Cardiovascular Health Practice Module

October 2025

The National Cardiovascular Health Program

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Purpose of Module

This Cardiovascular (CV) Health Practice Module provides a comprehensive overview of evidence-based information and resources focused on preventing and managing hypertension (HTN) and stroke. The module supports and enhances ongoing quality improvement efforts within healthcare practices. Quality Insights offers on-site and virtual technical assistance at no cost to engaged practices dedicated to improving CV health across their patient population. As an active participant in the Pennsylvania Department of Health's National Cardiovascular Health Program, this module aims to support and supplement practice quality improvement efforts related to CV health, HTN, and hypercholesterolemia (HCL).

Sections are highlighted by the **"3 As" – Awareness, Assessment, and Action –** and include several tools and resources that can be located on the Quality Insights website.

Target Audience: The module was developed for healthcare professionals, including physicians, physician assistants, nurse practitioners, nurses, pharmacists, social workers, and care team members involved in managing cardiovascular disease (CVD) risk factors and patient care.

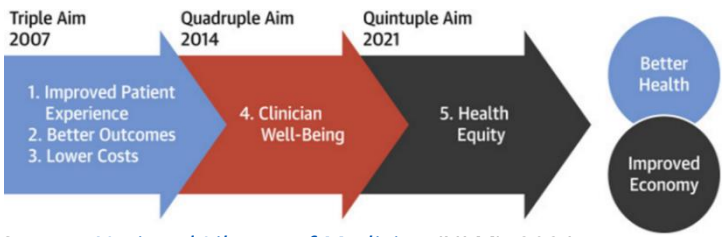
Note: *Guidelines referenced in this module are provided in a brief summary format. Complete recommendations should be reviewed in the original publication(s) and utilized with physician/clinician judgment, with consideration given to a patient's unique needs and circumstances.*

The Pressure is Off: Partner with Quality Insights

Quality Insights is committed to supporting your healthcare team in achieving optimal CV health and managing and preventing CVDs. In partnership with the Pennsylvania Department of Health, we provide a comprehensive range of services, at no cost, designed to assist your team in reaching your quality improvement goals, focused on hypertension and stroke prevention and management. Quality Insights provides on-site and virtual technical assistance to accommodate your practice needs.

Key services offered by Quality Insights include:

- **Workflow Assessments:** Workflow assessments consist of exploring current workflows, protocols, and processes, including the use of health information technology, team-based care, disease management, and strategies for clinical quality improvement based on ideals within the Quintuple Aim.



Source: National Library of Medicine (NLM), 2021.

- **Workflow Modifications:** Quality Insights developed evidence-based transformation solutions to increase practices' proactive outpatient management of patients with HTN and/or HCL. Workflow modifications can be located in the Quality Insights' Practice Education Modules appendix and on the Quality Insights PA CVD Education web page.
- **Technical Assistance:** Quality Insights' Practice Transformation Specialists are available to support your clinical quality improvement goals and improve value-based care in your practice setting at no cost.
- **Achievement Recognition:** Are you making significant progress in blood pressure (BP) control in your practice with National Quality Forum (NQF) #0018 Controlling High Blood Pressure reporting above 70% or 80%? If so, Quality Insights can help you apply for national recognition through the Target: BP™ initiatives.

Quality Improvement Solutions for You and Your Patients

The services above represent a small sample of Quality Insights' offerings. Discover all the ways the team at Quality Insights can help you and your patients make reducing HCL and achieving BP control the goal by reviewing this CV Workflow Modification Guide. Email Ashley Biscardi or call **1-800-642-8686, Ext. 2137** for more details.

AWARENESS: The Value of Blood Pressure and Cholesterol Targets and Control

CV health remains a top public health priority. While heart disease continues to hold the #1 cause of death, stroke has risen to the fourth leading cause of death in Pennsylvania and the United States alike (Centers for Disease Control and Prevention [CDC], 2024; CDC, 2023).

Globally, the leading modifiable risk factor for premature CV-related death continues to be high systolic BP (Vaduganathan et al., 2022). HTN is a contributing factor to significant health conditions, including heart attack, heart failure, stroke, and kidney failure. Nearly 34% of adults in Pennsylvania have been diagnosed with high blood pressure (America's Health Rankings, 2021).

The Global Burden of Cardiovascular Diseases and Risk: A Compass for Future Health (Vaduganathan et al. 2022) asserts, "Multi-level pharmacological and non-pharmacological interventions are needed to address the risks of high blood pressure on health." The publication also suggests simplifying BP control strategies and emphasizes the vital role of public health strategies in promoting screening, detection, and treatment of HTN.

The American Heart Association (AHA) reports, "Heart disease and stroke claimed more lives in 2022 in the United States than all forms of cancer and chronic lower respiratory disease combined. Between 2017 and 2020, 127.9 million US adults (48.6%) had some form of CVD.

Between 2020 and 2021, direct and indirect costs of total CVD were $417.9 billion ($233.3 billion in direct costs and $184.6 billion in indirect costs/mortality)."

The 2023 Guideline on the Management of Blood Cholesterol is a complete revision of the 2013 American College of Cardiology (ACC)/AHA Guideline on the

- "In 2022, 1 in 6 deaths from CVD were due to stroke.
- Every 40 seconds, someone in the U.S. has a stroke.
- Every 3 minutes and 14 seconds, someone dies of stroke.
- The risk of having a first stroke is nearly twice as high for non-Hispanic Black adults as for White adults. Non-Hispanic Black adults and Pacific Islander adults have the highest rates of death due to stroke."

Source: CDC, 2024.

Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. It provides current cholesterol-lowering recommendations, including lifestyle interventions, statin and non-statin regimens, risk assessment tools, and management of specific patient populations.

Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults

The Top Ten Take-Home Messages for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults highlights current hypertension-lowering recommendations, including control guidelines, recommendations for multi-disciplinary care approaches, and lifestyle change programs.

A Guidelines Made Simple summary is also available and highlights key messages listed below:

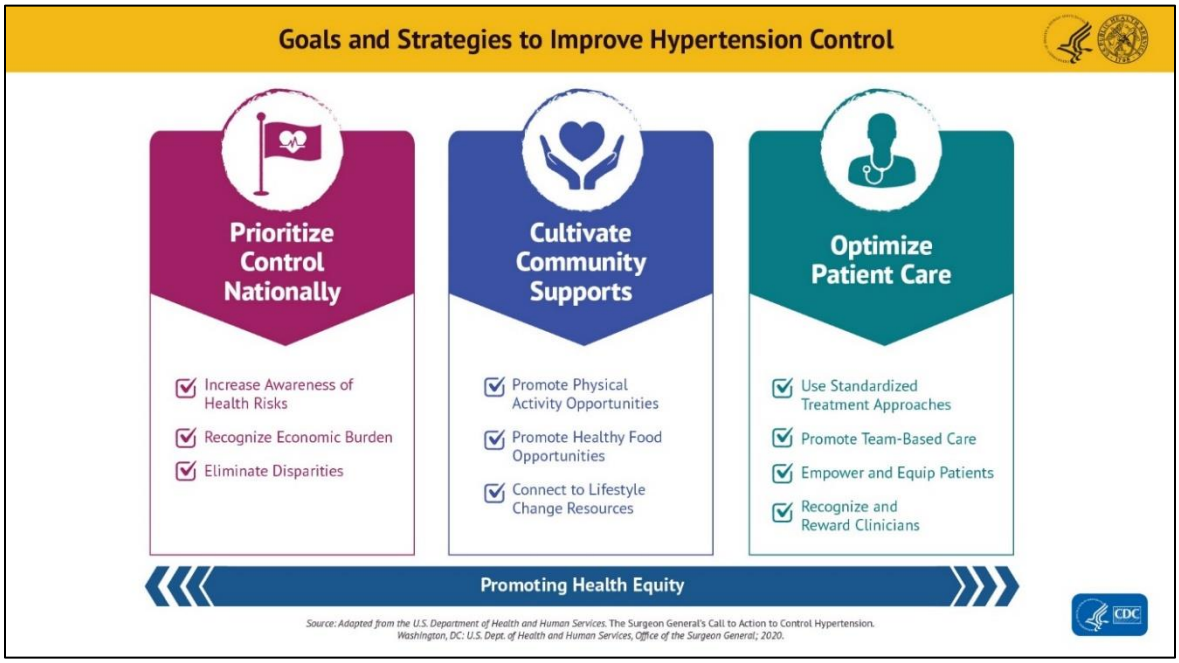
Top Ten Take-Home Messages to Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults	
1	High blood pressure is the most prevalent and modifiable risk factor for the development of cardiovascular diseases, including coronary artery disease, heart failure, atrial fibrillation, stroke, dementia, chronic kidney disease, and all-cause mortality. The overarching blood pressure treatment goal is <130/80 mm Hg for all adults, with additional considerations for those who require institutional care, have a limited predicted lifespan, or are pregnant.
2	Clinicians should collaborate with community leaders, health systems, and practices to implement screening of all adults in their communities and implement guideline-based recommendations regarding prevention and management of high blood pressure to improve rates of blood pressure control.
3	Multidisciplinary team-based care is effective in assessing and addressing patient access to medications and other structural barriers to support individual patient needs and thereby reduce barriers to achieving hypertension control. Team members may include physicians, pharmacists, nurse practitioners, nurses, physician assistants/associates, dietitians, community health workers, and other health care professionals.

4	Blood pressure is classified by the following framework: normal blood pressure is defined as <120 mm Hg systolic and <80 mm Hg diastolic; elevated blood pressure as 120 to 129 mm Hg systolic and <80 mm Hg diastolic; stage 1 hypertension as 130 to 139 mm Hg systolic or 80 to 89 mm Hg diastolic; and stage 2 hypertension as ≥140 mm Hg systolic or ≥90 mm Hg diastolic
5	For all adults, lifestyle changes, including maintaining or achieving a healthy weight, following a heart healthy eating pattern (such as DASH [Dietary Approaches to Stop Hypertension]), reducing sodium intake, increasing dietary potassium intake, adopting a moderate physical activity program, managing stress, and reducing or eliminating alcohol intake are strongly recommended to prevent or treat elevated blood pressure and hypertension.
6	Initiation of medication therapy to lower blood pressure in addition to lifestyle interventions is recommended for all adults with average blood pressure ≥140/90 mm Hg and/or for selected adults with average blood pressure ≥130/80 mm Hg who have clinical cardiovascular disease, previous stroke, diabetes, chronic kidney disease, or increased 10-year predicted cardiovascular risk of ≥7.5% defined by PREVENT™ (Predicting Risk of CVD EVENTs).
7	In adults with average blood pressure ≥130/80 mm Hg and at lower 10-year cardiovascular disease risk defined by PREVENT of <7.5%, initiation of medication therapy to lower blood pressure is recommended if average blood pressure remains ≥130/80 mm Hg after an initial 3- to 6-month trial of lifestyle modification.
8	For all adults with stage 2 hypertension, the initiation of antihypertensive drug therapy with 2 first line agents of different classes in a single-pill, fixed-dose combination is preferred over 2 separate pills to improve adherence and reduce time to achieve blood pressure control.
9	Home blood pressure monitoring combined with frequent interactions with multidisciplinary team members using standardized measurement and treatment protocols and home measurement protocols is an important integrated tool to improve rates of blood pressure control. Reliance on cuffless devices, including smartwatches, for accurate blood pressure measurements should be avoided until these devices demonstrate greater precision and reliability.
10	Severe hypertension in nonpregnant individuals, defined as blood pressure >180/120 mm Hg, without evidence of acute target organ damage, should be evaluated and treated in the outpatient setting with initiation, reinstitution, or intensification of oral antihypertensive medications in a timely manner.

The Surgeon General's Call to Action to Control Hypertension

The Surgeon General's Call to Action to Control Hypertension (Call to Action), released in October 2020, "seeks to avert the negative health effects of hypertension by identifying evidence-based interventions that can be implemented, adapted, and expanded in diverse settings across the United States" (DHDSP, 2024). This report may be utilized to enhance patient care, drive tailored interventions, educate care team staff, and guide public health collaboration.

"The *Call to Action* outlines three goals to improve hypertension control across the United States (US), and each goal is supported by strategies to achieve success" (CDC, 2024).



From The Surgeon General's Call to Action to Control Hypertension, CDC, 2024.

Learn more about the Surgeon General's Call to Action:

- CDC Prevent and Manage High Blood Pressure website
- The Surgeon General's Call to Action to Control Hypertension: How Health Care Professionals Can Help
- CDC High Blood Pressure: The Surgeon General's Call To Action to Control Hypertension

Preventing and Treating High Blood Pressure is About More than Just the Numbers

A February 17, 2022, *Health and Well-Being Matter* feature from Paul Reed, MD, Director of the Office of Disease Prevention and Health Promotion, emphasized that "preventing, identifying, and treating hypertension should be about much more than just measuring BP and prescribing medicine. Instead, addressing high BP should be an exemplar of comprehensive, person-centered care — promoting greater overall health, well-being, and personal resilience." Read more on the ODPHP's blog.

Download the AHA Guidelines on-the-go mobile app and stay up-to-date no matter where you are. Actionable at the point of care, users can retrieve relevant content and access additional support details and evidence.

- Download for iPhone/iOS.
- Download for Android.

Assessment Resources for Providers:

- ACC Cholesterol Guideline Tool: Overview of Primary & Secondary Prevention
- 2019 AHA/ACC Special Report: Use of Risk Assessment Tools to Guide Decision-Making in the Primary Prevention of Atherosclerotic Cardiovascular Disease
- 2020 AHA *Circulation: Cardiovascular Imaging* research article: Predictive Value of Coronary Artery Calcium Score Categories for Coronary Events Versus Strokes: Impact of Sex and Race
- Clinician pocket guide: Treatment of high blood cholesterol.

National Campaigns Support BP Control and/or Cholesterol Management

Several national campaigns are raising awareness of the importance of BP control and cholesterol management to prevent stroke. One such initiative promoted by Quality Insights is Healthy People 2030. Healthy People 2030 is the fifth iteration of national public health priorities created by the U.S. Department of Health and Human Services' Office of Disease Prevention and Health Promotion in 1980.

As a Healthy People 2030 Champion, Quality Insights is committed to working toward a society where all people can achieve their full potential for health and well-being across the lifespan, the Healthy People 2030 vision. Healthy People 2030 has several objectives that target BP control and cholesterol management and address SDOH to improve CV health and reduce deaths from stroke.

Included in Healthy People 2030 are objectives aimed at increasing the control of high blood pressure in adults to 18.9%. 2017-2020 data reflect that only 16.1% of adults had their BP under control. This particular objective is one of 23 Leading Health Indicators, a subset of high-priority objectives that affect significant causes of death and disease in the United States. The initiative additionally targets increasing cholesterol treatment in adults to 54.9%. 2013-2016 data reflect a rate of 44.9%. Additional resources for healthcare providers and patients are listed below.

Blood Pressure Control Initiatives
Live to the Beat - Led by the CDC Foundation and the Million Hearts®, this is a belief change campaign promoting heart-healthy eating, physical activity, and working with a healthcare professional to improve the CV health of Black adults aged 35 to 54. Also offered as part of the campaign is Pulse Check, an interactive learning tool for those empowered to take charge of their health.

Know Your Numbers - Launched by the National Forum for Heart Disease and Stroke Prevention, this campaign provides multiple videos and media resources emphasizing the importance of patients knowing their BP, blood sugar, and cholesterol levels to improve and maintain CV health.
Heart-Healthy Steps - Led by the CDC Foundation and the Million Hearts® initiative, this website supports a heart-healthy lifestyle for adults 55 and over by encouraging small steps, like eating healthy, getting active, and lowering stress. This program is part of the "Start Small. Live Big." campaign.
U.S. Department of Health & Human Services Office on Women's Health Self-Measured Blood Pressure Partnership Program - Quality Insights is a proud partner of this national network of public and private organizations to amplify and increase knowledge about HTN and CV disease, expand access to SMBP resources, and more.
National Heart, Lung, and Blood Institute: The Heart Truth® - This health education program focuses on ensuring women know about their risk for heart disease and encourages them to implement heart-healthy living practices. Review these high BP education resources.
Release the Pressure Campaign - This coalition of national healthcare professional organizations and heart health experts aims to empower Black women to enhance their self-care through improved heart health. Visit their patient-facing website for BP resources.
Get Down With Your Blood Pressure™ or **Éntrale a Bajar tu Presión™** - This high BP control campaign is led by the American Medical Association (AMA) and the AHA. It encourages daily BP monitoring and regular communication with the healthcare provider.
National Hypertension Control Roundtable (NHCR) - This CDC Foundation and National Association of Chronic Disease Directors-led coalition is dedicated to eliminating disparities in blood pressure control by supporting people where they live, learn, work, play, and pray. Quality Insights is a participating member of the NHCR.

A Practical Solution: Self-Measured Blood Pressure (SMBP) Monitoring

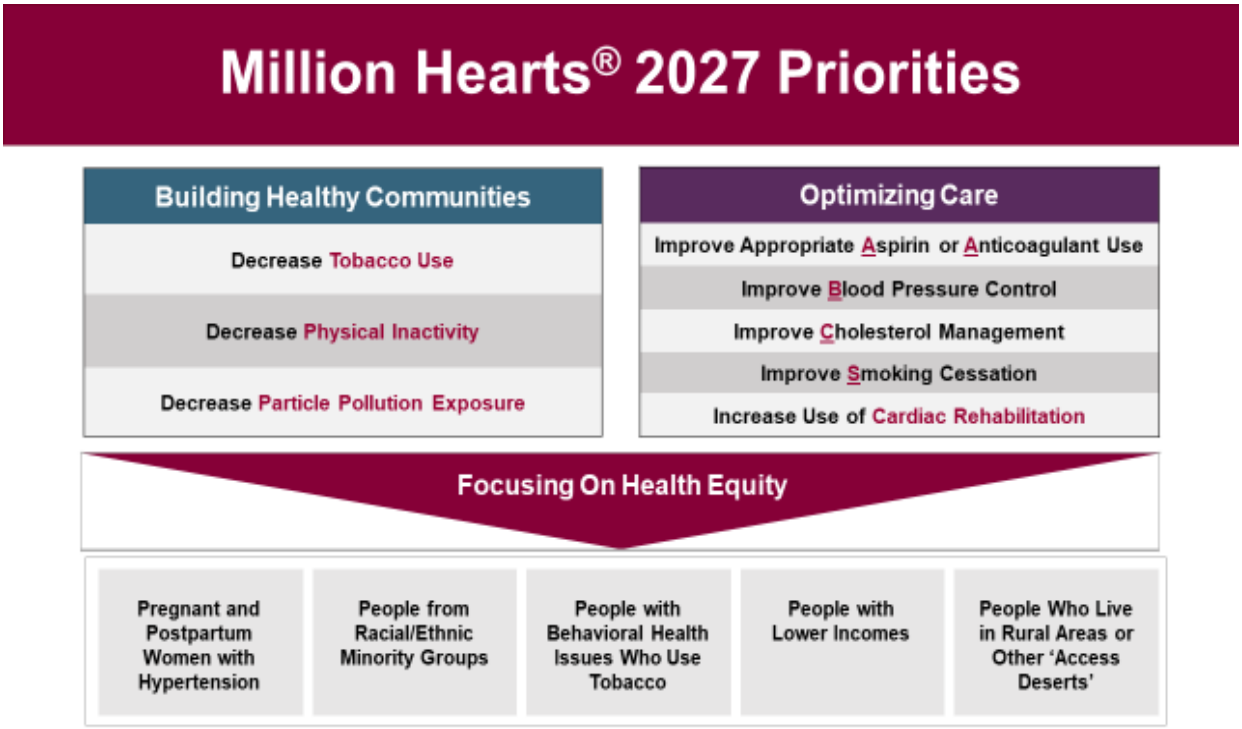
Self-Measured Blood Pressure Monitoring (SMBP) is defined as the regular measurement of blood pressure by a patient at home or elsewhere, outside the clinic setting, using a personal home BP measurement device (Million Hearts®, 2023). SMBP interventions combined with team-

based care or additional clinical support (e.g., educational classes, one-on-one counseling, and telephonic/web-based support) can assist patients in reducing their blood pressure, facilitate a more precise diagnosis of HTN, improve access and quality of care, and prove to be cost-effective.

Evidence Supporting SMBP

The effectiveness of SMBP is backed by scientific evidence accumulated over many years. Recent findings supporting its benefits include:

- In April 2021, the U.S. Preventive Services Task Force (USPSTF) issued a Grade A Final Recommendation Statement recommending "screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining BP measurements outside of the clinical setting for diagnostic confirmation before starting treatment."
- A 2020 *Journal of Community Health* paper reviewed a 2016-2018 CDC-funded project of the National Association of Community Health Centers (NACHC), the YMCA of the USA, and the Association of State and Territorial Health Officials (ASTHO) to increase the use of SMBP through coordinated action of health department leaders, community organizations, and clinical providers. Nine health centers in Kentucky, Missouri, and New York developed and implemented collaborative SMBP approaches, leading to 1,421 patients with uncontrolled HTN receiving a recommendation or referral to SMBP. Associated SMBP implementation methods, toolkits, and bilingual resources, including recommendations for statin therapy for high-risk patients with HCL, can be accessed on the National Association of Community Health Centers (NACHC) Million Hearts® Initiative web page.
- Million Hearts® released the second edition of its Hypertension Control Change Package in 2020. It features tested tools and resources that have enabled HTN Control Champions to achieve high levels of BP control with patients. SMBP-focused content is included as an important aspect of HTN control.



Source: Million Hearts®, 2024.

NACHC SMBP Best-Practices Video

Gain valuable insight into effective strategies used in nine health centers to improve the use of SMBP by watching the three-minute video, Collaborative Care Models for Improving Hypertension Control through SMBP Monitoring, created by the National Association of Community Health Centers.

Educational Resources for Patients: BP Measurement

As important as ensuring accurate BP readings in the clinical setting is, the same is true for patients collecting measurements at home. SMBP empowers patients to play an active role in managing their hypertension and cardiovascular health.
Review the links below to access important educational resources to guide your patients' participation in SMBP.

Organization	SMBP Patient Resource	Summary
American Medical Association	How to Measure Blood Pressure Accurately	A brief video that reviews seven tips to obtain an accurate BP reading.
	Self-Measured Blood Pressure Cuff Selection	Identify steps to determine the appropriate upper arm cuff size.
American Heart Association	Blood Pressure Measurement Instructions	Printable graphic with simple instructions for taking blood pressure at home.
Quality Insights	Blood Pressure Tracker	Printable BP log that includes brief instructions for patient use.
	Hypertension Management Apps	Provides a listing of apps available to help patients track their BP readings.
Target: BP™	What is SMBP?	Overview for patients to understand what SMBP is and why it is important.
	SMBP Training Video	Available in English and Spanish, this educational video helps train care teams and patients to properly self-measure BP.
	SMBP Infographic: How to Measure Your Blood Pressure at Home	Separation, positioning, and measurement are the steps to perform SMBP monitoring correctly. This document is available to download in English, Spanish, and Vietnamese.

Team-Based Care to Improve Cardiovascular Health and Outcomes

The Community Preventive Services Task Force (CPSTF) recommends team-based care to improve a patient's BP control. Team-based care is an approach to achieving BP control in which care is provided by a team consisting of the patient and various health professionals, including primary care providers, pharmacists, nurses, dietitians, social workers, or other health workers, rather than by a single doctor. Care team members work together to help

Provider Resource

Unify your team around CV prevention by reviewing Quality Insights' Care Team Interventions to Implement American Heart Association CVD Primary Prevention Guidelines.

patients manage their medications, increase healthy behaviors, and follow their BP control plan.

A CPSTF systematic review "shows team-based care increases the proportion of patients with controlled blood pressure and reduces systolic (SBP) and diastolic (DBP) blood pressure." Furthermore, CPSTF's review of economic evidence finds that providing team-based care is cost-effective, making it an option for all health systems aiming to improve patient BP management outcomes. For additional information, review the full CPSTF Finding and Rationale Statement.

Benefits of Team-Based Care and Responsibility for Addressing SDOH

Implementing team-based care is crucial to prevent and reduce CVD risk. Emphasis should be on HTN/HCL prevention, detection, control, and management while addressing social barriers to improve outcomes. It is believed that adding health equity as a fifth goal in healthcare will rapidly improve population health.

Adapted from CHESS Health Solutions, The Quintuple Aim, 2023.

The medical community has the opportunity to foster and promote inclusiveness in a value-based care model by focusing on patient-centered care, population health, cost efficiency, care team well-being, and health equity. This approach not only promotes better health outcomes but also contributes to the sustainability of the healthcare system.

In 2021, the CDC's Hilary Wall, Acting Lead, Million Hearts® Science Team, and a team of experts published "How Do We Jump Start Self-Measured Blood Pressure Monitoring in the United States Beyond the Published Literature" in the *American Journal of Hypertension.* This publication highlights the importance of SMBP as a key strategy for improving BP control among individuals in the United States. The federal and national actions timeline started in June 2008, with a Call to Action for using and reimbursing home BP monitoring (see Table 1).

In 2025, we have yet to establish national standards and expansive insurance coverage for blood pressure monitors for home use, which has been a barrier for patients using SMBP;

however, efforts to address these challenges include the creation of resources like **ValidateBP.org**, a website that provides a list of validated blood pressure devices. Additionally, some states have established Medicaid coverage requirements for BP devices. Implementing team-based care is imperative to establishing an optimal SMBP program in practices with steps for successful implementation and monitoring. The table below displays SMBP tasks by role.

The National Community Health Centers SMBP Implementation Guide provides additional resources to support implementing an SMBP program.

Must Be Done by a Licensed Clinician	Can Be Done by a Non-licensed Person (e.g., medical assistant, local public health department, community health organization, community health workers)	Must Be Done by Patient
1. Diagnose hypertension 2. Prescribe medication(s) 3. Provide SMBP measurement protocol 4. Interpret patient-generated SMBP readings 5. Provide medication titration advice 6. Provide lifestyle modification recommendations	1. Provide guidance on home blood pressure (BP) monitor selection 2. If needed, provide home BP monitor (free or loaned) 3. Provide training on using a home BP monitor 4. Validate home BP monitor against a more robust machine 5. Provide training on capturing and relaying home BP values to care team (e.g., via device memory, patient portal, app, log) 6. Reinforce clinician-directed SMBP measurement protocol 7. Provide outreach support to patients using SMBP 8. Share medication adherence strategies 9. Provide lifestyle modification education	1. Take SMBP measurements 2. Take medications as prescribed 3. Make recommended lifestyle modifications 4. Convey SMBP measurements to care team 5. Convey side effects to care team

Optional Tasks – Can be Done by a Non-licensed Person
1. Reinforce training on using a home BP monitor
2. Reinforce training on capturing and relaying home BP values to care team (e.g., via device memory, patient portal, app, log)

Source: NACHC, 2018.

Multiple studies assert the need for standardized treatment protocols and targeted strategies for achieving BP control by addressing the differing barriers of each racial/ethnic group. The CMS is a tool to assist healthcare stakeholders with identifying, prioritizing, and taking action to achieve health equity for all populations.

According to CMS, "Participants receive personalized technical assistance focused on strengthening your quality improvement program through a series of consultations from subject matter experts." Provided on the tool is an email address for health equity technical assistance. To strengthen your care team and provide optimal patient care for HTN/HCL management, review the resources below.

Resources for Promoting SMBP

Organization	Resources	Description
AMA	7-step SMBP Quick Guide	This quick guide offers an easy reference for physicians and care teams to help train patients to perform SMBP monitoring.
CDC	Best Practices for Heart Disease and Stroke	The guide details 18 strategies to address heart disease, stroke, and other cardiovascular conditions.
Target: BP™	Implement SMBP	Step-by-step guidance to help you launch a successful program.
	Target: BP™ Combined Quick Start Guides	Serves as a reference for the care team.
	Webinar: Evolving SMBP Policy and Practice	Discusses policy developments, program design, reimbursement, successes, and challenges associated with SMBP.
Million Hearts®	An Economic Case for Self-Measured Blood Pressure (SMBP) Monitoring	One-pager that provides information on return on investment based on Medicare reimbursement.
	Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians	Guide for implementation of SMBP plus clinical support in four key areas.
	Hypertension Control Change Package (HCCP), 2nd Edition	Presents a listing of process improvements that outpatient clinical settings can implement. It comprises change concepts, ideas, and evidence- or practice-based tools and resources.

Additional Resources:

- Register for the Million Hearts® SMBP Forum to learn best practices and troubleshoot obstacles with others. The Forum meets online quarterly.
- Quality Insights 2021 White Paper: *Team Up for Quality Care: The Role of Primary Care Teams in Prevention of Cardiovascular Disease*
- Success Story: Pennsylvania-based Million Hearts® Hypertension Control Champions

Social Determinants of Health (SDOH)

The 2023 Pennsylvania Health Assessment confirms, "Health disparities persist throughout Pennsylvania and the nation, and COVID-19 has underscored and magnified this reality. Some residents across the state die prematurely and live with a poor quality of life due to social, economic, service environment, and physical environment factors, which are called the social determinants of health."

SDOH Definition

SDOH are defined as "the conditions in the environments where 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."

Source: Healthy People 2030.

Screening for Social Needs

As healthcare providers become increasingly responsible for achieving population health goals, they require tools and strategies to identify the upstream socioeconomic factors contributing to poor health outcomes and higher costs. With this data, providers can transform care through integrated services to meet the needs of their patients, address SDOH factors, and demonstrate the value these services bring to patients, communities, and payers.

Several screening instruments are available to aid practices in identifying SDOH. The following are a sample of options for consideration:

1

PRAPARE Assessment Tool

The National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences tool (PRAPARE) is both a standardized patient social risk assessment tool consisting of a set of national core measures and a process for addressing the social determinants at both the patient and population levels. By using PRAPARE, providers can better target clinical and non-clinical care (often in partnership with other community-based organizations) to drive care transformation, delivery system integration, improved health, and cost reductions. Additional benefits are listed below.

Electronic Health Record (EHR) Integration:

Data from the PRAPARE assessment is transferred directly into many electronic health records (EHRs) as structured data. EHR templates and video demos are available for eClinicalWorks, Cerner, Epic, Athenahealth®, Greenway Intergy, and NextGen.
If an SDOH assessment template or the PRAPARE tool is not available within the EHR, utilize a paper form (available in 30 languages) or Excel file template to collect standardized data until the EHR template is developed.
When integrated into the EHR, PRAPARE can automatically link to relevant ICD-10 Z codes (where applicable) that can be added to the assessment, diagnostic, or problem list in most EHRs.

Implementation Tools for Practices:

PRAPARE Readiness Assessment Tool: Use this tool to help identify your organization's readiness to implement PRAPARE.
Implementation Strategy Work Plan: Outlines tasks, roles, and responsibilities and provides space to document progress.
Training: Free webinars and resources are accessible from the PRAPARE website and the PRAPARE YouTube Channel

American Academy of Family Physicians (AAFP) Social Needs Screening Tool

The AAFP offers the Social Needs Screening tool through the EveryONE Project™, which can be self-administered or administered by clinical or non-clinical staff. Using validated screening questions, it screens for five core health-related social needs, including housing, food, transportation, utilities, and personal safety. Additional questions assess employment, education, childcare, and financial strain. The EveryONE Project™ Toolkit offers a variety of helpful strategies for use in the clinical setting to improve patients' health and address SDOH.

Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities' Health-Related Social Needs Screening Tool

The CMS 10-question **Health-Related Social Needs Screening Tool** is a self-administered questionnaire that can help providers identify patients' needs in five core domains that community services can help, including housing instability, food insecurity, transportation problems, utility needs, and interpersonal safety.

Take the Next Step: The best first step to get started with PRAPARE and/or evaluate your current use of this tool is to review the PRAPARE Implementation and Action Toolkit. If you need assistance or have questions, contact Quality Insights.

Available Online Support Services Platforms

There are online information platforms available that provide support services and social care solutions to improve health equity.

Findhelp.org

Findhelp.org is a database curated by Findhelp, a public benefit corporation. This platform connects individuals with resources for food, housing, medical care, transportation, support, education, legal, and much more. Quality Insights has created a resource to help you navigate and utilize the Findhelp.org online platform.

PA Navigate is a statewide, online community information tool launched by the Pennsylvania Department of Human Services. It can address Pennsylvanians' health and social care needs by connecting them to community services such as food, housing, and childcare.

The Findhelp platform powers PA Navigate and facilitates referrals and communication between healthcare providers, community-based organizations, and social service agencies. This platform is accessible to both healthcare professionals and the public and hopes to improve health and social outcomes across the state.

PA Navigate can be integrated into EHRs for provider ease. This integration allows providers to make direct referrals within the patient's EHR and streamlines connecting patients with SDOH resources and support. The platform then tracks referrals, providing information regarding outcomes back into the patient's EHR.

To learn more about the benefits of PA Navigate, watch Pennsylvania's Secretary of Human Services, Valeria A. Arkoosha, MD, MPH, explain more. The Pennsylvania Department of Health developed a YouTube video to help you utilize and find the services you need using PA Navigate and a flyer to share with staff members and patients.

Utilizing ICD-10-CM Codes (Z Codes)

Applying ICD-10-CM codes, specifically Z codes, is fundamental in addressing patients' social needs within clinical and hospital settings. Z codes identify non-medical conditions that influence health status and outcomes, enabling providers to gain a comprehensive view of factors affecting a patient's health beyond clinical symptoms. Existing Z codes identify issues related to a patient's socioeconomic situation, including education and literacy, employment, housing, lack of adequate food or water, or occupational exposure to risk factors like dust, radiation, or toxic agents. Robust data collection related to patients' social needs is critical to clinic and hospital efforts to improve the health of their patients and communities. Clinical staff should prioritize the importance of documenting and coding patients' social needs and allow coders extra time to integrate coding for social determinants into their processes. Employing a standardized approach to screening, documenting, and coding social needs enables sites to:

- Track the social needs that affect their patients, allowing personalized care to address both medical and social needs.
- Aggregate data across the patient population to develop a social determinants strategy.
- Identify population health trends and guide community partnerships.

What Can Quality Insights Do to Support the Next Step?

Contact your Quality Insights Practice Transformation Specialist for support in effectively implementing ICD-10-CM Z codes into your workflow. Through education, training, workflow integration, and data management with Quality Insights, Z codes can enhance your practice's ability to identify and address the SDOH that impact your patients.

Z-code Resources

Download the below coding resources for more information about Z codes, including coding categories, frequently asked questions, and addressing common barriers:

- Quality Insights: Quick Guide to Social Determinants of Health ICD-10 Codes

- American Hospital Association: ICD-10-CM Coding for Social Determinants of Health
- CMS: Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes Infographic
- CMS: 2025 ICD-10-CM Official Guidelines for Coding and Reporting
- CMS: Improving the Collection of Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes

Leveraging the Care Team to Address Barriers to Statin Adherence

A 2024 article cites nonadherence to statin therapy as a pervasive issue that can lead to poor health outcomes, including increased risk for cardiovascular disease, cardiovascular events, and mortality. A comprehensive care team approach, that leverages pharmacists and pharmacy techs, rooted in understanding the causes behind patient nonadherence and a willingness to engage with nonadherent patients may improve future adherence or adherence with other caregivers.

Assessing and Improving Medication Adherence

Medication adherence is a significant barrier to the control of HTN and HCL. A scientific statement (2021) from the AHA listed many factors associated with nonadherence in patients with HTN. The factors include but are not limited to low health literacy, lack of health care insurance, lack of positive reinforcement from providers, the complexity of medication regimen, provider-patient relationship, lack of provider knowledge about adherence and interventions for improving it, cognitive impairment, chronic conditions, and perceived benefit of treatment. There are many correlating factors present with suboptimal adherence to HCL treatments. In Table 2 of the AHA statement, there is a list of "Factors Associated with Nonadherence" with patient, provider, and health system-related causes. These factors contribute to nonadherence to dietary and medication recommendations. Shared decision-making with the patient, in addition to a multidisciplinary approach, can improve adherence. Improving these areas will increase quality and reduce costs.

The following resources are available to assist you in improving medication adherence in your practice setting:

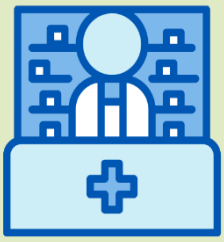
- The Medication Adherence Office Protocol can assist medical practices with educating the care team to promote medication adherence and establish a protocol to ensure communication and patient education.
- Adherence Estimator®: This tool is a patient-centered resource designed to help you gauge a patient's likelihood of adhering to newly prescribed oral medication for certain chronic, asymptomatic conditions.
- Free Apps to Help You Better Manage Your Medicines: This handout provides a list of useful apps your patients can download to help them track and monitor their medication usage.
- For assistance with addressing health literacy, review Quality Insights' Health Literacy Supplement (October 2022).

Another evidence-based strategy for addressing medication adherence is collaborating with pharmacists as extended team members to provide medication therapy management (MTM). Pharmacists play a crucial role in reducing the risk of heart disease and stroke in the U.S.

For additional guidance on collaborating with pharmacists to improve your patient outcomes:

- The Pennsylvania Pharmacists Association offers an array of resources promoting and advancing MTM in pharmacies statewide.
- The Pharmacists' Patient Care Process Approach: An Implementation Guide for Public Health Practitioners Based on the Michigan Medicine Hypertension Pharmacists' Program: This CDC implementation guide (2021) encourages public health practitioners and health care professionals to collaborate with pharmacists in HTN management through the Pharmacists' Patient Care Process. The guide includes key examples that healthcare teams can replicate in their own programs.

The Pennsylvania Pharmacists Care Network (PPCN)

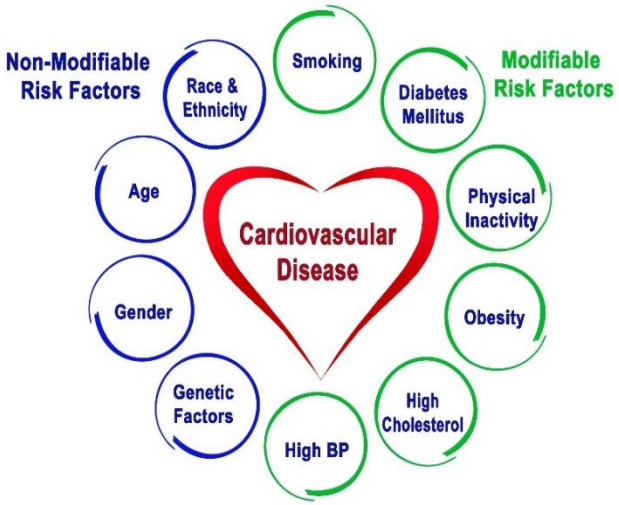


PPCN is an organization committed to working collaboratively with healthcare providers, standing as a consortium of over 200 pharmacies committed to delivering exceptional care to their patients. Providers may collaborate with PPCN pharmacists to cultivate a comprehensive medication management workflow. PPCN pharmacists may assist in providing patients with education as it relates to taking their medications correctly and managing potential side effects. Leveraging resources and expertise available through PPCN enables healthcare providers to enhance medication adherence among their patients, leading to improved health outcomes and management of chronic CV health conditions.

ACTION: Implement BP Control Programs at Your Practice and Referrals to Lifestyle-Change Programs

Evidence-Based Lifestyle Change Strategies and Programs

The 2019 ACC/AHA Guideline highlights the importance of living a healthy lifestyle, comprised of a nutrient-dense diet and the inclusion of regular physical activity. Lifestyle changes that have proven to be effective include weight loss, a healthy diet with reduced intake of dietary sodium, enhanced intake of dietary potassium, physical activity, and moderation in alcohol intake. By focusing on these lifestyle adjustments, individuals can significantly improve their heart health and reduce their risk of cardiovascular diseases.



The CDC recommends the following evidence-based lifestyle change programs designed to assist adults with high blood pressure in managing their condition effectively:

- The National Healthy Heart Ambassador Blood Pressure Self-Monitoring (HHA-BPSM) Program launched in Pennsylvania last year. To learn more about the programs and their offerings, as well as their contact information visit Quality Insights' educational flyer.
- Taking Off Pounds Sensibly (TOPS)
- Curves: In-club and at-home memberships are now available.
- WW® (formerly WeightWatchers)
- Supplemental Nutrition and Assistance Program Education (SNAP-Ed)
- Expanded Food and Nutrition Education Program (EFNEP)

Take Control with Lifestyle Change Programs in PA

- National HHA-BPSM Program
- National Diabetes Prevention Program (National DPP): Many patients with HTN/HCL are eligible for the National DPP. The CDC Risk Test to determine a patient's risk for prediabetes is here.

Quality Insights developed an at-a-glance guide to highlight benefits of CDC-approved lifestyle change programs available in Pennsylvania. For a handout specific to WW, TOPS, and Curves only, consider this updated resource.

For patients interested and ready to begin their journey towards improving their health and lifestyle, the following resources may be of assistance:

- The DASH Eating Plan is a flexible and balanced plan that helps create a heart-healthy lifestyle.
  - From Quality Insights: DASH Your Way to Lower Blood Pressure
  - Visit the National Heart, Lung, and Blood Institute (NHLBI) website for additional heart-healthy cooking resources for a wide range of ages and ethnicities.

- Sodium reduction patient resources:
  - Why Should I Limit Sodium? (AHA)
  - Sodium in Your Diet: Use the Nutrition Facts Label and Reduce Your Intake (FDA) – English
  - Sodium in Your Diet: Use the Nutrition Facts Label and Reduce Your Intake (FDA) – Spanish

Sodium Reduction

Encouraging patients to reduce sodium intake typically results in a reduction in BP within weeks. Read about this and other sodium reduction benefits, challenges, and strategies in the AHA's Blood Pressure Abstract.

- Smoking Cessation Program: Listing of national Quitlines in various languages, online resources, and medicines to help patients quit smoking.
- PA Online Quitline Resources and Chat
- PA Free Quitline Promotional Materials order form for tobacco cessation print materials directly shipped to your practice.
- "Answers by Heart" Blood Pressure Fact Sheets and Multilingual Resources, including:
  - African Americans and High Blood Pressure
  - How Can I Reduce High Blood Pressure? (available in Spanish)
  - Infographic: Consequences of High Blood Pressure (available in Spanish and Traditional Chinese)
  - Lifestyle Chart: What Can I Do to Improve My Blood Pressure? (available in Spanish and Traditional Chinese)

Reminder: Start Tracking Your Results and Be Recognized

Participating in initiatives like the AHA's Target: BP™ program can bring acknowledgement to healthcare providers who reach and surpass hypertension management benchmarks. Quality Insights can assist your practice in applying for national recognition for evidence-based interventions and/or HTN control through the Target: BP™ initiative if you have reached 70% for National Quality Forum #0018.

Additionally, Quality Insights honors its partners for their work in successfully managing HTN by awarding **Hypertension Hall of Fame** awards to practices when at least 70% of their patients with HTN have their BP controlled (<140/90). The **2025 Hypertension Hall of**

Fame (award for their excellent work in successfully managing HTN) and the **2025 Cardiovascular Disease Prevention Champions** (award for work in successfully managing patients with HCL in the prevention of CVD via statin therapy) winners are listed on the Quality Insights website.

Target: BP™ Recognition Program

The Target: BP™ Recognition Program celebrates provider practices and healthcare systems that treat patients with hypertension for achieving blood pressure control rates at or above 70% or completing evidence-based interventions within the populations they serve. These achievements will ultimately reduce the number of Americans who suffer heart attacks and strokes.

Congratulations to the over 2,300 organizations that submitted data to be considered for the 2025 Target: BP Award Achievement and expressed their commitment to improving blood pressure control rates.

View the complete list of 2025 Target: BP Recognized Organizations.

In Pennsylvania, Quality Insights worked with eight practices that received awards through the Target: BP Recognition Program. Congratulations to all of these practices!

Pennsylvania Target: BP™ Gold+ Status Practice

Gold + status recognizes practices that have 70% or more of their adult patients with high blood pressure in control and have demonstrated a commitment to measurement accuracy. Below are practices working with Quality Insights in Pennsylvania that achieved Gold + status.

- Banmaha, P.C.
- Linda Sebastian Frantz, M.D., F.A.C.P
- NEPA Community Healthcare – Hallstead
- NEPA Community Healthcare – Montrose
- The Wright Center for Community Health

Pennsylvania Target: BP™ Gold Status Practices

Gold status recognizes practices that have 70% or more of their adult patients with high blood pressure in control. Below is a practice working with Quality Insights in Pennsylvania that achieved Gold status.

- Lackawanna Medical Group, P.C.

Pennsylvania Target: BP™ Silver+ Status Practices

Silver + status recognizes practices that submit data and attest to at least 4 of 6 evidence-based criteria in the Measure Accurately Pillar, the Act Rapidly Pillar and one additional Pillar. Below are practices working with Quality Insights in Pennsylvania that achieved Silver status.

- Community Health and Dental Care
- Neighborhood Health Centers of the Lehigh Valley

Quality Insights: Your Partner in CVD Care Improvement

At Quality Insights, we understand the challenges and complexities of managing hypertension and hypercholesterolemia within diverse healthcare settings. To support your internal efforts, we offer the expertise of our Practice Transformation Specialists. Our specialists are available to assist your health system, Federally Qualified Health Center, or independent practice in achieving your goals of improving HTN control and HCL management.

If your practice is interested in participating in the program, email Ashley Biscardi or call **1.800.642.8686, ext. 2137.** Quality Insights is here to be your partner in transforming patient care and accomplishing improved health outcomes.