**B. Generic Collection of Information Employing Statistical Methods If statistical methods will not be used to select respondents and item 17 on Form 83-I is checked "No" use this section to describe data collection procedures.**

The American Heart Association will not be employing statistical methods in assessing the National Hypertension Control Initiative (NHCI). There are four data collection activities that will result in tabulations and reporting for internal project purposes and publication. All data collection activities will result in summary descriptive statistics and means testing as appropriate. The data collection will not result in metrics generalizable to the population, but findings will inform future implementation of similar activities. The four data collection activities to be conducted are:

1. Qualtrics Survey to be completed by Community Health Centers CHCs) within 3 months of OMB approval
2. Data Reporting, Evaluation, and Monitoring (DREaM) dashboard to be completed by CHCs and Community-based Organizations (CBOs) within 6 months of OMB approval and quarterly thereafter.
3. Feasibility assessment focus groups with CHCs and CBOs to be completed within 3 months of OMB approval and 3 times a year thereafter
4. Empowered to Serve Health lessons curriculum assessing hypertension awareness, education and corresponding quizzes to be administered to CBO participants within 3 months of OMB approval and on an ongoing basis throughout years 1-3 of the NHCI initiative. In years 2-3, CBOs will also report the aggregate number of referrals they make to CHCs.
5. Social Needs Platforms. CBOs and CHCs will be asked to use one of two publicly-available social needs platforms (Find Help or Unite Us) and CHCs will be asked to use the Unite Us social needs platform to connect individuals receiving services at the CBOs to Community Health Centers (CHCs), and vice versa, to receive additional blood pressure-related services.
6. Remote Patient Monitoring. AHA will be partnering with Canary Telehealth to collect aggregate metrics from a subset of Community Health Centers (CHCs).
7. Blood Pressure Control Metrics via Electronic Health Records**.** AHA will be partnering with external research partners to obtain reports of aggregated blood pressure control metrics from NHCI CHCs to inform clinical decision making, clinical quality improvement, and clinical outcomes.

Data collection procedures, the respective population, and reporting metrics are described for each of the four data activities.

**1. Qualtrics Survey of CHCs**

The purpose of the survey is to track activities across the NHCI initiative regarding efforts to raise public awareness, strengthen health center care, and build health center-community linkages to improve blood pressure control. Specifically, CHCs and CBOs will provide qualitative and aggregated quantitative data regarding patient blood pressure health metrics, referrals, practitioner training, and patient blood pressure control

education on a quarterly basis throughout the duration of the grant. The survey will be administered to 350 CHCs previously recruited using an OMB approved CHC Assessment Survey (OMB Control #: 0990-0379) within 3 months of OMB approval and up to 16 CBOs. A secondary purpose of the Qualtrics survey will be to streamline NHCI's process for identifying the primary points of contacts, data analyses, and data collection approaches to inform the development of an online monitoring and evaluation reporting database where CHCs and CBOs can provide responses to the Qualtrics survey questions on a quarterly basis.

The unit of analyses for this data collection is the CHC and CBO. Each CHC and CBO includes satellite sites where services are provided. Each site will collect information to address questions such as:

i. The number of partner or referring CBOs each site serves
ii. Counts of the various type of NHCI BP activities being conducted/experienced at each site, for example the aggregate number of patients with high blood pressure served, the types of treatment protocols used at the site, number of staff trained on correct use of self-monitored blood pressure measurement etc.
iii. The number of consumers completing educational lessons on screening, monitoring, and controlling blood pressure.

Data collected from each site will be aggregated up to provide a single report by CHCs and CBOs respectively. AHA will generate descriptive statistics for these types of questions. When possible, the data will be cross-sectioned by urban/rural status of the CHCs/CBOs with T-tests being conducted to determine true differences in urban/rural status. Per quarter, this would be presented in a bar chart but could be presented in a line chart once more quarterly data collection periods have been completed.

**2. Data Reporting, Evaluation, and Monitoring (DREaM)**

The DREaM builds on the Qualtrics survey by providing an online platform for CHCs and CBOs to provide the same information. The advantage of the DREaM will be database enhancements that will pull information from external resources such as information completed in previous quarters to minimize user burden. The DREaM will also offer CHCs and NHCI administrators access controlled snapshots or visualizations of data entered, for example, comparing current entries to previous entries in real-time. This "dashboard" component will enhance value for CHCs entering information on a quarterly basis about their NHCI activities. CHCs will begin using the MERD within 6 months of OMB approval and on a quarterly basis thereafter.

As with the Qualtrics Survey, data reported by CHCs will presented as summary descriptive statistics and tabulated by urban/rural status. Means testing will be used to assess the urban/rural differences observed, if any. Data collected from CBOs will also be presented as summary statistics with the unit of analyses being the CBO.

## 3. Feasibility Assessment Focus Groups of CHCs and CBOs

A primary component of the NHCI intervention is to build partnerships with gatekeepers and trusted organizations that serve local communities and make connections between these partners and HRSA-funded health centers who provide hypertension management services. To design and deliver an effective intervention, AHA will collect qualitative data regarding the feasibility of intervention implementation from CBOs and CHCs. AHA will analyze these data in conjunction with quantitative data (e.g., from the DREaM portal) and secondary data sources to understand from the perspective of its implementation partners **what works, what doesn't work, and how to optimize the intervention moving forward**.

Upon OMB approval, the feasibility assessment focus groups and interviews will be conducted annually at the beginning, middle and end of the year, through to year 2 and 3 of the NHCI project.

**Recruitment.** Qualitative data from CBOs and CHCs will provide rich, contextual information into implementation feasibility, barriers, and best practices. AHA will recruit a purposive sample of sixteen "collaborative units" to participate in focus groups—that is, pairings of pre-existing CBO-CHC partnerships who have started implementing systems changes to connect community members to hypertension resources and care. AHA will conduct four focus groups with CBOs (n = 4 participants per group) and four focus groups with CHCs (n = 4 participants per group).

Table 1. Feasibility Study Sample Size Matrix

| | |
|---|---|
| **CHC Group #1** (at least one site-level participant)<br>n = 4 | **CBO Group #1**<br>n = 4 |
| **CHC Group #2** (at least one site-level participant)<br>n = 4 | **CBO Group #2**<br>n = 4 |
| **CHC Group #3** (at least one site-level participant)<br>n = 4 | **CBO Group #2**<br>n = 4 |
| **CHC Group #4** (at least one site-level participant)<br>n = 4 | **CBO Group #2**<br>n = 4 |

All CBO-CHC collaborative units currently identified by AHA will be sent a series of screening questions via email to assess factors such as geographic location, target audiences, and organizational size/scope (see Sections 1.4 and 1.5 for screeners). Participants will be selected for participation in the feasibility study using the following criteria:

- All participants will have attended at least two AHA NHCI training sessions (e.g., webinars).

- All collaborative units will identify each other as current partners
- *At least one* collaborative unit from each of the following groups will be included in the study:
    - Serves a primarily rural community
    - Serves a primarily urban and/or suburban community
- All CBOs will have recommended (i.e., referred) at least one community member to their partner CHC for care
- *At least three* of the following CBO types will be represented in the study:
    - Faith-based organizations
    - Barber shops/beauty salons
    - Recreation and community organizations
    - Senior centers
    - Pharmacies
- *At least one* CHC from each of the following groups will be included in each of the two CHCs focus groups:
    - Small size (1 – 9 sites)
    - Mid/large size (10+ sites)
- At least *one* site affiliated with each of the CHCs participating in a focus group will be included in each of the two CHCs focus groups

Reporting of findings will be qualitative summaries and counts synthesized across the focus groups. These findings will be used to inform program implementation and improvements.

**4. EmPOWERED to Serve Health Lessons and Quizzes**

Within 3 months of OMB approval, AHA will begin engaging CBOs in the EmPOWERED to Serve (ETS) Health Lessons online platform. ETS Health Lessons offer a way to engage communities and motivate community members to take steps towards creating a culture of health. The curriculum consists of four training modules:

i. Control your Blood Pressure
ii. Get Active
iii. Know Diabetes by Heart
iv. Salt and Cardiovascular Risk

Each module is capped with a 10-minute quiz. AHA will compute the total # of participants who completed the quizzes. These raw numbers will be compared against the total number or participants engaged in health lessons to assessed the percentage of participants that completed a posttest, per organization.

Within 3 months of OMB approval CBOs will begin reporting to AHA key aggregate

metrics from the EmPOWERED to Serve health lessons and curriculum. Specifically, CBOs will report:

i. Total number of participants engaged in EmPOWERED health lessons
ii. Percentage of participants that engaged in health lessons and completed health lessons quizzes
iii. Number of recommendations made to CHCs (within 6 months of OMB approval)

**5. Social Needs Platforms**

CBOs and CHCs will be asked to use one of two publicly-available social needs platforms (Find Help or Unite Us) to connect individuals receiving services at the CBOs to CHCs, and vice versa, to receive additional blood pressure-related services. The AHA has entered into an agreement with CBOs, Find Help, and Unite Us to facilitate the data collection. AHA will work with each of the platforms as they ask CHCs and CBOs to complete the readiness assessment during the recruitment process. AHA will work with CHCs and CBOs to increase their capacity and ability to engage with either of two publicly-available online social needs platforms – Unite Us or Find Help.

The agreement permits the social needs platforms to share individually deidentified data (secondary data) with AHA about the number of referrals CBOs are making to CHCs. In addition, the platforms will share aggregate data about participant demographic characteristics and social needs such as transportation needs, food insecurity, and perceived stress.

To assess the social needs of patients/consumers seeking services at CHCs and CBOs, AHA will tabulate descriptive statistics about aggregate number of participants facing transportation needs, food insecurity, and perceived stress.

**6. Remote Patient Monitoring**

Upon OMB approval, AHA will begin working with Canary Telehealth to collect aggregate metrics from a subset of Community Health Centers (CHCs). Canary Telehealth currently engages with community partners to collect patient-level data through an app-based method. As such, Canary Telehealth and their partners are engaged in independent data sharing agreements, and privacy and confidentiality agreements enabling Canary Telehealth to share aggregate data with AHA on key questions pertaining to blood pressure self-management.

AHA will generate descriptive statistics. When possible, the data will be cross-sectioned by urban/rural status of the CHCs with T-tests being conducted to determine true differences in urban/rural status. Per quarter, this would be presented in a bar chart but could be presented in a line chart once more quarterly data collection periods have been completed.

## 7. Blood Pressure Control Metrics via Electronic Health Records

Upon OMB approval, AHA will begin working with an external research partner to obtain reports of aggregated blood pressure control metrics from NHCI CHCs to inform clinical decision making, clinical quality improvement, and clinical outcomes. These data will be aggregated at the CHC level and are expected to be provided on a quarterly basis. The desired EHR-derived metrics will include process, structural, performance, and quality improvement measures for the diagnosis and management of high blood pressure.

AHA will generate descriptive statistics using the secondary data provided. When possible, the data will be cross-sectioned by urban/rural status of the CHCs with T-tests being conducted to determine true differences in urban/rural status. Per quarter, this would be presented in a bar chart but could be presented in a line chart once more quarterly data collection periods have been completed. As additional data are collected, AHA conduct statistical analysis designed to evaluate comparative improvements in BP control during initiation of data collection through December 2023.