Kansas Healthcare Collaborative

Blood Pressure Reduction Challenge

Mini-Grant Request For Proposals
2018 Quarter 2

Overview of the Kansas Healthcare Collaborative Blood Pressure Reduction Challenge

Kansas Healthcare Collaborative, in partnership with the Kansas Department of Health and Environment, invites practices to apply for funds, not to exceed $20,000 per practice, to support a practice-led, evidence-based intervention designed to reduce blood pressure in their patient population. Five projects will be supported. Each project will include a practice-led, evidence-based intervention and a structured data collection plan with data support provided by the Kansas Healthcare Collaborative.

Evidence-Based Interventions

Practices are invited to apply for funds to implement one of the following, evidenced-based interventions, designed to reduce patient blood pressure.

- Nurse-Driven Care Protocol for Patients with Hypertension (Intervention Outline)
  Goal: Reduce physician burden, increase joy in the workplace, and reduce blood pressure of a population of patients by implementing a nurse-driven care protocol for patients with hypertension.

- Collaborative Practice Agreement with a Pharmacist (Intervention Outline)
  Goal: Establish a CPA with a local pharmacist to enable collaborative drug therapy management for patients with hypertension. The CPA can be time limited for the duration of the project.

- Promoting Self-Management and Education with Community Partnerships (Intervention Outline)
  Goal: Partner with the community to provide self-management education and support for patients with hypertension. Practices can choose to host a CDSMP workshop; or, practices can choose to refer to a community entity of their choosing (gym, dietitian, CHW, health educator).

- Patient-Centric Goal Setting with Patient Navigator or CHW (Intervention Outline)
  Goal: Prescribe a lifestyle change (self-measured blood pressure monitoring, increased physical activity, or dietary changes) with goal setting to patients with hypertension. Document goals in the medical record and regularly provide clinical support through monthly, accountability check-ins with patients (phone, email, no-cost nurse visit, other).

Timeline

Application due: March 8, 2018
Grant Awardee Notification: March 12, 2018
Initial Planning Period: March 12, 2018 – March 31, 2018
Intervention Period: April 1, 2018 – June 30, 2018
Wrap Up Period: July 1, 2018 – July 31, 2018
Panel Presentation, 2018 Kansas PTN Learning Event: August/Sept TBD

Eligibility and Funding

Practices may apply for funding, not to exceed $20,000 per practice, to support a practice-led, evidence-based intervention reduce blood pressure in their patient population. Preference will be given to Kansas practices currently participating in the Compass Practice Transformation Network or who have recently graduated. Awardees will receive 25% of funds upon notification of acceptance. The remaining funds will be paid to the practice upon completion of the project. Only one application per practice will be considered. Funds may be used to support staff time to implementing interventions. Funds may not be used for food/beverage items or the purchase of blood pressure cuffs.

Application Process

Applications, including supplemental documentation, **must be received by the Kansas Healthcare Collaborative no later than March 8, 2018. Awardees will be notified by phone and email, March 12, 2018**. Applications with supplemental documentation can be submitted to:

Kansas Healthcare Collaborative
Blood Pressure Reduction Challenge
c/o Amanda Prosser
623 SW 10th Ave. Topeka, KS 66612
Email: aprosser@khconline.org

Questions? Please contact the Kansas Healthcare Collaborative, 785 – 235 – 0763.

Kansas Healthcare Collaborative

Blood Pressure Reduction Challenge

Mini-Grant Request For Proposals
2018 Quarter 2

Practice Name:_____

Mailing Address:_____

City:_____State:_____Zip:_____

Email:_____Telephone:_____

Point of Contact Name: _____

Email, if different than above:_____ Telephone, if different than above: _____

Is the practice currently enrolled in the Compass Practice Transformation Network? [ ] Yes [ ] No

Grant Amount Requested: _____

Chosen Intervention (Please check only one):

[ ] Nurse-Driven Care Protocol for Patients with Hypertension
- ✓ Application with budget proposal (Required)
- ✓ Physician Letter of Support (Required)
- ✓ Draft protocol and/or workflow diagram (Suggested)

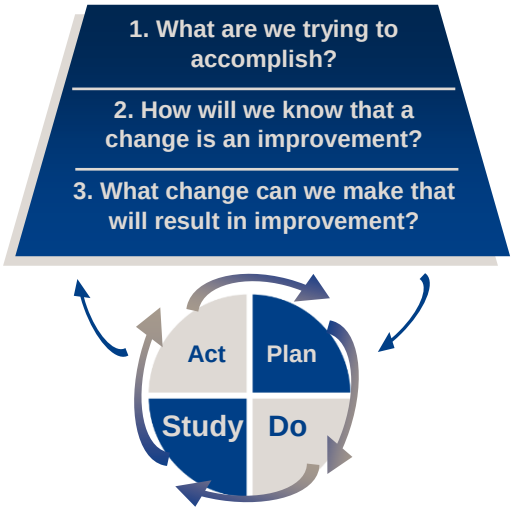
[ ] Collaborative Practice Agreement with a Pharmacist
- ✓ Application with budget proposal (Required)
- ✓ Physician Letter of Support (Required)
- ✓ Pharmacy Letter of Support (Required)
- ✓ Draft CPA (Suggested)

[ ] Promoting Self-Management and Education with Community Partnerships
- ✓ Application with budget proposal (Required)
- ✓ Letter of Support (Required)

[ ] Patient-Centric Goal Setting with Patient Navigator or CHW
- ✓ Application with budget proposal (Required)
- ✓ Letter of Support (Required)

Kansas Healthcare COLLABORATIVE

Model for Improvement



Application Due: March 8, 2018

Plan

Please list applicable practice staff, community partners, and their assigned roles for the selected intervention.

Staff	Organization	Role

Consider the suggested timeline included in the Intervention Outline. Please provide a similar timeline for your practice-specific project. Please note, items in bold are a requirement of the project. The initial meeting will be confirmed upon notification of awarded grant. Program update calls will also be scheduled during the initial meeting. Please use the additional space to provide dates for any other tasks relevant to the chosen intervention.

Date / Time	Task	Assigned Staff
March 12 – March 31: Planning Period		
Initial meeting:	**Review plan, finalize work flow process and data collection plan.**	**Practice, KHC staff, and community partners (as applicable)**
April 1 – June 30: Intervention Period		
April:	**Program Update Call**	**Practice, KHC staff, and community partners (as applicable)**
May:	**Program Update Call**	**Practice, KHC staff, and community partners (as applicable)**
June:	**Program Update Call**	**Practice, KHC staff, and community partners (as applicable)**
July 1 – July 31: Wrap Up Period		
July Wrap Up Call:	**Wrap Up Call**	**Practice, KHC staff, and community partners (as applicable)**

Budget Proposal

Please provide a budget justification and expense details. Awardees will receive 25% of funds upon notification of acceptance. The remaining funds will be paid to the practice upon completion of the project. Only one application per practice will be considered. Funds may be used to support staff time to implementing interventions. Funds may not be used for food/beverage items or the purchase of blood pressure cuffs.

Item	Use of Item	Item Quantity	Unit Cost of Item	Total Cost

Total Grant Request: _____

Kansas Healthcare COLLABORATIVE

Application Due: March 8, 2018

Do

Please describe, in detail, how the practice proposes implementing the intervention in their practice.

Study

As part of the project, the practice will work with KHC staff to develop a study design and data collection/analysis plan during the initial planning period. You will need to collect data on a sample of patients according to the study design. The data you collect must include documentation of how you will implement your intervention (process measure), a measurement of blood pressure control (outcome measure), and a business-related measure. See the intervention outline for examples.

The intervention must directly involve a minimum of 20 patients. In the space below, please describe how you will select patients for the project. Which patients will be involved or will receive the intervention?

After reviewing the example process, outcome, and business-related measures in the intervention outline, what measures does the practice plan to use?

Process Measure:

Outcome Measure:

Business-Related Measure:

Act

Heart disease is the leading cause of death in men and women in the United States. Together, heart disease, stroke, and other vascular diseases claim over 800,000 lives each year. Although individuals can take steps to reduce their own risks of CVD, public health approaches working in tandem with health systems have the potential to reduce risks among entire populations.

The interventions of this challenge stem from evidence-based strategies identified and confirmed through an extensive review process at the Centers for Disease Control and Prevention (CDC). CDC included subject matter experts and practice partners both within and externally to review the strategies.

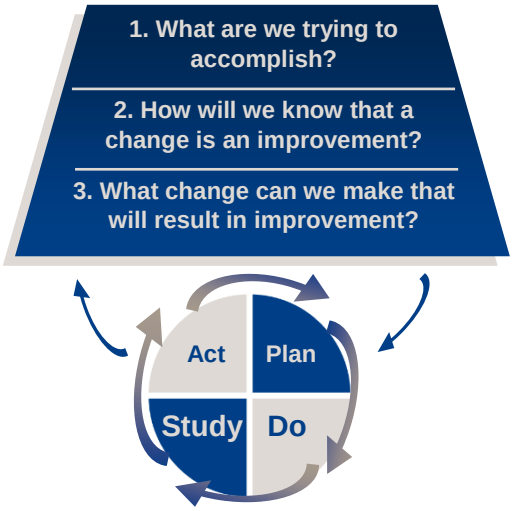
By signing and submitting this application for the Kansas Healthcare Collaborative **Blood Pressure Reduction Challenge**, the practice is committing to supporting a practice-led, evidence-based intervention to lower the blood pressure of their patient population. To complete the challenge, the practice agrees to

- Submit non- identifiable data, relevant to the project through a rigorous pre- and post-intervention data collection plan. The plan will be finalized during the planning period following notification of award. Final data submission must be completed by July 31, 2018 to receive the remainder of requested funds.
- Participate in monthly program update calls between the practice, KHC staff, and community partner (as applicable) throughout the duration of the challenge (Planning Period, Intervention Period, Wrap Up Period).
- Submit an Intervention Summary to KHC by July 31, 2018 (template provided upon notification of awarded grant),
- Participate and share experiences in a panel presentation at the 2018 Kansas PTN Learning Event. Date and location will be released in early summer, 2018.

Printed Name: _____

Signature: _____ Date: _____

Model for Improvement



Kansas Healthcare COLLABORATIVE

Application Due: March 8, 2018

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*