Wisconsin Chronic Disease Prevention Program
Grant Funding Opportunity

Improving Heart Health Through Community-Clinical Linkages

I. IMPORTANT DATES

February 24, 2025	Grant Funding Opportunity released
April 7, 2025	Application Materials due by 11:59 p.m.
April 28, 2025	Notification of Awards (estimated)
June 30, 2025 – June 29, 2026	Period of Performance with option for additional budget periods

II. FUNDING OPPORTUNITY OVERVIEW

INTRODUCTION

The Wisconsin Department of Health Services (DHS) Chronic Disease Prevention Program (CDPP) is a recipient of the National Cardiovascular Health Program five-year cooperative agreement from the Centers for Disease Control and Prevention (CDC). To implement the strategies of this cooperative agreement (known as 23-0004), CDPP partners with a variety of organizations across the state, offering funding, technical assistance, and connections to peer support.

As we enter into the third year of the CDC cooperative agreement, CDPP is issuing this Grant Funding Opportunity (GFO) to provide interested parties with information on preparing and applying for the *Improving Heart Health Through Community-clinical Linkages* grant to implement a multidisciplinary learning collaborative to improve heart health in their community.

BACKGROUND

Cardiovascular disease (CVD) and stroke are among the most significant causes of disability and death in Wisconsin. While CVD and stroke are common, they do not impact Wisconsin residents equally. Differences in primary care access, poverty status, unemployment, and other factors drive persistent disparities across these conditions, and the likelihood of mortality when they occur.

In 2020, CVD was the leading cause of death in Wisconsin, taking over 12,000 Wisconsinites from their families, and stroke was the fifth leading cause of death, at over 1,900 people[1,2]. Disparities persist in CVD deaths; about 6 in 10 CVD deaths were male Wisconsin residents, and about 1 in 10 CVD deaths were residents who identify as Black[2]. The trends and disparities in CVD deaths have remained the same since 2010[3].

Wisconsin continues to be impacted by factors that lead to CVD, including high cholesterol and high blood pressure; both high cholesterol and high blood pressure rates have stagnated since 2011. In 2021, 30.6% of Wisconsin adults reported having high cholesterol, and 28% of adults in Wisconsin had high blood pressure. The percent of adult men with high cholesterol (31.9%) and high blood pressure (30.6%) are greater than the overall state prevalence[3]. While the rate of high blood pressure has

increased in adults between 25 - 54 years old since 2015, the rate has not changed in adults older than 55 years old[3].

Controlling high blood pressure can lower the risk of CVD, but nearly one million Wisconsin adults do not have their blood pressure under control[4,5]. Nonmedical factors contribute to the ability of people to control their blood pressure, such as poverty, employment status, access to primary care, insurance status, lack of transportation, and food insecurity. Individuals who experience these barriers are less likely to reach blood pressure control (79%) compared to individuals with fewer barriers (85%)[6]. Since 2019, blood pressure control has decreased across the state[7].

The CDC-23-0004 cooperative agreement lays out specific evidence-based strategies and performance measures to be implemented by June 29, 2028, to address these persistent heart health disparities:

Strategy 1: Electronic health record (EHR)/health information technology (HIT)
Use EHR, HIT, or population health management system (PHMS) as well as standardized clinical quality measures (CQMs) and social need tools to identify and track those experiencing disparities, with a focus on hypertension and high cholesterol, specifically to increase the number of:

- Clinics using EHR/HIT/PHMS and CQM to identify and monitor disparities by looking at hypertension control CQM by race, ethnicity, or other factors.
- Clinics using a tool to identify, assess, and address social and support needs.
- Adults with hypertension who reached blood pressure control (overall and among priority population).

Strategy 2: Team-based care
Use team-based approaches and expand resources/services available to address the social and support needs identified among the priority population, specifically to increase the number of:

- Clinics using EHR/HIT/PHMS clinical data to coordinate care.
- Clinics using an evidence-based/-practiced team-based care approach.
- Social services and supports available and accessible to the priority population, including types of those social service and supports.

Strategy 3: Community-clinical linkage
Refer to lifestyle programs or social services and supports, engage Community Health Workers (CHWs), and use self-measured blood pressure (SMBP) programs with clinical support to address the social and support needs identified among the priority populations, specifically to increase the number of:

- Adults who are referred to a lifestyle program or social service and support *and* those who have accessed or participated in those programs/services.
- CHWs who are engaged and addressing social and support needs.
- Adults participating in a SMBP program tied with clinical support.

PURPOSE

DHS CDPP is seeking a community organization (e.g., non-profit, local, or Tribal health department, membership entity, coalition) who has a history of successfully working with clinical organizations

(e.g., health system, federally qualified health center, free and charitable clinic, health plan) and other multi-sector partnerships to advance health and social outcomes in the community.

The applicant will lead an interdisciplinary heart health learning collaborative (HHLC) aimed at addressing the persistent disparities in CVD and its related health factors, with a focus on the nonmedical factors that increase disparities. The HHLC will bring together community members alongside clinicians and health system representatives, community-based organizations (CBOs), payors, CHWs, and other interested parties to facilitate communication and exchange of ideas to inform data-driven healthcare practice improvements, link community and clinical resources, and address community-identified nonmedical needs to reduce hypertension and high cholesterol.

Using the CDC-defined strategies and performance measures (see Background above), the program will focus on shared goals, leveraging collective expertise, and implementing evidence-based solutions. Applicants will work with partners to develop a shared aim statement that defines clear goals, guide all activities, collect relevant data, and align efforts to achieve measurable health improvements.

HHLCs must focus on addressing heart health disparities for at least one identified priority population. Priority populations are defined by CDC as those who have systematically experienced greater obstacles to health with uncontrolled high blood pressure or high cholesterol. CDPP identified statewide priority populations for the 23-0004 by investigating disparities in high blood pressure, high cholesterol, and socioeconomic status. Using the Behavioral Risk Factor Surveillance System data and the Wisconsin Collaborative for Healthcare Quality disparity reports, five statewide priority populations have been identified:

- Adults 24 to 54 years old
- Males
- People who identify as Black
- Medicaid recipients
- Individuals with disabilities (deaf, blind, and physical disabilities)

The intended outcomes for the HHLC are:

- Increased blood pressure and cholesterol control among priority populations
- Decreased disparities in hypertension and cholesterol control among priority populations
- Increased utilization of social services and support among populations at highest risk of CVD, with a focus on hypertension and high cholesterol.

SCOPE OF WORK

The selected applicant will be awarded up to $100,000 for one year to coordinate a HHLC aimed at addressing heart health disparities experienced by at least one priority population in their community. The selected priority population must be supported by quantitative or qualitative data showing increased risk for poor heart health outcomes.

The initial months will focus on engaging partners to join the HHLC and creating a leadership committee that will help guide the direction of the HHLC and determine projects to achieve the grant strategies. At least 51% of the HHLC membership must represent and/or directly serve the selected priority population.

The applicant will also act as a fiscal agent, distributing $50,000 in additional funds as subcontracts to support the implementation of quality improvement (QI) projects directly tied to the grant strategies (see Background above). Together with CDPP, the applicant and leadership committee will determine the process for deciding how QI project funding will be distributed.

Example QI projects could include (but are not limited to) testing new processes for screening and referring to address social service needs, increasing participation in an SMBP program, or creating a new process for connecting individuals managing hypertension to a CHW for wrap-around care. Each QI project must document progress through at least two Plan Do Study Act (PDSA) cycles, including clear descriptions of the problem, interventions tested, outcomes and lessons learned. Templates for PDSA documentation will be provided by CDPP. Additional projects may be funded and documented utilizing different QI frameworks as seen fit.

As a cooperative agreement, CDPP will provide close partnership and oversight of the grant activities. Ongoing technical support and guidance will be provided to share best practices, connection with other HHLCs within Wisconsin and nationwide, and support in documenting within QI frameworks.

A detailed scope of work for the first year of funding is outlined below:

Objective	How to achieve this
Engage Key Partners to form HHLC Engage and recruit partners including health systems, CHWs, social workers, patient navigators, pharmacists, and other members of care teams, as well as CBOs, local and tribal health departments, payors, statewide organizations, and other interested parties. At least 51% of collaborative partners must represent the HHLC's priority population of focus.	1. Develop a partner engagement plan outlining communication frequency and responsibilities. 2. Create a partnership agreement or memorandum of understanding to formalize collaboration. 3. Form leadership committee. 4. Host kick-off meeting to introduce grant strategies
Develop a Shared Aim Statement Work with partners to create a clear and focused aim statement that outlines the goals of the HHLC. This aim statement should reflect the needs of priority populations by reviewing available data to understand health disparities and barriers and engaging with community partners, such as patients, providers, and local organizations, to gather input on needs and priorities.	1. Discuss goals and gather input at kick-off meeting 2. Review CDC guidelines and performance measures to ensure the aim statement supports required objectives. 3. Use templates or guided discussion tools to help define the aim statement. 4. Review draft versions with partners for feedback and finalization.
Support health care partners in utilizing EHR data to inform projects to reduce heart health disparities Partner with at least one clinical organization to report on CQMs (e.g. CMS 165, NQF 18, or	1. Provide clinical partner(s) with guidance on utilizing CQM data for identifying and tracking heart health disparities 2. Connect clinical partner(s) with CDPP for technical assistance

PQRS 236) stratified by race, gender, zip code, payor, and other demographics as available.	
Implement and Monitor Evidence-Based Strategies With support from CDPP, guide HHLC partners in implementing evidence-based strategies including screening and referring to address social service and support needs, utilizing multidisciplinary care teams to improve chronic care management, and connecting individuals with lifestyle change programs and SMBP programs.	1. Partner with CDPP to educate HHLC partners on evidence-based strategies 2. Create HHLC workgroups that will implement QI projects related to CDC strategies 3. Select 2-5 projects to support with sub-grants 4. Use the PDSA cycle and other QI tools to document at least two data-driven improvements.
Report and Evaluate Progress To track the success of the HHLC and projects implemented, collect data, and regularly report progress. This includes tracking key performance measures, identifying barriers and solutions to improve program effectiveness, and using QI methods to test and refine strategies.	1. Partner with CDPP to collect performance measure data from HHLC partners on an annual basis 2. Provide monthly reports and monthly check-in calls with CDPP staff to provide updates and receive technical assistance.

III. ELIGIBILITY

APPLICANT QUALIFICATIONS

Eligible applicants include, but are not limited to, non-profit organizations, local or Tribal health departments, membership or professional associations, and coalitions.

Applicants must have the following qualifications:

- Have sufficient staff and capacity to coordinate a multidisciplinary learning collaborative and support members in implementing projects tied to the grant strategies,
- Have a history of collaborating with multi-sector partners to achieve sustainable change,
- Can identify and regularly convene community members, clinical partners, CBOs, payors, and CHWs interested in addressing heart health disparities in your community,
- Have a linkage or relationship with at least one clinical partner (including health systems, federally qualified health centers, or free and charitable clinics) who is committed to participating in the HHLC and willing to share de-identified CQM data to track improvements in heart health disparities,
- Have experience in collecting quantitative and qualitative data to facilitate evaluation and performance measure reporting.

IV. FUNDING INFORMATION

FUNDING AVAILABILITY

The selected applicant will be awarded up to $100,000 for one year to coordinate a HHLC aimed at addressing heart health disparities experienced by at least one priority population in their community

(see Purpose above for example priority populations). The selected applicant will also act as a fiscal agent, distributing $50,000 in additional funds as subcontracts each year to support the implementation of QI projects directly tied to the grant strategies (see Background above for strategy descriptions).

This is a scored GFO application survey. Submission does not guarantee funding within this opportunity. This allows DHS to assess capacity of interested parties to conduct the work outlined in the scope of work. DHS reserves the right not to award funding to any applicant, DHS reserves the right to award more than one applicant, and DHS may award additional funding if more funding becomes available. DHS also reserves the right to award grants for less than an applicant's proposed amount. Should additional funding become available at any point during the grant period, DHS reserves the right to use the results of this application to increase funding to the selected applicant(s) or fund additional applicants that submitted an application but were not selected.

Moreover, DHS reserves the right to negotiate with the successful applicant(s) separate cost reimbursement for additional work that is related to other state or federal initiatives.

Funding for this budget period and for subsequent years or budget periods may be awarded based on performance and availability of funding.

USE OF FUNDING

Funding may be used for staff to coordinate the HHLC including member recruitment, planning and facilitating meetings, and guiding/overseeing QI projects implemented by HHLC members. Funding may also support fringe benefits, travel related to the project, data collection, analysis and reporting activities and other project related costs. The applicant is expected to administer $50,000 of the $150,000 total funding in subcontracts to HHLC members to facilitate the implementation of QI projects related to the grant strategies. The applicant must ensure that subcontracts follow allowable and unallowable cost guidance.

Selected applicants will be required to use the Grant Enrollment, Application and Reporting System (GEARS). Selected applicants will report costs incurred on expenditure reporting forms and submit the forms to the GEARS Unit monthly. Additional expenditure information will also be submitted to CDPP staff. Awarded grantee(s) will need a STAR Supplier identification number and GEARS Agency number.

Applicants selected for award will need to agree to direct deposit payments and agree to the terms in DHS' grant agreement. A draft copy of a grant agreement can be provided upon request.

DHS uses a cost-based reimbursement model that limits reimbursement to actual allowable incurred costs. If funding is awarded, expenses can be submitted for reimbursement only after they have been incurred.

Recommended indirect rate, if applicable, should be $\leq$ 15%.

Allowable Costs and Activities (not inclusive list) Grant recipients will be required to comply with the DHS Allowable Cost Policy Manual: https://www.dhs.wisconsin.gov/business/allow-cost-manual.htm
Staff time to coordinate and implement the project

Meeting expenses related to the project (meeting room, audiovisual (AV) equipment, travel, speakers, etc.)
Public health evaluation
Office supplies, postage, copying, etc. related to the project
Consultant and contract services needed to implement the project
Unallowable Costs and Activities
Direct or indirect lobbying activities
Clinical care such as health screening, patient care, personal health services, medications, patient rehabilitation, and other costs associated with treatment and direct care
Costs or activities not directly related to the overall project description and scope of work
Research
Construction
Capital expenditures and capital equipment. Capital equipment costs are defined as all costs associated with the acquisition of assets having a value in excess of $5,000, and a useful life in excess of one year.
Projects outside of Wisconsin

UNIQUE ENTITY IDENTIFIER (UEI)

Applicants must have, or obtain prior to grant agreement execution, an UEI and must not be disbarred, suspended, or ineligible. The UEI is a 12-character alphanumeric identifier (ID) that is issued through SAM.gov. You can go to SAM.gov and search to see if your organization already has a UEI. If it does not have one, you can request one by following the prompts at SAM.gov. It is free and usually takes a day or two to receive the number. Please note that you do not have to go through the full registration process, which takes longer. If you do need to obtain an UEI, please review Before You Get Started for more information. The video Get a Unique Entity ID - YouTube is also helpful. If additional help is needed, visit the Federal Service Desk at FSD.gov.

V. APPLICATION REQUIREMENTS

APPLICATION SUBMISSION

- **Complete the grant application by 11:59 p.m. on Monday, April 7, 2025**
- Access the grant application via Alchemer here. Only applications submitted through this link will be considered.
- Letters of Commitment: Provide letters of commitment from at least 1 clinical partner and 3 other partners that are committed to participating in the HHLC. See Application Questions #9 and #10 for further details.
- Budget and Justification: Provide a detailed outline of how the funds will be used per budget category. See Application Question #11 for budget template and further details.
- If the applicant does not provide the information necessary to meet the Application Requirements, DHS reserves the right to remove the application from further consideration.

APPLICATION TIPS

- Depending on your experience and interest, the time it takes to complete the application will vary. Therefore, we recommend you work "offline" until you are ready to complete the

application in Alchemer in full. You may use the Application Questions section below to work "offline" and prepare your application.

- Use the navigation buttons at the bottom of the page instead of your internet browser's navigation.
- You will not be able to navigate to any previous responses once "Submit" is selected on the last page.
- Complete this application in one sitting. You will not be able to return to your earlier responses.
- You must complete all required questions to submit your application *and* be considered for this funding opportunity. Required questions are indicated by a red asterisk (*).
- Any question with a maximum number of words set word are indicated after the question in parenthesis as well as under the text box field where applicable.

APPLICATION QUESTIONS:

These are the application questions you will complete in Alchemer. You may use this section to work "offline" and prepare before submitting your application in full using Alchemer.

1. Name of lead organization applying*

2. Contact information for who will serve as the primary point of contact for communication regarding this application. *

    - First Name
    - Last Name
    - Title
    - Street Address
    - City
    - State
    - ZIP Code
    - Email
    - Phone

3. Organization website (if applicable)

4. Describe the population your organization serves and how it aligns with the goals of this program. Please include quantitative and/or qualitative data to help describe your community (e.g., geographical reach such as name of county or list of ZIP codes, total population, demographics, etc.) and show how your community would benefit from an HHLC (e.g., high blood pressure prevalence, disparities present). Quantitative data can include local sources and/or publicly available data like County Health Rankings, Community Health Needs Assessment, and/or CDC PLACES. Qualitative data sources can include community feedback from focus groups or interviews that identify heart health needs among the community. (500 words) *

5. Heart disease affects the majority of Wisconsinites and any heart health initiatives should have broad impacts. However, particular efforts should be made to reach the community members at greatest risk. Based on the data, briefly describe the priority population(s) you intend to focus on to address heart health disparities in your community. (250 words) *

6. How could the creation of an HHLC help your community leverage existing assets and overcome challenges to address heart health disparities? (500 words) *

7. Share why your organization is well-poised to lead a HHLC in your community. Describe your staff capacity and expertise, as well as your organization's history of collaborating with both health care organizations and CBOs for collective impact. Please provide specific examples of work that is related to cardiovascular health and/or chronic disease prevention where possible. (750 words) *

8. How will you approach implementing the scope of work described in this funding opportunity? Offer a rough timeline for accomplishing the key activities and list organizations that you have engaged or plan to engage to join the HHLC (with particular focus on those that would form your leadership committee). Share any challenges that you foresee and how you will work to overcome them. (500 words) *

9. Provide at least one letter of commitment from a clinical partner that has agreed to participate in the HHLC and share de-identified CQM data. The letter should emphasize the organization's commitment to improving heart health and collaborating with community partners to address social needs. You will attach the letter of commitment in Alchemer, following the file naming convention: Applicant Name_Clinic LOC_230004 HHLC. *

10. Provide at least three letters of commitment from partners from various sectors that will participate in the HHLC and contribute to the multisector and interdisciplinary intent of the HHLC. The letters should emphasize their connection to the priority population and the expertise that they will bring to the HHLC that will help you accomplish the Scope of Work. You will attach the three letters of commitment in Alchemer, following the file naming convention: Applicant Name_ LOC 1_230004 HHLC, Applicant Name_ LOC 2_230004 HHLC, Applicant Name_ LOC 3_230004 HHLC. *

11. Complete the budget template for the period June 30, 2025 – June 29, 2026. Click here to automatically download the Budget Template in its ready-to-use .xlsx format. Please check your internet browser's or computer's downloads. You will attach your completed budget template in Alchemer, following the file naming convention: Applicant Name_Budget _230004 HHLC. *

12. What other comments or questions would you like to share with the Chronic Disease Prevention Program? (250 words)

QUESTIONS

If you have any questions, please e-mail the CDPP team at DHSChronicDiseasePrevention@dhs.wisconsin.gov. Include "230004 HHLC GFO" in the subject line.

VI. APPLICATION SCORING

Applications are reviewed by an evaluation committee and scored against defined criteria.

Application Section Scoring	Maximum Points
A. Heart Health Landscape Description and selection of priority population	15
B. How an HHLC will leverage community assets and overcome challenges	10
C. Organizational capacity and expertise	20
D. Approach to Scope of Work	15
E. Letters of Commitment	30
F. Budget and Justification	10
Maximum Total Points:	**100**

VII. NOTIFICATION OF AWARD

The CDPP anticipates the date of notification of awards will be **April 28, 2025** or shortly after this date. For applicants who are awarded, the period of performance is from **June 30, 2025 – June 29, 2026.** Depending on available funding and acceptable performance, two additional years of funding may be awarded to extend grant activities through June 29, 2028. Applicants not chosen for funding will be notified accordingly.

VIII. POST AWARD MONITORING AND REPORTING

DHS CDPP staff will monitor progress and provide technical assistance during the grant period. Written monthly reports and monthly check-in meetings will be required during the grant period to assist CDPP in reporting detailed progress to CDC. Applicants are also required to evaluate activities and participate, contribute, and inform the DHS CDPP annual evaluation and performance measurement plan. To assist in meeting these requirements, award recipients will need to monitor and report barriers, facilitators, and lessons learned.

Applicants are also required to complete and/or disseminate data collection tools as needed to assist in QI efforts as well as reporting on evaluation and performance measures. For example, participating in an informal interview to better understand workflow processes or ensuring HHLC members and subgrantees complete a survey created by DHS CDPP to collect end-of-year performance measures:

- Blood pressure control rates
- Blood pressure control rates by race and ethnicity
- Number of healthcare systems that are utilizing a team-based care approach for managing patients at risk for CVD
- Number of individuals at risk for CVD who are referred to social services or evidence-based lifestyle change programs
- Number of CHWs who are engaged in the work
- Number and type of social services provided by organizations in the area of focus

- Number of patients enrolled in SMBP programs

IX. GLOSSARY

Award: Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.

Budget Period or Budget Year: The duration of each individual funding period within the period of performance.

Standardized Clinical Quality Measures: As defined by The Centers for Medicaid and Medicare Services, clinical quality measures, or CQMs, are tools that help measure and track the quality of health care services provided by eligible professionals, eligible hospitals and critical access hospitals within the health care system. These measures use data associated with providers' ability to deliver high- quality care or that relate to long term goals for quality health care. CQMs measure many aspects of patient care including adherence to clinical guidelines, clinical processes, patient safety, efficient use of health care resources, care coordination, patient engagements, health outcomes, and population and public health. Specifics on CQMs related to hypertension can be found here.

Cooperative Agreement: A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.

Collective impact: A network of community members, organizations, and institutions who advance a common goal by learning together, aligning, and integrating their actions to achieve population and systems level change.

Community-Clinical Linkages: Connections between community and clinical sectors to improve population health. Community-clinical linkages are a recommended approach to prevent and control chronic conditions.

Community Engagement: The process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their well-being.

Contracts: An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.

Evaluation (program evaluation): The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.

Evaluation and Performance Measure Plan (EPMP): A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The EPMP is used to describe how DHS CDPP and/or CDC will determine whether activities are implemented appropriately, and outcomes are achieved.

Grant: A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition does not include a federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.

Health Disparities: Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.

Multi-sector Collaboration: A partnership that results when government, non-profit, private, and public organizations, community groups, and individual community members come together to solve problems that affect the whole community.

Nonmedical factors: The conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life (i.e., economic or policies and systems, development agendas, social norms, etc).

Outcome: The results of program operations or activities; the effects triggered by the program. For example, increased knowledge, changed attitudes or beliefs, improved hypertension, reduced morbidity and mortality.

Performance Measurement: The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A "program" may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.

Plan Do Study Act (PDSA): A four-step model used to solve problem, improve processes and carry out change. It's a cyclical iterative process that emphasizes learning and adaptation through feedback.

Priority Populations: Those who have systematically experienced greater obstacles to health due to social, demographic, environmental, and other factors or characteristics.

Quality Improvement (QI): The use of a deliberate and defined improvement process to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve outcomes that improve the health of the community.

Social Service and Support Needs/Social Needs: Resources needed for every individual to survive and thrive. This can include but is not limited to basic needs like food, shelter, and health care, as well as needs related to safety, mental health, and financial security.

Technical Assistance: Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation provided by the funding agency.

X. CITATIONS & RESOURCES

Citations

1. Centers for Disease Control and Prevention. National Center for Health Statistics - Wisconsin Key Health Indicators. Accessed on March 22, 2023. Available online: https://www.cdc.gov/nchs/pressroom/states/wisconsin/wi.htm
2. Centers for Disease Control and Prevention. Interactive Atlas of Heart Disease and Stroke. Accessed on March 22, 2023. Available online: http://nccd.cdc.gov/DHDSPAtlas.
3. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. Chronic Disease Indicators (CDI) Data. Accessed March 22, 2023. Available online: https://nccd.cdc.gov/cdi.
4. Centers for Disease Control and Prevention. Facts about hypertension. Accessed on March 22, 2023. Available online: https://www.cdc.gov/bloodpressure/facts.htm
5. United States Census Bureau. QuickFacts Wisconsin. Accessed on March 22, 2023. Available online: https://www.census.gov/quickfacts/fact/table/WI/PST040222#PST040222
6. Wisconsin Collaborative for Healthcare Quality. 2020 Wisconsin Health Disparities Report: Rural and Urban Populations. Accessed March 22, 2023. Available online: https://www.wchq.org/disparities#:~:text=Report%20Overview&text=The%20Wisconsin%20Collaborative%20for%20Healthcare,are%20working%20to%20eliminate%20disparities.
7. Wisconsin Collaborative for Healthcare Quality. Disparities in Blood Pressure Control - A Healthy Metric 2022 Brief Report for Wisconsin. Accessed March 22, 2023. Available online: https://www.wchq.org/disparities#:~:text=Report%20Overview&text=The%20Wisconsin%20Collaborative%20for%20Healthcare,are%20working%20to%20eliminate%20disparities.

Resources

- Best Practices for Heart Disease and Stroke Prevention and Management
- Collective Impact Forum
- A Public Health Framework to Improve Population Health Through Health Care and Community Clinical Linkages