

**Maryland Department of Health and Mental Hygiene
Center for Chronic Disease Prevention and Control
Request for Proposals (RFP)**

TITLE: Identifying Undiagnosed Hypertension in Health Systems

Funding Opportunity:

The Maryland Department of Health and Mental Hygiene (DHMH), Center for Chronic Disease Prevention and Control (CCDPC), with funding from the Centers for Disease Control and Prevention (CDC), will award up to three (3) Local Health Departments (LHDs) up to \$55,000 each to identify individuals in health systems with undiagnosed hypertension and link them to follow up care by working with at least two (2) target health systems/practices. The award period will be July 1, 2016 to June 29, 2017, with the potential for a second year of funding (July 1, 2017 to June 29, 2018).

All LHDs in Maryland are eligible to apply except for LHDs currently funded through the State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease (1422) Grant. LHDs not eligible for this RFP include Allegany County, Baltimore City, Caroline County, Dorchester County, Garrett County, Somerset County, Washington County, Wicomico County, and Worcester County.

LHDs interested in submitting a proposal in response to this RFP may also apply for funding through the “Quality Improvement in Health Systems” RFP, which will be made available by CCDPC during the same timeframe; however, any LHD applying for both awards must identify different target health systems/practices in each proposal.

Competitive applications will be detailed and comprehensive. All applications will be objectively reviewed and scored by a grant review team based on criteria outlined in this RFP.

Background:

Despite great progress over the past decade, chronic diseases including heart disease, cancer, stroke, diabetes, and obesity remain the leading causes of death and disability in both the United States and Maryland. In Maryland, one third of adults report having been told by a doctor or health care professional that they have high blood pressure.¹ Research shows that less than half of people with hypertension have their blood pressure adequately controlled.² Among those with uncontrolled hypertension, many people (40% or 14.1 million people) are unaware they have hypertension and millions more (45% or 16 million people) are taking blood pressure medicines, but still are not under control.³ Nearly 90% of U.S. adults with uncontrolled hypertension have a usual source of health care and insurance, representing a missed opportunity for hypertension control.⁴ Research shows that closer examination of patient population level data from electronic health record (EHR) systems in practices can reveal that up to 40% of patients meeting the clinical criteria for hypertension may not have a diagnosis code in their medical record.⁵

By working within the health system, public health practitioners can drive population-based outcomes in chronic diseases. Specifically, LHDs have the unique opportunity to improve clinical outcomes in chronic diseases

¹ Maryland Behavioral Risk Factor Surveillance System, 2013. Available at www.marylandbrfss.org.

² Centers for Disease Control and Prevention. Vital Signs: Awareness and Treatment of Uncontrolled Hypertension Among Adults-United States, 2003-2010. MMWR September 7, 2012: 61(35); 703-709.

³ Ibid.

⁴ Ibid.

⁵ Wall, HK; Hannan, JA; Wright, JS. Patients with Undiagnosed Hypertension: Hiding in Plain Sight. *American Medical Association*. November 19, 2014: 312(19); 1973-1974.

through population-based quality improvement efforts. Strategies outlined in the Scope of Work section in this RFP focus on interventions to identify individuals in the health system who remain undiagnosed with hypertension and linking these patients to clinical and community-based services.

Summary:

Total Award Amount: Up to \$55,000 per LHD

Total Number of Awards: 3

Approximate Award Period: July 1, 2016 to June 29, 2017

Note: The award may be extended for a second year, depending on available funding, sufficient year one progress, and the submission and approval of a year two budget and work plan

Eligibility: All LHDs in Maryland except for LHDs currently funded through the State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease (1422) Grant. LHDs not eligible for this RFP include Allegany County, Baltimore City, Caroline County, Dorchester County, Garrett County, Somerset County, Washington County, Wicomico County, and Worcester County.

Application Deadline Date: April 29, 2016, 2:00pm Eastern Daylight Savings Time

An informational webinar will be held on Friday, April 8, 2016 from 1:00 – 2:00 PM EDT. All LHDs interested in applying for this RFP should participate. Prior to the webinar, please contact marti.deacon@maryland.gov to register. LHDs may participate by [clicking here to join the WebEx meeting](#) (Meeting Number: 640 851 879) and joining by phone at 1-415-655-0003 (Access Code: 640 851 879).

Scope of Work:

LHDs have the opportunity to play an important role in integrating public health approaches into health care delivery through collaboration with health systems partners. The purpose of this RFP is to encourage LHDs to work with health systems/practices to develop and implement policies, systems, and environmental changes to:

1. Identify patients with undiagnosed hypertension; and,
2. Link them to follow up care, including clinical and/or community-based services.

LHDs will work within their jurisdictions to develop and implement interventions and activities in alignment with the priority strategies outlined in this RFP. LHDs will be expected to fully implement health system interventions to identify at least 50 patients with potentially undiagnosed hypertension, re-engage those patients, and link them to follow up clinical and/or community-based services. Additionally, LHDs will be expected to implement systems changes to improve the identification and diagnosis of patients with hypertension going forward.

Strategies:

Applicants must implement **all of the following strategies** in target health systems/practices during the grant period:

- I. Utilize health information technology (e.g. algorithms, decision supports, etc.) to develop patient registries or patient lists that identify patients with potentially undiagnosed hypertension, and engage those patients in follow up care and, if appropriate, diagnosis and treatment.
 - i. Funded LHDs should base interventions and activities for this strategy on identifying and re-engaging patients who have two or more elevated blood pressure readings in the past two years but no diagnosis of hypertension in the EHR/medical record.
- II. Implement policies, systems, and environmental changes (e.g. flagging elevated readings, decision supports, data validation policies to standardize EHR entry and eliminate free text diagnosis, etc.) to improve the identification and diagnosis of patients with hypertension and linkage to follow up clinical or community-based services.

Applicants are encouraged to also include one or more of the following activities in their work plan to promote follow up care through clinical and community-based services:

- I. Implement policies, systems, and environmental changes in health systems/practices to establish referral systems to evidence-based programs, such as Chronic Disease Self-Management Programs, as appropriate.
- II. Utilize health information technology to facilitate bi-directional data sharing to support care coordination and to improve health outcomes.
- III. Increase engagement of non-physician team members (i.e., nurses, pharmacists, community health workers, and patient navigators) in hypertension management in health systems.
- IV. Promote pharmacist delivered medication therapy management (MTM) services to patients with uncontrolled hypertension.

Outcomes:

Outcome 1: Improved identification of hypertension.

Outcome 2: Improved linkage to clinical and community-based services for patients with hypertension.

Performance Measures:

Throughout the duration of the grant period, funded LHDs must provide **quarterly data** for the following performance measures for each target health system/practice:

- Prevalence of hypertension, including:
 - Numerator - Number of patients, 18 to 85 years of age, in practice with a diagnosis of hypertension
 - Denominator - Total number of patients, 18 to 85 years of age, in the practice
 - Percent – Percent of patients, 18 to 85 years of age, in the practice with a diagnosis of hypertension
- Number of patients identified as potentially having undiagnosed hypertension based on the following guideline: Two or more elevated blood pressure readings documented in the past two years (24 months) with no diagnosis of hypertension in the EHR/medical record.
- Number of patients identified as potentially having undiagnosed hypertension who were re-engaged and brought in for follow up clinical care.
- Number of patients identified as potentially having undiagnosed hypertension who were re-engaged and brought in for follow up clinical care and subsequently received a diagnosis of hypertension.
- Number of patients referred to:
 - Stanford-licensed Chronic Disease Self-Management Programs (CDSMP or Living Well)
 - Maryland QuitLine
 - Other community resources (Please specify)
 - Other clinical services (Please specify)

Awardee/Reporting Requirements:

LHDs will be required to work with at least two (2) health systems/practices to:

- Complete a summary of each health system/practice at the beginning and end of the grant period, and submit to CCDPC. (Attachment B)
- Guide health systems/practices in completing Plan-Do-Study-Act worksheets (Attachment C) monthly to describe quality improvement interventions, and submit to CCDPC as an attachment to LHD monthly narrative updates.
- Work with health systems/practices to report data on performance measures on a quarterly basis, and submit to CCDPC (template will be provided).

LHDs will be required to:

- Participate in monthly Community of Practice calls organized by CCDPC.
- Participate in monthly one-on-one calls organized by CCDPC.
- Submit narrative updates monthly to CCDPC (template will be provided).
- Submit expenditure reports on a quarterly basis.
- Submit a final evaluation report (template will be provided).

Technical Proposal Submissions:

Interested LHDs shall send a narrative technical proposal that must be no smaller than 12-point font, double-spaced, with one-inch margins. Technical proposals shall be no longer than 10 pages (this excludes work plan attachment, budget, budget narrative, letters of commitment, letters of support, and any additional attachments).

Technical Proposals:

The narrative technical proposal must be no longer than 10 pages and must include the following:

1. Contact Information
 1. Organization name, billing address, Federal Employer Identification Number (FEIN), and DUNS
 2. Name, address, telephone number, e-mail address, fax number, and position/title of the individual who will serve as the primary contact for this project.
2. Background Information
 1. Description of the burden of hypertension in the jurisdiction.
 2. Description of the problem statement.
3. Approach
 1. Identification and description of at least two (2) target health systems/practices. Include the rationale for selecting these health systems/practices.
 2. Description of strategies, and interventions and activities to address strategies. Include the rationale for proposed interventions and activities. Include estimated reach, and specify whether the proposed interventions and activities will impact the entire health system/practice population or will focus on a targeted subgroup.
4. Capacity and Commitment
 1. Description of organizational capacity, including experience working with health systems and building community-clinical linkages.
 2. Description of key staff/contractors, including their role, time commitment to interventions and activities described in the approach/work plan, and relevant skills and experience.
 3. A realistic timeline for filling staff vacancies to meet project outcomes.
 4. Description of organization commitment to the project, such as in-kind staff support, leadership involvement, leveraging additional funding, or other opportunities to enhance the impact and sustainability of this project.
5. Demonstrated Readiness to Implement Scope of Work
 1. Established commitment of at least two (2) target health systems/practices to implement proposed strategies and interventions, as supported by attached Letters of Commitments.
 2. Description of capacity of target health systems/practices to implement RFP strategies.

3. Inclusion of baseline data from target health systems/practices. Applicants must include the total number of patients in each target health system/practice and baseline hypertension prevalence data for each target health system/practices.
6. Program Evaluation
 1. Description of process and outcome measures for proposed interventions. Include targets as applicable.
 2. Description of the process for data collection and reporting. Include the frequency with which data will be collected and staff responsible.
 3. Description of how evaluation findings will be used for continuous improvement during the project period.
7. Sustainability
 1. Description of plans to promote program sustainability.
 2. Description of how work will result in sustainable policy, systems, and environmental changes.

Required Attachments:

The following attachments must also be included (and are not counted in the 10 page limit):

1. Completed Work Plan Template (Attachment A)
2. A minimum of two signed Letters of Commitment from health systems partners detailing past collaborative efforts, current role, alignment with strategic direction, description of expectations for strategy implementation, and if applicable in-kind contributions.
3. A detailed, narrative budget including a justification or rationale for all line items.
 - LHDs are encouraged to budget at least 5-10% of the total funding award to evaluation activities which could entail data analysis support.
 - Funds may **not** be used for food, lobbying, the purchase of medical equipment (including blood pressure cuffs/monitors), the delivery of evidence-based community programs (such as the Chronic Disease Self-Management Programs), or the provision of direct clinical services (education and screening are acceptable).
4. A budget submitted using the DHMH UFD Excel template

Review Criteria and Scoring:

1. Background Information (10 points) – The extent to which the applicant:
 - a. Describes the burden/need. (5)
 - b. Describes the problem statement. (5)
2. Approach/Work Plan Attachment (25 points) – The extent to which the applicant:
 - a. Identifies and describes at least two target health systems/practices, and provides a rationale for selecting those systems/practices. (4)
 - b. Clearly describes selected strategies and proposed interventions/activities, including rationale. (5)
 - c. Clearly describes the reach of proposed interventions/activities, and specifies whether interventions/activities will impact the entire health system/practice population or will focus on a targeted subgroup. (4)
 - d. Work plan demonstrates alignment with the strategies and performance measures listed in the RFP. (2)

- e. Work plan outlines SMART (specific, measureable, achievable, realistic, and time-phased) objectives for the project period including plans for identifying and accessing data for any performance measures where data is currently unavailable. (5)
 - f. Work plan lists appropriate objectives and activities that will be done to accomplish the work and achieve the performance measures for each strategy. (5)
3. Capacity and Commitment (12 points) – The extent to which the applicant:
- a. Describes organizational capacity, including quality improvement expertise and experience working with health systems partners. (5)
 - b. Describes key staff/contractors, including their role, time commitment to interventions and activities described in the approach/work plan, and relevant skills and experience. (4)
 - c. Includes a realistic timeline for filling staff vacancies to meet project outcomes. (1)
 - d. Describes organization commitment to the project, such as in-kind staff support, leadership involvement, leveraging additional funding, or other opportunities to enhance the impact and sustainability of this project. (2)
4. Demonstrated Readiness (23 points) – The extent to which the applicant:
- a. Describes established health systems partnerships relevant to the strategies and interventions and provides supporting Letters of Commitments from those partners. (3)
 - b. Describes capacity of target health systems/practices to implement RFP strategies. (10)
 - c. Inclusion of baseline data from target health systems/practices. Number of patients and hypertension prevalence in target systems/practices seems appropriate to demonstrate reach and impact through RFP strategies. (10)
5. Program Evaluation (15 points) – The extent to which the applicant:
- a. Describes process and outcome measures for proposed interventions, including targets as applicable. (5)
 - b. Describes the process for data collection and reporting. Include the frequency with which data will be collected and staff responsible. (5)
 - c. Describes how evaluation findings will be used for continuous improvement during the project period. (5)
6. Sustainability (15 points) – The extent to which the applicant:
- a. Describes plans to promote program sustainability. (5)
 - b. Describes how work will result in sustainable policy, systems, and environmental changes. (10)

SUBMISSION DEADLINE:

Completed proposals with all required attachments must be emailed to marti.deacon@maryland.gov no later than 2:00 p.m. (Eastern Time) on April 29, 2016. You will receive an email confirming receipt.

(Attachment A) Work Plan Template

Instructions:

1. Use the below work plan template to outline strategies, objectives, and activities for the project period (July 1, 2016 to June 29, 2017).
2. Add further sections or rows as necessary.
3. Refer to the following definitions for use in this document:
 1. **Outcome Objectives:** Measureable changes in supportive policy, systems, or environments. Objective must be SMART (Specific, Measurable, Achievable, Realistic, Time-phased). CDC Guide to Writing SMART Objectives: <http://www.cdc.gov/healthyyouth/evaluation/pdf/brief3b.pdf>
 2. **Activities:** A list of key actions that will be implemented. If possible, these actions should be specific, measurable and sufficient in quantity such that their completion should lead to the accomplishment of the outcome objective.

Jurisdiction:	
Contact Person:	
Email Address:	
Phone Number:	

Strategy #1:	Utilize health information technology (e.g. algorithms, decision supports, etc.) to develop patient registries or patient lists that identify patients with potentially undiagnosed hypertension, and engage those patients in follow up care and, if appropriate, diagnosis and treatment.			
Outcome Objective #1:				
Activity	Person Assigned	Key Partners	Measure	Timeline

Strategy #2:	Implement policies, systems, and environmental changes (e.g. flagging elevated readings, decision supports, etc.) to improve the identification of patients with hypertension and linkage to follow up clinical or community-based services.			
Outcome Objective #1:				
Activity	Person Assigned	Key Partners	Measure	Timeline

Strategy #3:				
Outcome Objective #1:				
Activity	Person Assigned	Key Partners	Measure	Timeline

Strategy #4:				
Outcome Objective #1:				
Activity	Person Assigned	Key Partners	Measure	Timeline

(Attachment B) *Sample* Health Systems/Practice Summary Template

Funded LHDs will be required to work with at least two (2) health systems/practices during the project period. LHDs will be required to submit the following information for each target health system/practice at the beginning and end of the project period (template will be provided):

- Practice Name
- Total number of patients [All patients in practice at point of time]
- Total number of adult patients [All patients 18 and over in practice at point of time]
- FQHC or Private practice (select one)
- Using EHR (Y/N)
 - ONC certified (Y/N)
- NCQA PCMH certified (Y/N)
 - NCQA PCHM level (1/2/3)
- Practice team includes pharmacist(s) (Y/N)
- Practice team includes community health worker(s) (Y/N)
- Practice team includes other (fill in)
- Practice refers to:
 - Stanford licensed Chronic Disease Self-Management Programs (CDSMP or Living Well)
 - Maryland QuitLine
 - Other community resources (Please specify)
- [End of Project Report Only] Number of patients referred to each program during the project period:
 - Stanford licensed Chronic Disease Self-Management Programs (CDSMP or Living Well)
 - Maryland QuitLine
 - Other community resources (Please specify)
 - Other clinical services (Please specify)

(Attachment C) *Sample* PDSA Template

Million Hearts: Tests of Change
Plan-Do-Study-Act (PDSA) Cycle Worksheet

1. Local Health Department:
2. Contact Person:
3. Email:
4. Phone Number:

5. Name of Health System/Practice:

6. Title of PDSA Test of Change:

7. Is this PDSA Test of Change...?
 - In progress/Not finalized
 - Final

	ACTIVITY OR TEST OF CHANGE
PLAN Describe the test, including the purpose and goal(s). Include a SMART objective.	
DO List observations from the test.	
STUDY List what worked. Include successes. Include (or attach) all relevant data, including reach and outcomes.	
STUDY List what didn't work. Include barriers and lessons learned. Include (or attach) relevant data.	
ACT Indicate whether you adopted, adapted, or abandoned the change you tested. List next steps based on decision.	

Practices should complete the PDSA Cycle above, describing a major grant activity or test of change being implemented. Include all relevant data in the PDSA or as an attachment. DO NOT include "anticipated result" in the Do, Study, or Act sections as was done in the previous year. Only report actual results.