****

**National Cardiovascular Health Program**

**Each applicant must propose work in all strategies below.**

**These are the required Outcomes for Strategy 1:**

|  |
| --- |
| 1. Increased use of electronic health records or health information technology to report, monitor, and track clinical and social services and support needs data to improve detection of health care disparities and the identification, management, and treatment of patients at highest risk of cardiovascular disease, with a focus on hypertension and high cholesterol.
 |
| 1. Increased use of standardized processes or tools to identify, assess, track, and address the social services and support needs of patient populations at highest risk of CVD.
 |
| 1. Improved blood pressure control among populations within partner health care and community settings.
 |
| 1. Increased utilization of social services and support among populations at highest risk of CVD, with a focus on hypertension and high cholesterol.
 |

**Enter the following information for Action Steps to support Strategy 1A to achieve the Strategy 1 Outcomes above.**

**REQUIRED Strategy 1A:** Advance the adoption and use of electronic health records or health information technology, to identify, track, and monitor measures for clinical and social services and support needs to address health care disparities and health outcomes for adults at highest risk of CVD with a focus on hypertension and high cholesterol.

|  |  |  |  |
| --- | --- | --- | --- |
| **Action Steps** (specific activities that assist in accomplishing the outcome) | **Responsible Party/Partners** (individual or agency responsible for action step) | **Outputs**(e.g., products, new findings) | **Timeline** (estimated completion date) |
| *Enter Action Step* |  |  | *Enter Date* |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Enter the following information for Action Steps to support Strategy 1B to achieve the Strategy 1 Outcomes above.**

**REQUIRED Strategy 1B:** Promote the use of standardized processes or tools to identify the social services and support needs of patient populations at highest risk of CVD, with a focus on hypertension and high cholesterol, and monitor and assess the referral and utilization of those services, such as food assistance, transportation, housing, childcare, etc.

|  |  |  |  |
| --- | --- | --- | --- |
| **Action Steps** (specific activities that assist in accomplishing the outcome) | **Responsible Party/Partners** (individual or agency responsible for action step) | **Output**(e.g., products, new findings) | **Timeline** (estimated completion date) |
| *Enter Action Step* |  |  | *Enter Date* |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**These are the required Outcomes for Strategy 2:**

|  |
| --- |
| 1. Increased use of electronic health records or health information technology to support communication and coordination among care team members to monitor and address patients’ hypertension and high cholesterol.
 |
| 1. Increased use of multidisciplinary care teams adhering to evidence-based guidelines to address patients' social services and support needs and improve the management and treatment of hypertension and high cholesterol.
 |
| 1. Increased multidisciplinary partnerships that address identified barriers to social services and support needs within populations at highest risk of CVD.
 |

**Enter the following information for Action Steps to support Strategy 2A to achieve the Strategy 2 Outcomes above.**

**REQUIRED Strategy 2A:** Advance the use of health information systems that support team-based care to monitor population health with a focus on health disparities, hypertension, and high cholesterol.

|  |  |  |  |
| --- | --- | --- | --- |
| **Action Steps** (specific activities that assist in accomplishing the outcome) | **Responsible Party/Partners** (individual or agency responsible for action step) | **Output**(e.g., # of trainings, partners) | **Timeline** (estimated completion date) |
| *Enter Action Step* |  |  | *Enter Date* |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Enter the following information for Action Steps to support Strategy 2B to achieve the Strategy 2 Outcomes above.**

**REQUIRED Strategy 2B:** Assemble or create multidisciplinary teams (e.g., nurses, nurse practitioners, pharmacists, nutritionists, physical therapists, social workers, and community-based workers) to identify patients' social services and support needs and to improve the management and treatment of hypertension and high cholesterol.

|  |  |  |  |
| --- | --- | --- | --- |
| **Action Steps** (specific activities that assist in accomplishing the outcome) | **Responsible Party/Partners** (individual or agency responsible for action step) | **Output**(e.g., # of trainings, partners) | **Timeline** (estimated completion date) |
| *Enter Action Step* |  |  | *Enter Date* |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**These are the required Outcomes for Strategy 3:**

|  |
| --- |
| 1. Increased community clinical links to identify and respond to social services and support needs of populations at highest risk of CVD with a focus on hypertension and high cholesterol.
 |
| 1. Increased engagement of community health workers (or their equivalents) to provide a continuum of care extending clinical interventions and addressing social services and support needs.
 |
| 1. Increased use of self-measured blood pressure with clinical support within populations at highest risk of hypertension.
 |
| 1. Reduced disparities in hypertension control among populations within partner health care and community settings.
 |

**Enter the following information for Action Steps to support Strategy 3A to achieve the Strategy 3 Outcomes above.**

**REQUIRED Strategy 3A:** Create and enhance community-clinical links to identify social determinants of health (e.g., inferior housing, lack of transportation, inadequate access to care, and limited community resources) and respond to the social services and support needs of populations at highest risk of CVD with a focus on hypertension and high cholesterol.

|  |  |  |  |
| --- | --- | --- | --- |
| **Action Steps** (specific activities that assist in accomplishing the outcome) | **Responsible Party/Partners** (individual or agency responsible for action step) | **Output**(e.g., # of trainings, partners) | **Timeline** (estimated completion date) |
| *Enter Action Step* |  |  | *Enter Date* |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |