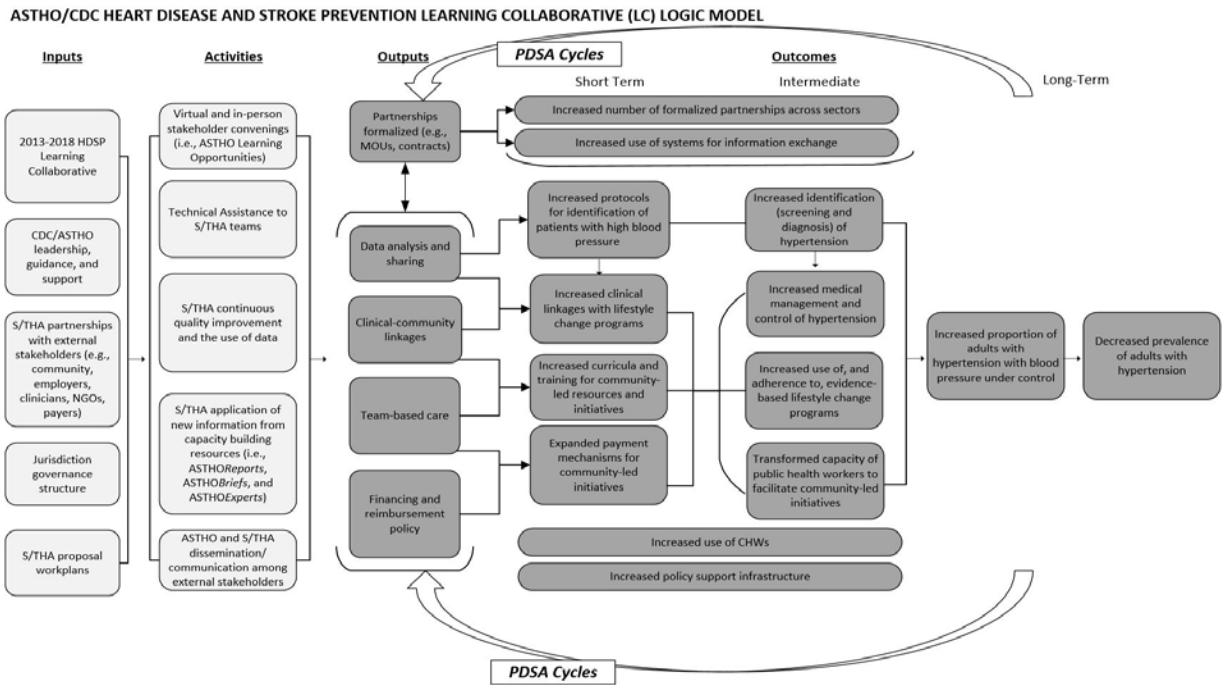
- Dec. 15, 2021: RFP released
- Feb. 11, 2022, 11:59 PM EDT Deadline for submission of grant proposals
- Feb. 23, 2022: Contract award announced
- Feb. 28, 2022: Contract period commences
- June 30, 2022: Final report due
- July 31, 2022: Contract period ends

Disclaimer Notice:

This RFP is not binding on ASTHO, nor does it constitute a contractual offer. Without limiting the foregoing, ASTHO reserves the right, in its sole discretion, to reject any or all proposals; to modify, supplement, or cancel the RFP; to waive any deviation from the RFP; to negotiate regarding any proposal; and to negotiate final terms and conditions that may differ from those stated in the RFP. Under no circumstances shall ASTHO be liable for any costs incurred by any person in connection with the preparation and submission of a response to this RFP.

APPENDIX A

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



APPENDIX B

Source: *Interactive Atlas of Heart Disease and Stroke Tables, 2020*. Center for Disease Control and Prevention. Available at <https://nccd.cdc.gov/DHDSPAtlas/Reports.aspx>

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

Source: U.S. Department of Health and Human Services. *The Surgeon General's Call to Action to Control Hypertension*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2020.

Information follows on next two pages.

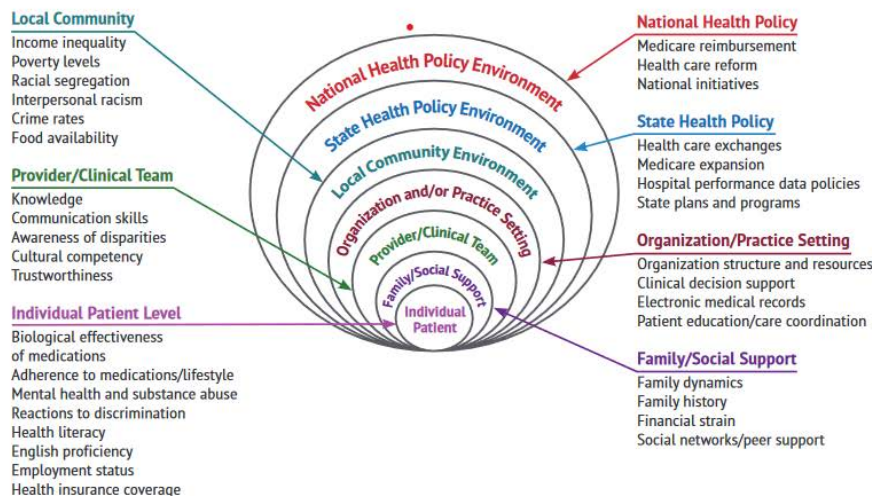
Strategy C. Eliminate disparities in the treatment and control of hypertension.

Early and consistent access to health care can reduce or prevent hospitalizations and poor outcomes related to hypertension. However, as noted in Section 2, disparities exist in hypertension control, the adoption of healthy behaviors, and the presence of risk factors.^{143,144,145} 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.”¹⁴⁶ 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.”¹⁴⁷ 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.^{47,148}

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.⁴⁷ Culturally competent best practices that support individuals, their families, and clinicians

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



Source: Mueller M, Purnell TS, Mensah GA, Cooper LA. Reducing racial and ethnic disparities in hypertension prevention and control: what will it take to translate research into practice and policy? *Am J Hypertens*. 2015;28(6):699–704.

“There is no known biological reason why every population should not be as healthy as the best.... The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social.”

—Geoffrey Rose, author of *The Strategy of Preventive Medicine*

within unique communities are needed.¹⁴⁹ This may include increasing clinician awareness of disparities in the communities they serve and how their awareness may influence the care provided.¹⁵⁰ 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.^{15,151,152,153} For example, interventions that incorporate addressing social determinants of health have been shown to help individuals improve both their systolic and diastolic blood pressure.¹⁵⁴ 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 research¹⁵⁵ and that this research systematically evaluates which interventions work for which populations and in which settings¹⁵⁶

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.