

Actions to Decrease Disparities in Risk and Engage in Shared Support for Blood Pressure Control (ADDRESS- BP) in Blacks

PROTOCOL: COMMUNITY HEALTH WORKER IMPLEMENTATION STRATEGY

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Community Health Worker Protocol Summary

Study Overview

- Use of a **Practice Facilitation + Community Health Worker (CHW) Implementation Strategy** to implement a Community-Clinic Linkage Model of 3 multi-level evidence-based interventions for hypertension control for Black patients in 25 Primary Care Practices
- **Intervention Components:**
 - (1) Remote Blood Pressure Monitoring (RBPM)
 - Use of valid automated remote BP monitor devices (OMRON), provided by the study, to remotely monitor patient BP
 - (2) Centralized Nurse Case Management (NCM)
 - NCMs conduct behavioral counseling and provide medical regimen recommendations, based on patient BP readings
 - (3) Social Determinants of Health (SDoH) Support
 - NCMs complete social needs screening.
 - CHWs provide patients with culturally/contextually tailored health information, technology support, and community referrals to address SDoH-related barriers to hypertension management
- **Sample** 500 Black patients with uncontrolled HTN ($\geq 130/\geq 80$ mmHg) at 25 NYU Langone practices

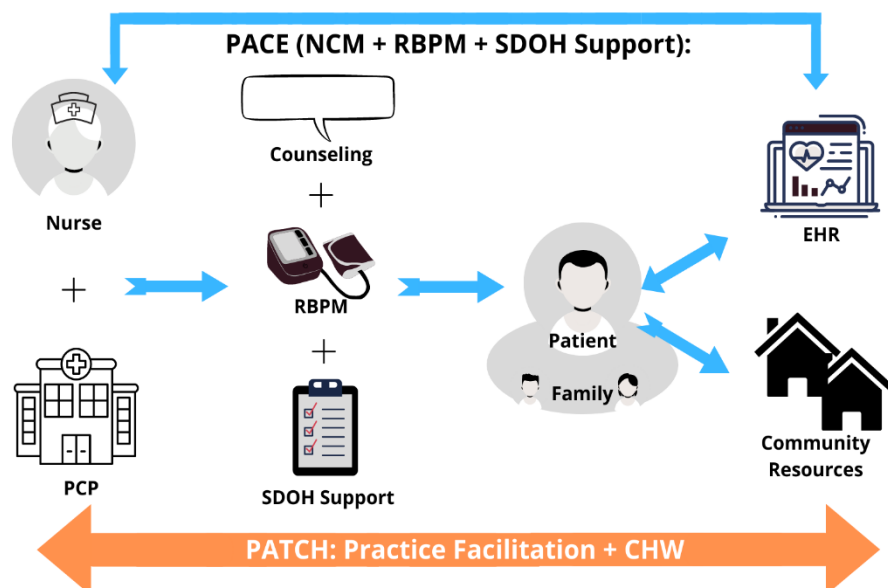


Figure : Practice support And Community Engagement (PACE) Intervention + Practice facilitation And social deTerminants of health support utilizing CHWs (PATCH) Implementation Strategy

Protocol Summary for Implementation Study (UH3 Phase)

Community Health Worker Protocol Overview

Purpose

The purpose of this protocol is to provide guidelines for the community health worker (CHW) delivering the implementation strategy as part of the ADDRESS-BP project within 25 primary care Faculty Group Practices (FGP) at NYU Langone Health.

Goal

To use the protocol as standard procedure for CHWs to effectively support nurse case managers (NCMs) and pharmacists in implementing the ADDRESS-BP intervention at the patient-level. The following guide includes communication workflows, data entry procedures, database references, and scripts.

Intervention Summary

Practice support And Community Engagement (PACE) comprises three evidence-based multi-level interventions (EBIs) to address barriers to hypertension at the patient, physician, health system and community levels. The 3 EBIs that comprise PACE include remote blood pressure monitoring [RBPM], nurse case management [NCM], and social determinants of health [SDOH] support. Centralized nurses deliver PACE and (1) introduce RBPM to patients; (2) engage in behavioral counseling; (3) provide medication regimen recommendations; and (4) provide SDOH support, including assessment and referral to community resources. All centralized nurses are employed within NYULH's Clinically Integrated Network (CIN) who provide clinical care coordination such as patient education and post discharge assessments.

CHW Implementation Strategy Summary

The CHW Implementation Strategies used in this project come from the ERIC Framework (See Appendix A Table 1):

- 1) Preparing patients to be active participants and active in their care
- 2) Conduct educational meetings
- 3) Support patients to enhance uptake and adherence

The PACE intervention components are provided to enrolled patients during both the TAU and PATCH phases; however, the level of patient engagement by CHWs differs by phase:

Training as Usual (TAU): During the 9-month 'training as usual' (TAU) period, centralized NCMs work across practices to deliver the PACE intervention, including social needs screening and referral to community resources with "light touch" assistance from a community health worker.

PATCH: When practices transition to the PATCH condition at the end of the 9-month TAU period, practices receive PATCH (PF+CHW support), which is designed to increase adoption, reach, fidelity, and other implementation outcomes of the PACE intervention. In this period, 2 practice facilitators, who are NYULH staff trained in practice facilitation (e.g. translating evidence-based systems interventions into routine practice), and 3 CHWs, who are employed by NYULH and part of the study team, and who are trained in strategies to enhance patient activation, work across practices in the integration of PACE through a centralized model.

CHWs support NCM efforts by engaging patients through 1-on-1 interactions or group sessions (groups consist of patients of a single practice), either in-person or remotely, to enhance adoption of PACE. They do this by: 1) preparing patients to be active participants in their care, to ask questions, and inquire about care guidelines/evidence/treatments; 2) conducting educational meetings to teach patients about the clinical innovation (NCM counseling visits, RBPM) and encourage adoption; and 3) supporting patients to enhance adherence to RBPM and NCM counseling visits and developing strategies to encourage and problem-solve around challenges to uptake. NCMs inform patients that CHW support is available.

CHWs support the practice facilitator and are integrated into the care team at practices in order to provide "connective" services that support the success of team-based care. CHWs support infrastructure development for integrating a clinic-community model and light touch of counseling through engagement of patients via calls and outreach, leveraging their shared lived experience, troubleshooting technology-related barriers to remote BP monitoring, assessment of social needs and referrals to community services, and providing access to culturally tailored health education materials. CHWs provide support to patients on developing problem-solving strategies around lifestyle changes through culturally tailored patient-centered health education sessions and health coaching. The CHW component of the implementation strategy facilitates connective services outside of clinic, in the clinic, and back out to social services; in this way, CHWs serve as the bridge of the community-clinical linkage model.

CHW Implementation Strategies

All 3 CHWs deliver all three implementation strategies to enhance patient activation.

- 1) Preparing patients to be active participants in their care, to ask questions, and inquire about care guidelines/evidence/treatments.
 - a. Engage patients through 1-on-1 interactions or group sessions (groups consist of patients of a single practice) to support:
 - i. Preparing patients for their upcoming primary care visits
 1. CHWs implement this strategy through health educational sessions, offered to all patients participating in the program. Session content follows a structured CHW Curriculum (see Appendix B). CHWs prepare patients for their upcoming visits by encouraging them to ask questions about their care, medications, and to speak up if there are any concerns.
 2. CHWs focus on medication management on their first virtual one-on-one check-in. Discussions are around medication uptake, challenges and barriers to medication adherence and how to address them (see below CHW Implementation Activities: CHW Check in Virtual Visits). All patients receive this virtual one on one check in call.
 - ii. Troubleshoot technology related barriers to BP monitoring
 1. Once referred by NCMs, CHWs reach out to patients and assist with setting up their Remote BP Monitor. RBPM set up is provided by CHWs one on one either virtually or in person, depending on each site's capacity. During set up, CHWs encourage patients to take BP readings four times a week, twice a day, and to ask NCM or PCP questions regarding any trends in their BP readings, BP medications or any concerns about their care (see below CHW Implementation Activities: RBPM Support).
 - iii. Discuss strategies to enhance self-efficacy and healthcare efficacy in clinical encounters with primary care team. Encouraging patients to ask providers about their BP readings, asking questions about medications and address any SDoH needs that result in barriers to care.
 1. Strategies are discussed with all patients through health educational sessions (see below CHW Implementation Activities) and are offered to all patients participating in the program. Session content follows a structured CHW Curriculum (see Appendix B).
 2. CHWs focus on medication management on their first virtual one on-one check-in. Discussion is around medication uptake, challenges and barriers to medication adherence and how to address them (see below CHW Implementation Activities: CHW Check in Virtual Visits). All patients receive these virtual one-on-one check-in calls.
 - b. Utilize goal-setting and motivational interviewing strategies to activate the patient to improve health behaviors
 - i. Patients have the opportunity to create SMART goals around enhancing their healthcare experience during their one on one calls. CHWs provide guidance to create a structured plan and address any challenges and barriers (see below CHW Implementation Activities: Goal Setting). Only those patients who convey this particular need through their one-on-one bi-weekly calls create a goal setting plan specifically for PCP visit preparedness/enhancing healthcare experience.
- 2) Conducting educational meetings to teach patients about the clinical innovation (NCM counseling visits, RBPM) and encourage adoption

- a. CHWs facilitate RBPM set-up for those patients identified by NCM as needing assistance. CHWs troubleshoot any technology related barriers to RBPM and emphasize the importance of continuing monitoring (see below CHW Implementation Activities: RBPM Support). In some cases, if the patient has not uploaded any blood pressure readings or has stopped uploading them for an extended period, the CHW will follow up to address RBPM technical issues and/or encourage re-engagement. During RBPM set-up, CHWs reinforce information found on the patient packet (see Appendix C) and ensure patients understand their readings and circumstances where they could be misinterpreted (eg. “white coat syndrome”, if patient have been rushing, etc.). CHWs emphasize the importance of submitting BP readings and encourage submission while addressing any feelings that may come up with the reading (fear, shame, feeling anxious) (Appendix K).
 - b. CHWs implement this strategy through virtual one-on-one or group sessions (see below CHW Implementation Activities) that are offered to all patients participating in the program. Session content follows a structured CHW Curriculum (see Appendix B). CHWs discuss the importance of consistent blood pressure monitoring and encourage uptake of NCM counseling.
 - c. CHWs focus on hypertension management on their second virtual one-on-one check-in (see below CHW Implementation Activities: CHW Check in Virtual Visits). Discussions are focused on the particular patient’s needs and challenges surrounding management of their hypertension. CHWs may discuss diet and nutrition, physical activity, stress management as it relates to blood pressure, and other risk factors (cholesterol/diabetes, smoking). CHW discuss patients’ barriers and challenges, how to address them and provide any specific SDoH referrals as needed. All patients receive these virtual one-on-one check-in calls but the discussion content varies depending on patient’s needs.
- 3) Supporting patients to enhance adherence to RBPM and NCM counseling visits and developing strategies to encourage and problem-solve around challenges to uptake
- a. CHWs facilitate RBPM set up for those patients identified by NCM as needing assistance and those who have not uploaded blood pressure readings. CHWs troubleshoot any technology related barriers to RBPM and emphasize the importance of continuing monitoring (see below). In some cases, if the patient has not uploaded any blood pressure readings or has stopped uploading them for an extended period, the CHW will follow up to address RBPM technical issues and/or encourage re-engagement. During set-up, CHWs reinforce information found on the patient packet (see Appendix C) and ensuring patients understand their readings and circumstances where they could be misinterpreted (eg. “white coat syndrome”, if patient was rushing, etc.). CHWs emphasize the importance of submitting BP readings and encourage submission while addressing any feelings that may come up with the reading (fear, shame, feeling anxious) (Appendix K).
 - b. Utilize goal-setting and motivational interviewing strategies to support patients to enhance RBPM and NCM counseling. Patients have the opportunity to create goals around their blood pressure monitoring during their one on one calls. (e.g. *‘My goal is to take my blood pressure Mondays, Wednesdays and Fridays, twice a day for the next month using the Bluetooth blood pressure monitor’*). CHWs provide guidance to create a structured plan and address any challenges and barriers (see below CHW Implementation Activities: Goal Setting). Only those patients who convey this particular need through their one-on-one bi-weekly calls create a goal setting plan specifically for RBPM adherence and NCM counseling visits. The goals are revisited bi-weekly and CHWs address any challenges and barriers and provide any specific SDoH referrals as needed.

CHW Programmatic Data Entry

CHWs complete all data entry in REDCap for record keeping and EPIC to close the loop with NCMs referrals and requests.

EPIC

All calls made to patients are recorded on EPIC as a patient encounter and entered into each patient's EHR. These include all calls pertinent to:

- a. Program Introduction
- b. Setting up RBPM
- c. Scheduling a curriculum session
- d. Bi-Weekly follow up calls
- e. Curriculum session calls
- f. Referrals and SDOH Needs

A short 1-2 line documentation is included with each patient encounter that summarizes the purpose of the call and if any pending requests (assisting with RBPM, community referral, etc) was resolved (See Epic Documentation tipsheet in Appendix D).

REDCap

1) CHWs complete all data entry in REDCap through specific data entry forms depending on the purpose of the interaction. Participant data entry forms include (see Appendix E for all REDCap data entry forms):

- a. Tracking Form
- b. RBPM Set Up Form
- c. Participant Referrals Form
- d. Participant Goal Setting Form
- e. Participant Progress Note (Repeating Form)
- f. Virtual Check In #1
- g. Virtual Check In #2
- h. Contact Attempts Implementation
- i. Participant Encounter Form (Repeating Form)
- j. Endpoint Form

2) CHW manager runs weekly data reports to monitor accurate data entry and follow up for any pending contact including patients who:

- Need a bi-weekly follow up
- Need a community referral pending the SDOH screener
- Have not uploaded a blood pressure reading
- Have not been in communication with the NCM

CHWs follow up with patients who have any outstanding needs.

CHW Implementation Activities

TAU: Training as Usual Phase

As part of program launch once the practice enters the onboarding phase, CHWs:

- 1) Identify community resources (FBOs, food pantries, public gyms, etc) local to clinic sites through neighborhood mapping. These are documented on the Community Directory saved on NYU's OneDrive and shared with NCM team.

The file is found in the following link within the NYU OneDrive:

https://nyulangone-my.sharepoint.com/:x/g/personal/smiti_nadkarni_nyulangone_org/ETbERn2J3xFJruJwluci45oBjT8wMPj5NwABMfDEMO0x-A

Throughout the TAU phase:

- 2) Onboarding: Project coordinator (PC) reviews EPIC report daily for new patients enrolled into RBPM by providers. Once received, PC share patient's details to CHW team who outreaches the newly enrolled patient to introduce the program details and all program staff that will be in touch with them, including:
 - a. Program Coordinator and other program staff
 - b. Nurse Case Manager
 - c. Pharmacist

The purpose of the call is to introduce the program as a team-based approach and answer any questions relating to their participation. The CHW introduces the Program Coordinator as their next touchpoint (See Appendix N for script). PC will then complete the onboarding call (see Appendix F) to officially onboard the patient. The purpose of this call is to provide program expectations and confirm the patient's address in order to mail the blood pressure monitor. Once the onboarding call is complete, PC mails the BP monitor to the patient's mailing address per RBPM mailing protocol (see Appendix G)

- 3) Provide assistance to potentially eligible patients who need MyChart activation (patient portal). Provide guidance using MyChart tools: scheduling appointments, messaging providers, viewing lab results and BP measurements, etc (see Appendix H for MyChart Activation Protocol).
- 4) Provide SDOH Assistance through light touch protocol: Once a patient reports an SDOH need upon completion by the screener delivered by the NCM, NCM notifies the CHW team (CHWs, CHW manager) of any patient needs via EPIC secure chat. CHW team responds to NCM to confirm that the message was received and that the need will be addressed. CHW proceeds with sharing resources with patients regarding SDOH need and enter all pertaining information on the Referrals Form on REDCap. CHW also documents this call on the patient's EHR (see Appendix D). During the TAU phase, CHW does not assist the patient in filling out forms or contacting the organization but rather encouraging the patient to connect with the resource/organization on their own. Patients receive a MyChart message with referral/resource and contact information sent by the CHW. CHWs attempt to contact patients twice to provide referrals and for follow up. If after two contact attempts the patient is not reached, CHW lets the NCM know that no referrals were provided directly but that a MyChart message was sent to the patient with the information. (see Appendix I for CHW Light Touch Protocol, Appendix J for MyChart Messages).

PATCH: Practice facilitation And social deTerminants of health supporting utilizing CHWs Phase

I Months 1-2: Troubleshooting technology-related barriers to Remote BP Monitoring / Supporting NCM / SDOH Support

- Assist potentially eligible participants in activating MyChart account and provide guidance in using MyChart tools: scheduling appointments, messaging providers, viewing lab results and BP measurements, etc.
- Assist participants in setting up BP monitor and connect to NYU MyChart account and accurately measuring blood pressure at home using BP monitor. Troubleshoot technology related barriers to RBPM and emphasizing the importance of continual monitoring.
- Identifying SDOH-related barriers to HTN control; providing referrals and service connection
- Reinforcing NCM counseling and providing support in community settings

A) RBPM Support

Onboarding protocol will continue as detailed during the TAU phase. Program staff will give or mail monitor to patients and record BP monitor number and date of receipt or delivery. Whether the device will be given in person or mailed will depend on each site's capacity to support staff presence at the clinic. Patients may also have the option to retrieve their monitors from NYU's office at 180 Madison Ave as an alternative. In this case, a program staff member will coordinate a pickup time with the patient. CHW manager will assign all patients enrolled during the TAU phase to CHWs and on an ongoing basis during the PATCH phase as their enrollment is confirmed by Program Staff. Once the patient is assigned, they will be uploaded to each CHW's dashboard on REDCap. CHW will then proceed with the following:

1. CHW confirms through Fedex tracking information if RBPM has been received by the patient.
 - a. RBPM tracking form found on OneDrive shared folder
2. CHW calls participant no more than 3 days after Fedex delivery date to confirm receipt and set up of RBPM. CHW will complete the RBPM Setup Form in REDCap Implementation Database (See Appendix E). Once RBPM is successfully set up, CHW will complete assistance by asking patient to submit a BP reading to MyChart so that they are officially onboarded.
 - a. If the patient declines assistance, CHW will note this on REDCap. CHW will run the 'RPM-MyChart Home Monitoring- FGP Hypertension Initiative' on EPIC to confirm if the patient has uploaded any readings. CHW will call patient for follow up if there are no readings uploaded after 2 weeks from initial call.

Note – patient receives the FGP patient packet with RBPM set-up instructions upon enrollment via MyChart. Program staff member also includes printed copy of patient packet in mailed BP monitor package. CHW can remind patients that the FGP patient packet for the BP monitor was sent to their MyChart and was included in their package. (See Appendix K for RBPM set up protocol).
3. CHWs makes the patient aware of their initial phone call with the NCM which includes one counseling session per month to patients to address barriers to medication adherence, behavioral health concerns, complete the SDOH screener and encourage adoption of recommended lifestyle behaviors. The NCMs conduct ongoing data reviews for patients each month and CHWs continue troubleshooting if patients require additional assistance in which NCMs outreach via secure chat messaging.

B) Social Determinants of Health (SDoH) Support

1. NCMs complete an SDOH screener during the patient's initial phone call and every 12 months thereafter. NCMs send secure chat to the CHW pool for patients that have an SDOH need. CHW manager assesses patients' social determinants of health needs by reviewing the 'RPM-MyChart Home Monitoring- FGP Hypertension Initiative- CHWs' report. For patients with a completed SDOH screener indicating potential SDOH needs, the CHW manager notifies the patient's assigned CHW for follow up. In addition, CHWs and manager monitor the CHW secure chat message group for any patients that an NCM notes has a need. CHWs have access to EPIC secure chat via their NYU cellphone through their Rover app to avoid missing any urgent messages (see Appendix P).
2. Within 1 week of NCM completing the SDoH screener, CHWs call the patient for follow up. During this call, CHWs connect the patient with community resources, such as food assistance programs, housing support, transportation –using platforms like Hitsite, FindHelp, and their own networks. Referrals to community resources and programs will be made based on the patient's neighborhood or preferred location, such as near their home, school, or workplace. During this call, additional SDOH needs not covered by the NCM including any technology, childcare and legal needs are assessed by the CHW (see Appendix E). The CHW guides patients through the process of accessing relevant social and health services and provide ongoing support as needed.

After this touchpoint, patients receive an NYU MyChart message detailing the resource/referral information. CHWs continue to collaborate with NCMs to develop holistic care plans that address both medical and social needs and refer patients to community-based organizations for needed resources. CHWs continue to monitor patients' needs throughout the program during the one-on-one bi-weekly calls, to identify any changes in circumstances or the need for additional referrals. All referrals and discussion addressing SDOH needs are tracked by the CHW team in REDCap in the "Patient Referrals Form". Any outcomes related to patients' SDOH needs will be documented in REDCap on the Encounter Form (See Appendix E).

SDoH Support: Linkages to Community Resources using HiteSite

The health Information Tool for Empowerment (HITE) is an online directory offering information on more than 6,000 health and social services available to low-income, uninsured, and underinsured individuals in New York City, Long Island and Westchester. HITE serves as a tool for hospitals, not-for-profits, and other organizations to address community and social needs with the operation of new programs, initiatives, and models of care. Most programs and organizations in the HITE directory are not-for-profit or public services and are free, low-cost, covered by Medicaid and sliding fee scale, or otherwise accessible to people in need. CHWs are able to search for programs and services by using the keyword search on the homepage, browse resources by category and sub-category and filter search results by age and population. Using the online directory, CHWs are able to see detailed information for programs and services including addresses, contact information, hours of operation and program description. As part of their training, CHWs completed a one-hour virtual orientation to the site facilitated by a HiteSite manager (see Appendix L). The HiteSite provides information on resources related to:

1. Health Insurance

Medicaid/Medicare

2. Healthy Eating

Physical Activity

3. Housing Services
4. Transportation Services
5. Unemployment Assistance
6. PCP Referral
7. Medication Assistance/Refills/Pharmacies
8. Aging

Immigration

SDoH Support: Connecting Community Resources using Findhelp

Findhelp was created to make it easier for people to connect to the help they need with dignity and ease. It is the largest closed-loop referral system in the United States with over 100,000 in-network community-based programs locations. Their platform enables community organizations, governments, and businesses across industries to easily manage and coordinate care. CHWs can use this service to connect patients with programs and services based on their location. CHWs participated in a Findhelp training webinar to learn how to best use the platform (see Appendix Q).

SDoH Support: Connecting Community Resources using CHW Community Directory

The CHW Community Directory was created by the CHW team to organize community resources from their own network based on the cluster sites' neighborhoods and zip codes. The directory is a shared file saved within the NYU Langone OneDrive folder and includes the organization/resources' name, type of assistance provided, address and contact information. Within the directory, there is a section covering "Universal Resources" which includes resources that are not neighborhood specific. The file is a living document that is updated as cluster sites and new resources are identified. Practice staff and centralized nurses have access to the CHW Community Directory in case patient needs are identified by the care team, especially during the TAU phase. The file is found in the following link:

https://nyulangone-my.sharepoint.com/:x/g/personal/smiti_nadkarni_nyulangone_org/ETbERn2J3xFJruJwlucI45oBjT8wMPj5NwABMfDEMO0x-A

Other resources:

[Community Resources for Immigrant NYers](#): New York Immigration Coalition compiled a list of resources for NYers that are immigrants.

[Directory of NYC Resources](#): The official website of the City of New York has a directory of resources you can filter through.

[Food Help](#): This is directory organized by the city of New York that provides a map of food banks and pantries across the city.

II Months 3 – 9: Intensive CHW Implementation Phase

CHWs prepare patients for upcoming primary care visits, support the adoption of NCM health education and counseling by addressing barriers / providing strategies to improve adherence to counseling recommendations related to patient's lived experiences (eg sharing resources on where to find healthy foods in their neighborhoods to support NCM healthy eating counseling), and support patients to enhance uptake and adherence to NCM counseling/health education recommendations. CHWs support NCM efforts by engaging with patients on a one on one basis and through virtual group sessions. Once a site reaches the PATCH phase, CHWs review patients' availabilities and schedule the launch of the group health education sessions. These are delivered via WebEx and scheduled at a time that works for all patients. CHWs follow the program's curriculum which includes each session's objectives, overview, educational content and exercises- all in a PowerPoint format (see Appendix B for CHW Curriculum). All patients receive the curriculum before the sessions are launched via a MyChart message and/or email according to patient's preference.

If a patient misses a session or is unable to participate at the scheduled time, CHW arranges a make-up session. Make-up sessions can be held in a group setting with others unable to participate at the scheduled session, or one-on-one, depending on the patient's schedule and availability.

The cohort of 10 patients participate in one introductory trust-building session where the CHW gets to know the group and share the goals of the sessions. A week after the introductory session is launched, the patients are invited to join five, one-hour, monthly health educational sessions. Session objectives are described below and the topic areas are included in Appendix B:

1. Introductory Session:

- a. Introductions (CHW + participants), trust-building, purpose of the program, cultural identity, environment and values
- 2) Session 1: Blood Pressure and the Heart
 - a. Understand causes of hypertension
 - b. Learn ways to manage blood pressure
 - c. The importance of keeping up with medications
 - d. Improving the healthcare experience
- 3) Session 2: Stress Management
 - a. Understand how stress can affect health
 - b. Learning skills and strategies to manage stressful situations and experiences
- 4) Session 3: Diet and Nutrition
 - a. Understand what a balanced meal is using the Plate Method
 - b. Identify which foods help control blood pressure
 - c. Understanding food labels and how to use them to make healthier choices
- 5) Session 4: Physical Activity
 - a. Understand the benefits of different types of physical activities
 - b. Learning how to incorporate physical activity into daily routine
- 6) Session 5: Heart Disease and Risk Factors
 - a. Understand risk factors that can lead to heart disease
 - b. Learn the warning signs of a heart attack and a stroke

Through the group sessions, CHWs facilitate a medication management discussion by addressing advantages and barriers of taking blood pressure medication along with strategies to increase adherence. Patients participate in a group discussion regarding their healthcare experience by addressing any current challenges and barriers to seeking care. CHWs prepare patients to be active in their care by encouraging them to ask questions at the time of their visit with their provider and coming prepared with their medications, any side effects and discuss any new symptoms and concerns. CHWs keep track of attendance and session completion for each patient on REDCap 'Tracking' form. Additionally, bi-weekly through one-on-one interactions, CHWs support implementation of PACE by addressing barriers and providing strategies to improve adherence to NCM counseling, preparing patients for their primary care visits and facilitate discussions for health behavior through goal setting.

At month 3 and month 5, CHWs hold 'Virtual Check ins, one-on-one calls that will focus exclusively on medication adherence and hypertension management. All CHW-Patient interactions are recorded in REDCap through 'Goal Setting Form', 'Progress Note' and 'Virtual Check-in 1 and 2' forms. For any call associated with CHW-Patient interaction, CHWs record on EPIC via a patient encounter. A short 1-2 line documentation is included with each patient encounter that summarizes the purpose of the call. Further description for the CHW activities is provided below:

A) Goal Setting

Through goal setting, patients take an active role in their own care and drastically increase their success at managing their health and hypertension. CHWs guide patients to set SMART (Specific, Measurable, Achievable, Relevant and Time-Bound) goals. CHWs guide patients through a goal setting exercise where patients are able to discuss the following prompts: *Why is a healthy lifestyle important to you? What does being healthy mean for you? Have you tried to make healthy changes before? What did you learn?* This discussion introduces the patient to goal setting and determine the motivation of achieving these goals as well as anticipate any challenges. Patients are encouraged to choose up to 5 goals ranging from Hypertension Management Goals (taking medication, lowering BP, maintaining BP), Diet and Exercise Goals (eating a healthy diet, losing weight, maintaining weight, being physically active), Access or SDoH Needs Goals (access to healthcare, finding a job,

finding housing in safe area) or Other Goals (cope with stress, resolve legal problem). Once goals are established, CHW guides the patient to rank the goals in order of importance and determine level of confidence in achieving it. CHWs document the goal setting exercise for each patient in REDCap using the “Participant Goal Setting” form.

B) Progress Note

Once healthy goals are established, CHWs reach out to each patient every two weeks via phone call. During these bi-weekly calls, CHW reviews patient’s current goals and determine whether each goal was successful, partially successful (ongoing) or unsuccessful (patient did not try). Any challenges encountered to attain goals will be addressed and CHW discusses with the patient any potential solutions for each challenge. The patient also has the opportunity to develop new short term action plans if needed or re-work their previous goal plans to address any barriers. During this bi-weekly call, CHW checks in with the patient regarding any referral needs that may have changed since their initial SDoH screening. CHWs document these bi-weekly check in calls for each patient in REDCap using the “Progress Note” form.

C) CHW Check In- Virtual Visits

Throughout their time in the program, patients participate in 2 virtual check-in visits with the CHW. Check-in virtual visits fall on the same schedule as one of their bi-weekly check-in calls, #1 at month Month 3 and #2 at Month 5. Virtual check-in visits have a similar structure to the follow-up calls plus an additional focused educational component. During these visits, CHWs review patient’s current goals and most recent progress note as well as check in on previous short term action plans and determine whether each goal was successful, partially successful (ongoing) or unsuccessful (patient did not try). Any challenges encountered to attain the goal are addressed and the CHW discusses with the patient any potential solutions for each challenge. The patient also has the opportunity to develop new short term action plans if needed or re-work their previous goal plans to address any barriers. During the virtual check ins, CHW checks in with the patient regarding any referrals needs that may have changed since their initial SDoH screening. Virtual check-in #1 includes a one-on-one discussion on medication management. The patient has the opportunity to share any labels of their medications with the CHW and report any challenges with medication management (financial, trouble remembering to take it, challenges with side effects, or others). CHWs share any appropriate recommendations as needed. Virtual check-in #2 includes a one-on-one discussion on general hypertension management based on the individual patient’s needs. This may include discussions on a heart healthy diet, stress management, taking their BP consistently, or others. CHWs document virtual check-in visits for each patient in REDCap using the “CHW Check-In Virtual Visit” form.

D) Encounters:

All other contacts and calls made by the CHW are scheduled based on patients’ availability. CHWs record their communication in REDCap by filling out the “Participant Encounter Form” where they indicate the purpose of the encounter (support with RBPM, doctor referral, scheduling a PCP appointment, among others), describe what was discussed and any actions taken or recommendations provided by the CHW along with any follow up plans. If further SDoH referrals are needed, these are discussed and indicated accordingly.

E) Lost to follow-up:

CHWs record all communication and contact attempts to patients in REDCap and EPIC. If a patient is responsive to CHWs call but not available at that time, a contact attempt is recorded and a subsequent call is scheduled at a more convenient time. If a patient is not responsive, CHWs leave a voicemail with their contact information requesting a call back. CHWs also send a MyChart message to the patient to attempt to connect if there has

been no contact (see Appendix M for MyChart message). After 6 unsuccessful attempts, a patient is considered lost to follow up and no further calls will be made. Their “Lost to Follow Up” status is documented in the “Tracking Form” on REDCap. An invite to the monthly healthy sessions will be sent out to the patient’s EHR through a MyChart message as an attempt to re-engage the patient.

F) Re-engaging the patient:

NCMs are consistently in communication with the CHW team through EPIC secure chat regarding a patient’s engagement in the program. If a patient needs to be re-engaged because they are either not sending BP readings or not answering NCM’s phone calls, the NCM loops in the CHW in an attempt to re-engage the patient and emphasize the importance of daily BP readings. CHWs and/or PC, depending on PATCH or TAU phase, will send a message to the patient via MyChart in an effort to keep them in the program and re-engage the patient (Appendix S).

G) Graduation:

When patients are approximately 1-2 months from graduating the program, the NCM will notify the CHW via EPIC secure chat message. The CHW will contact the patient and congratulate them on consistency in the program with uploading readings, responsiveness to team, maintaining normal BP ranges, etc. CHW will also provide the patient with information regarding what to expect moving forward, schedule any remaining CHW sessions, and determine if an additional 30 days of assistance will be needed after graduating from the program (only applicable during the PATCH phase). When the patient is ready to graduate, the NCM will notify the CHW via secure chat message and will include the date that the patient will graduate. The CHW will send a letter via mail or a MyChart message including a certificate of completion with the patients graduation date and any next steps if the patient decides to continue with an additional 30 days (only applicable during PATCH] (Appendix T).

Appendix:

- A) Table 1: Implementation Strategies based on Expert Recommendations for Implementing Change (ERIC) Framework
- B) Education Session Topics
 - 1. Introductory Session
 - 2. Session 1: Blood Pressure and the Heart
 - 3. Session 2: Stress Management
 - 4. Session 3: Healthy Eating and Nutrition
 - 5. Session 4: Physical Activity
 - 6. Session 5: Heart Disease and Risk Factors
- C) FGP Patient Packet
- D) EPIC CHW Documentation Protocol Patient
- E) REDCap Participant Forms
- F) PC Onboarding Call TAU
- G) RBPM Mailing Protocol
- H) MyChart Activation Protocol
- I) CHW TAU Light Touch Protocol
- J) MyChart Message for Light Touch Protocol
 - 1. Follow up
 - 2. Unresponsive
- K) RBPM Set Up
 - 1. Set Up Protocol
 - 2. Set Up Guide Apple
 - 3. Set Up Guide Android
- L) HITESITE Protocol
 - 1. Brochure
 - 2. User Guide
 - 3. Demo
- M) MyChart Message for unresponsive Patients
- N) CHW Introductory Call Script
 - 1. CHW Introductory Call TAU
 - 2. CHW Introductory Call PATCH
- O) Table 2: CHW Training Table
- P) EPIC secure chat - Rover
- Q) Findhelp Guide
- R) Community Engagement Handbook
- S) MyChart Message for re-engagement
 - 1. PATCH
 - 2. TAU
- T) Graduation Letter

Table 1: Implementation Strategies based on Expert Recommendations for Implementing Change (ERIC) Framework

Domain	Strategy: Facilitation: A process of interactive problem solving and support that occurs in a context of a recognized need for improvement and a supportive interpersonal relationship	Strategy: Prepare patients/ consumers to be active participants: Prepare patients/consumers to be active in their care, to ask questions, and specifically to inquire about care guidelines, the evidence behind clinical decisions, or about available evidence-supported treatments	Strategy: Conduct educational meetings: Hold meetings targeted toward different stakeholder groups (e.g., providers, administrators, other organizational stakeholders, and community, patient/consumer, and family stakeholders) to teach them about the clinical innovation	Strategy: Support patients/consumers to enhance uptake and adherence: Develop strategies with patients to encourage and problem solve around adherence
Actor(s)	Practice Facilitators	CHWs	CHWs	CHWs
Action(s)	<ol style="list-style-type: none">1. Site visits (i.e. workflow assessments) to help set performance goals and coaching on how to implement PACE-related practice changes2. Training staff on QI strategies for practice redesign3. Consulting on methods to identify and track patients via EHR4. Assisting teams in testing system changes and interpreting outcomes based on the PDSA cycle5. Audit and feedback of chart review data6. Creating learning collaboratives across sites to share best practices for integrating PACE7. Reinforcing NCM counseling and use of EHR templates to provide patients support in community settings	<p>Through 1-on-1 or group-based interactions (remotely or in-person) with patients, CHWs will support each of the components of PACE:</p> <ol style="list-style-type: none">1. NCM – preparing for upcoming primary care visits2. RBPM – Troubleshooting technology-related barriers to remote BP monitoring <p>SDOH – eg. discussions and strategies to enhance self-efficacy and healthcare efficacy in clinical encounters with primary care team include engaging patients in coaching sessions that prepare them to understand and ask physicians about their blood pressure readings; ask questions about medication changes); CHWs also help patients to address unmet social needs such as</p>	<p>Through 1-on-1 or group-based interactions (remotely or in-person) with patients, CHWs will support each of the components of PACE:</p> <ol style="list-style-type: none">1. NCM – CHWs support the adoption of NCM health educational and counseling by addressing barriers / providing strategies to improve adherence to counseling recommendations related to patient’s lived experiences (eg sharing resources on where to find healthy foods in their neighborhoods to support NCM healthy eating counseling)2. RBPM – eg. emphasizing importance of continual monitoring to support adoption and fidelity; educating patients on why RBPM is effective	<p>Through 1-on-1 or group-based interactions (remotely or in-person) with patients, CHWs will support each of the components of PACE:</p> <ol style="list-style-type: none">1. NCM – CHWs will support patients to enhance uptake and adherence to NCM counseling/health education recommendations2. RBPM – eg. trouble shooting technology-related barriers to RBPM and emphasizing importance of continual monitoring3. SDOH – CHWs will support patients to “connect the dots” once referral information is shared by NCM; this may include addressing literacy issues, accessing referral locations, navigating to referral locations, completing applications, and

		transportation and other logistical barriers to care; so they feel self-efficacious to attend their healthcare visits	3. SDOH – eg. discussions and strategies for health behavior change that are tied to context of lived experience	facilitating direct contact with referral locations in target communities
Target(s) of the action	Centralized Nurses	Patients	Patients	Patients
Temporality	At month 0	At month 0, CHW will contact patient	Months 1-12	Months 1-12
Dose	Ongoing; weekly site visits for 6 months; monthly for 6 months	Frequency: Minimum of 1x and maximum of 15x 1-on-1 interactions or group sessions Duration: Minimum 40 min to 1.5 hours each time	Frequency: Minimum of 1x and maximum of 15x 1-on-1 interactions or group sessions Duration: Minimum 40 min to 1.5 hours each time	Frequency: Minimum of 1x and maximum of 15x 1-on-1 interactions or group sessions Duration: Minimum 40 min to 1.5 hours each time
Implementation outcome(s) affected	Centralized Nurse: Adoption of EHR RBPM and SDOH Smartsets Level of implementation fidelity of PACE intervention (adherence, dose, quality, responsiveness) Sustainability of the intervention	Adoption of the NCM-RBPM-SDOH intervention (PACE) Fidelity Sustainability of the intervention	Adoption of the NCM-RBPM-SDOH intervention (PACE). Fidelity Sustainability of the intervention	Adoption of the NCM-RBPM-SDOH intervention (PACE) Fidelity Sustainability of the intervention
Justification	Nurse-led interventions that use structured algorithms and telephone outreach are effective in reducing BP in patients with HTN ⁹¹	Evidence of CHWs helping to bridge the digital divide and improve digital literacy ⁹²	Coaching as an implementation strategy is effective for BP control ⁹³ CHWs demonstrated in literature to more effectively provide culturally and contextually appropriate coaching /education to improve behavior change as a result of lived	Coaching as an implementation strategy is effective for BP control ⁹³ CHWs demonstrated in literature to more effectively provide culturally and contextually appropriate coaching /education to improve behavior change as a result of lived

			experience with the community they serve	experience with the community they serve
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NYU Grossman School of Medicine

Project ADHERE

Blood Pressure Education Program

Introductory Session (HTN+RD)

Addressing Disparities in Hypertension and rEducing Racial inequity through Engagement

As of February 22, 2024

Introductions / Ice Breaker

- Share something about yourself
- What motivated you to join us today?

Who am I?

- I am a Community Health Worker (CHW)
- I was trained by NYU Langone
- I work with communities and NYU primary care practices to share important information about healthy living, managing high blood pressure, and preventing chronic diseases.

What is this program?

- Called “Project ADHERE”
- Led by NYU School of Medicine
- For Black patients with high blood pressure who
 - want to learn more about how to control it
 - want to learn how to be healthier
- We work in partnership with your doctor to help you achieve your healthy lifestyle goals.

What will we do in this program?

- Meet for 5 more 1-hour group health education sessions over the next 6 months to:
 - Build a supportive network
 - Share information about how to improve health and wellness
- Have individual phone calls with a CHW to check-in about your health goals and how to achieve them.
 - There are some things we can talk about right now, and some things we can talk about in more detail in our 1v1 meetings.
- Complete one more survey at the end of the program
 - to see how the program is helping you and how we can improve the program for future patients

How will this program benefit you?

- **We help you to live a healthier lifestyle!**
 - Understand why & how to manage blood pressure → More in Session 1!
 - Communicate questions & concerns to your doctor → More in Session 1!
 - Manage stress → More in Session 2!
 - Eat healthier → More in Session 3!
 - Increase your physical activity → More in Session 4!
 - Prevent heart disease & diabetes → More in Session 5!
 - Create & achieve your health goals → Let's discuss at your 1-on-1!
 - Receive referrals to services → Let's discuss at your 1-on-1!
 - We provide tips and strategies to manage stress and experiences of discrimination throughout.

We are here to help!

- Ask us if you need any help, such as:
 - Helping you with your blood pressure monitor
 - Helping you to join a walking group or exercise class
 - Helping you to connect with your doctor
 - Getting referrals and additional information about the resources available in your community

Program Guidelines

- Be on time
- Please keep your camera/video on to allow for more genuine conversations
- Listen actively and share your own story
- Respect others
- Keep what is discussed by the group private and confidential
- Ask questions and give your honest feedback
- Don't be judgmental
- Have fun!

Culture & Values



- Today we are going to talk about culture and how culture affects our health
- It is important to identify the values that keep us strong. Values help us grow, develop and create the future we want to experience.

What value that keeps you strong?

Cultural Identity, Environment, and Understanding of Health

- What did you learn growing up about taking care of your health?
 - What were you taught about taking care of your health?
- Who in your family/community taught you how to take care of your health?
- What feelings did you have around taking care of your health?
(fear, empowerment, pride...?)
- What does being healthy mean to you?
 - Why is it important for you to take care of your health?



Creating Health Goals

- What is the one important thing you would like to do in order to better take care of your health?
 - We share some common goals!
- What would you like to achieve from participating in this program as it relates to taking care of your Hypertension/High Blood Pressure?



We will help you reach your health goals by making changes that are:

- Gradual
- Healthy
- Reasonable

Environment & Blood Pressure Management

- What are some difficulties you have with being healthy and taking care of your health?
- Does your environment or where you live impact your ability to:
 - Receive healthcare?
 - Control your blood pressure?
- Do you have any barriers that prevent you from seeing the doctor for your blood pressure?
- What barriers in your healthcare would you like to address or change?

Experiences with Healthcare Providers

- What is your typical experience with the healthcare system? Tell me about:
 - When you make an appointment to see your doctor? Is it easy?
 - When you are speaking to the front desk staff or waiting to see the doctor?
 - When you are seen by the doctor?
 - When you pick up your medication?
- Do you feel heard by your healthcare providers?
- Do you feel comfortable asking your healthcare providers your questions about medications, treatment plans, side effects, or other concerns?

→ Participate in Session 1 to discuss tips for communicating with health providers

Taking Care of You: Deep Breathing

Life can be stressful. Take a few moments to yourself each day to relax— try this breathing exercise. I will talk you through it.

- Be sure you are sitting down in a comfortable position (at home, try to find a quiet place).
- Uncross your arms and legs and rest your feet gently on the floor.
- Take a slow, deep breath.
- Hold your breath for about 4 seconds.
- Exhale slowly, pushing out as much air as you can.
- Repeat these steps 5 times.

→ Participate in Session 5 to learn more stress management tips

Wrap-up

What is one thing you can do to better take care of your health?

What is one thing you can do TODAY?

Together, we will work to achieve your health goals.

Next Session: Blood Pressure and the Heart

- Please join us to learn about blood pressure and important tips to manage it!



NYU Grossman School of Medicine

Project ADHERE

Blood Pressure Education Program

Session 1: Blood Pressure 101 (HTN+RD)

Addressing Disparities in Hypertension and Reducing Racial inequity through Engagement

As of February 22, 2024

Objectives

- Understand causes of hypertension
- Learn ways to manage your blood pressure (Slides 14-18)
 - The importance of keeping up with your medications
- Discuss ways to improve the healthcare experience
- Learn strategies to cope with stress

Session 1 Overview: Blood Pressure 101

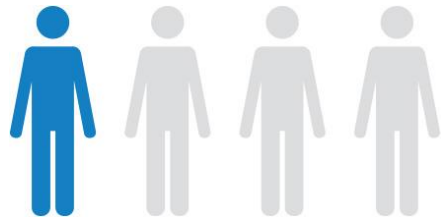
- Today we will discuss:
 - What is hypertension (high blood pressure) and its causes
 - Ways to manage your blood pressure
 - Tips for following up with your primary care provider and improving your healthcare experience

Discuss: What does hypertension mean to you?



How common is hypertension?

Nearly 1 in every 4 New Yorkers has hypertension



Many other New Yorkers have high blood pressure, but don't know it.

- High blood pressure (hypertension) can be overlooked because there are usually **no symptoms**. But it can cause **stroke**, **heart attack** and **early death**.
- Checking your blood pressure regularly helps you know if there is a problem.
- Groups more likely to have high blood pressure include people aged **65 and older**, **Blacks** and **Latinos**

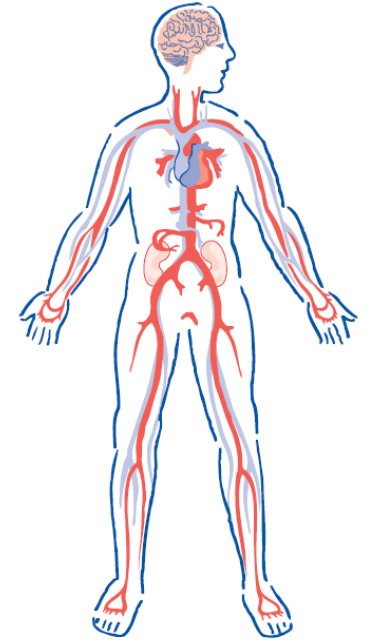
Hypertension Disparities in the Black Community

- 1 Uncontrolled hypertension is a cause of uneven mortality rates between Black and White populations
- 2 **Black Americans have the highest rate of hypertension in the US**
- 3 Compared to Whites, Blacks have:
Higher hypertension: (41.2% vs 28%)
- 4 **Lower hypertension control rates** when compared with Whites (48.5% vs. 55.7%)

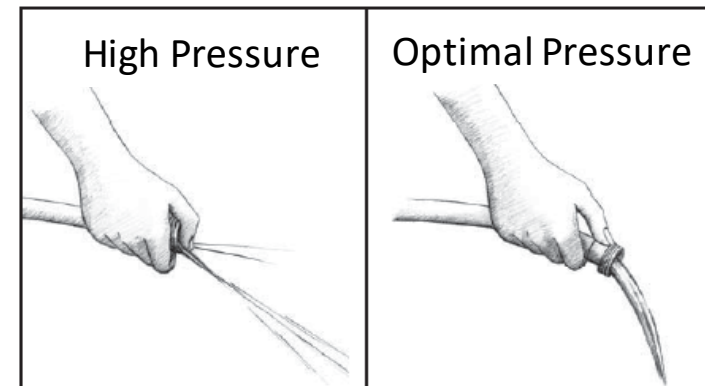
Achieving blood pressure control will prevent downstream unfavorable health conditions (e.g., stroke, heart attack)

What is High Blood Pressure / Hypertension?

- If you have high blood pressure—called “hypertension”—it means your heart has to pump harder than it should to get blood to all parts of your body.
- Hypertension is diagnosed if someone has high blood pressure (higher than 130/80) on two or more doctors visits.

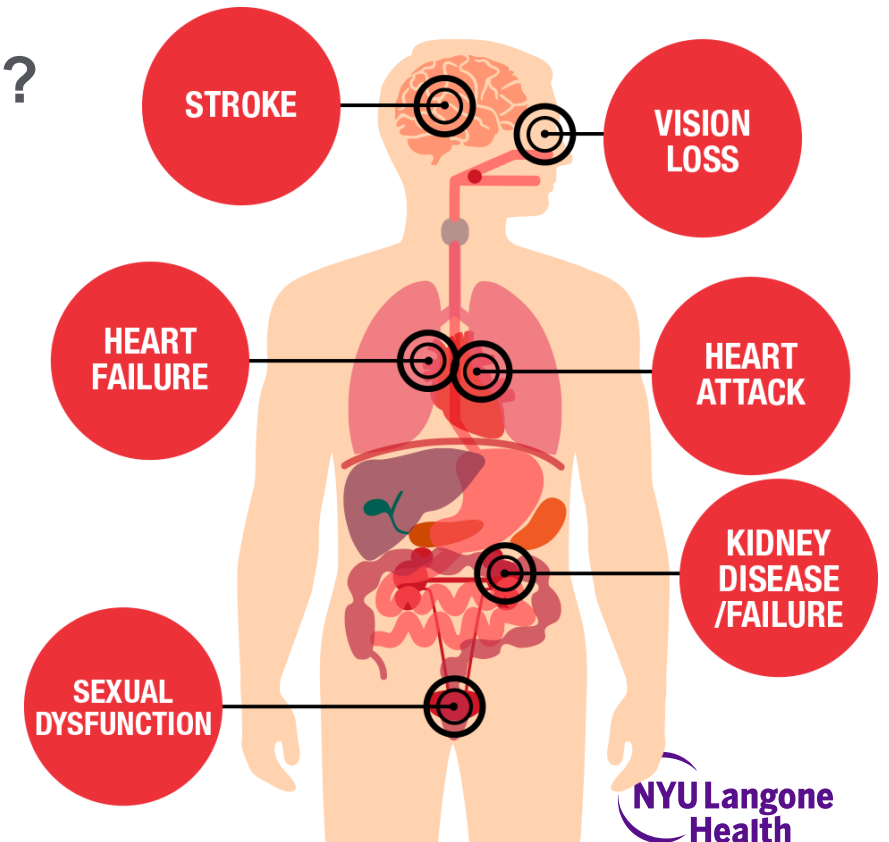


Having high blood pressure and blood vessels that are narrowed or clogged is like turning on a garden hose and holding your thumb over the opening.



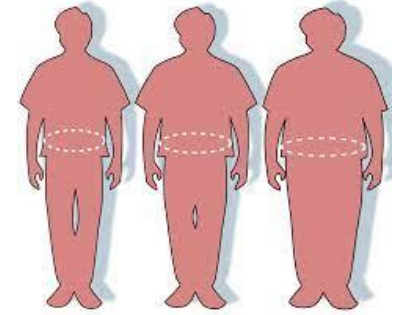
Why is it important to control high blood pressure?

- High Blood pressure is known as a “Silent Killer”
 - There are often **no symptoms...until it is too late** and a person may develop life-threatening problems
- What are the dangers of high blood pressure?
 - Complications may result in:
 - Vision loss
 - Stroke
 - Heart attack
 - Kidney disease/failure
 - Sexual dysfunction
 - Other heart disease



What increases risk for high blood pressure?

- Certain lifestyle choices can increase risk for high blood pressure:
 - **Unhealthy diet** (including high sodium)
 - **Excess Weight / Obesity**
 - **Physical Inactivity**
 - **Alcohol consumption/ smoking**
- Certain conditions can increase risk for high blood pressure:
 - **Diabetes**
- Certain factors and characteristics can increase risk for high blood pressure
 - **Genetics and Family History**
 - **Age** – Blood pressure risk increases as you age.
 - **Race or ethnicity** – Black people develop high blood pressure more than any other group.



Discussion: Measuring Blood Pressure

Are you checking your blood pressure every day?

How is that working out for you?



How can you manage your high blood pressure?



- Make Lifestyle Changes
 - Manage Stress and Get Plenty of Sleep → **Come to Session 2 to learn more!**
 - Eat a Healthy Diet → **Come to Session 3 to learn more!**
 - Be Physically Active → **Come to Session 4 to learn more!**
 - Quit Smoking and Limit Alcohol → **Come to Session 5 to learn more!**
- Take your medication properly (per doctors instructions)



How to Control High Blood Pressure: Blood Pressure Checks/Doctors Visits

- **Regular blood pressure checks**
 - Check your blood pressure regularly at home.
 - Check more often if your blood pressure is not under control and there have been changes to the medications.
- **Regular calls with a nurse and doctor visits**
 - These are important so doctors can properly adjust medicines.
 - Discuss your home blood pressure readings with a nurse or your doctor.
 - See your doctor at least **every 3 months if your blood pressure is uncontrolled** or if there have been changes to your medication

How to Control High Blood Pressure: Medication

- If lifestyle changes are not be enough to lower blood pressure, **medications can be effective.**
- Different medications work for different people. Sometimes people need to take more than one medication to get their blood pressure under control.
- Do NOT stop taking your medicine if you feel better or your blood pressure goes below 140/90. That means the medicine is working!
- A healthy diet and regular physical activity will help your medicine work better.

Discussion: Taking your Medicine



- What is it like for you to take your prescribed blood pressure medication?
 - What are the advantages of taking your blood pressure medications?
 - What are the disadvantages / side effects of taking your blood pressure medications?
- Are you using **alternative supplements (such as herbal remedies, teas, foods, or pills other than your blood pressure medications)** to control your blood pressure?
 - If so, how is that working for you?
 - Before using alternative methods, please discuss this with your primary physician

Preparing for your doctor's visit

- **Doctors visits are short**
 - you might only have 15 minutes to speak with your doctor.
- **Make the most of your limited time**
 - **come prepared so you can effectively discuss your concerns and ask questions**
- Write down all your questions for the doctor in advance and bring a pen and paper, or smartphone, to jot down answers and take notes.
- Make and bring a list of symptoms if you're not feeling well.
- Bring a list of all the medicines you take.
 - Write down the doses and how often you take them.
 - Include vitamins, other supplements, or herbal remedies.
 - Let your doctor know if you are experiencing any side effects.
 - Don't say you are taking a medicine if you're not.

Speak Up

- If you don't understand what the doctor is telling you, ask him or her to explain it again.
- If there are issues you want to discuss that the doctor doesn't mention, raise them yourself.
 - Examples: diet and weight, exercise, stress, sleep, tobacco and alcohol use, vaccines, and tests to find diseases.
- Find out what tests or shots you might need for your age, and ask your doctor about getting them.
- Mention any concerns about your emotional well-being. This affects your physical health and is just as important as any other health problem.
- Don't be embarrassed or ashamed to bring up sensitive topics.

Are you afraid to speak up at the doctor? Why?

Discuss: How does your experience at the doctor's office affect you, and how can you advocate for yourself?

- Do you ever feel judgement or hostility / racial discrimination from the office staff or the healthcare providers during your appointment?
 - Do you feel that you are treated differently because you are a person of color? How so?
- What are possible ways to reduce stressful situations when visiting the doctor?
- When do you feel most comfortable at the doctor's office?
- What can help you to improve your healthcare experience?

Taking Care of You: Guided Imagery

What it is: Guided imagery is a technique that is based on the fact that your mind and body are connected.

It focuses and directs your mind and senses on something pleasant to relax you.

How it works: When you are stressed, your mind races because you are thinking about many things, which can add to your stress. The goal is to think about one pleasant thing.

Guided imagery directs your mind and senses onto something specific that you like. This focuses your mind on something pleasant, which can help to decrease the stress you are feeling.

How to do it:

- Find a quiet, private place and sit down in a comfortable position.
- Uncross your arms and legs and rest your feet gently on the floor.
- Close your eyes and focus on your breathing.
- Start imagining yourself in a place that makes you happy (such as a park).
- Remember what the place *looked like* (sun, water, grass), *smelled like* (flowers, fresh air), *felt like* (the sun on your skin), *sounded like* (leaves blowing, birds chirping), and even what it tasted like!
- Try to experience this until you feel calmer, at least 5 minutes.

Creating SMART Health Goals

What is one thing you can do to better take care of your heart health?

Create a SMART Plan to achieve your health goals:

- Specific: *What will I do? Where will I do it? How often will I do it?*
- Measurable: *How can I track it? What progress do I want to see?*
- Attainable: *What might get in the way of my plan? What can I do about it?*
- Relevant and Realistic: *Is it a priority for me? If it's not, change my goal.*
- Time-bound: *When will I do it? For how long?*

Next Session: Managing Stress

- Please join us to talk more about the stress we all face, and to learn about how to reduce and manage stress.
- Next steps: phone call to discuss your health goals, referral needs, and any other questions you might have.



NYU Grossman School of Medicine

Project ADHERE

Blood Pressure Education Program

Session 2: Stress Management (HTN+RD)

Addressing Disparities in Hypertension and Reducing Racial inequity through Engagement

As of February 22, 2024

Session Objectives

- Understand how stress can affect your health
- Understand the relationship between racism / racial discrimination, stress, and high blood pressure
- Learn how to manage stress

Overview

- Discussion of Stress
- Stress and Racism
- Stress Management Strategies
- Shift and Persist Discussion
- Mindfulness Activity
- SMART Health Goals

What is stress? How does it affect your blood pressure?

- **Stress is tension or pressure.** Stress is a natural part of living life. Any change, good or bad, big or small, can cause stress.
- Stress is not always bad for you but **having stress too often can be bad for your body, mood, and behaviors**
- In dangerous situations, your body's response to stress gets it ready to fight or run away.
 - If you are walking in the woods and a snake is right in front of you, your brain will tell your body to either fight the snake or run away. Your heartrate and breathing will increase in order to help your body do this.
 - Your brain and body react the same way to stress, whether you are in danger or under a lot of pressure at work or at home, or from everyday lived experiences.
- **Frequent stress means your body is too often ready to fight or run away, which increases your blood pressure.**

Effects of stress on your body

Effects on your body right away:

Muscle tension

Temporary increase in blood pressure

Heart beats faster and harder

Raises blood sugar

Cold or clammy hands, Sweating

Shaking

Breathing harder and faster

Trouble sleeping

Headache

Trouble remembering or concentrating

Effects on your body over time:

Headaches, migraine, muscle pain

Can lead to high blood pressure

Increased chance of having a heart attack or stroke

Can lead to Type 2 Diabetes

Weakens immune system, frequent colds/infections

Weight gain

Digestive problems, upset stomach

Speeds up aging process

Low energy

Increased chance of infertility

Note: the rows do not correspond between effects on the body right away versus over time

Effects of Stress on your mood

Stress can make you feel:

A lot of tension or constant worrying

Restless

Forgetful, disorganized

Unmotivated, unable to focus

Feeling like you are losing control

Irritable or angry

Seeing everything in a negative way

Sad



How do you feel when you are stressed?

Effects of stress on your behavior

When you are stressed, it may be harder to focus on keeping up with a healthy lifestyle. Are there any behaviors you tend to do when you are stressed?

Stress can cause you to:

Eat too much, or eat to feel better rather than because of hunger

Eat too little

Have angry outbursts

Smoke or use tobacco

Drink too much alcohol

Not want to spend time with family and friends

Exercise less

Put off or avoid responsibilities



Discussion: What causes stress in your life?

Do you feel these stress triggers daily? Have you always felt this way?

How do these issues impact your health?

How do these issues impact your ability to manage your blood pressure?



Discussion: Does your community experience racism or racial discrimination? How does this affect health?

- Have you had a personal experience in which you were treated badly because of your race or ethnicity, or you saw someone else treated this way?
 - What happened? How did you *feel*?
- Do you feel stress or discomfort when expressing your true ethnic or multicultural background due to how others might judge you, or do you remain silent?
- Do you feel prejudice because of your race or ethnic background?
- How do you feel this impacts your health and your ability to manage your blood pressure?

Relationship between racism, stress, and blood pressure

- Racial or ethnic discrimination are social stressors in which people are targeted for unfair treatment because of their race or ethnicity.
- Racial discrimination can cause stress, contributing to high blood pressure and a diagnosis of hypertension

Long-term Sadness

Long-term sadness and worry can be harmful for your overall health.

You may:

- Want to spend a lot of time alone
- Feel hopeless and guilty
- Have trouble focusing or remembering
- Lie down and sleep a lot
- Eat too much, or not feel like eating at all

If you are feeling like this for a **LONG** period of time, it is best to speak to your doctor.

Shift & Persist Strategies

- Strategy to reframe stressors in a more positive way.
- **Shift and Persist**
 - It is when we give ourselves time to process a situation or our own emotions
 - You use your own inner resources – your capacity to shift the focus of your attention – to give yourself some mental space to consider the problems you face.

Shift & Persist

- There are 3 kinds of “shifting”

1. Shifting the focus to something else

- i. Bring your attention to your breathing, body, sounds/surroundings when feeling anxious/stressed

2. Shifting to a higher level

- i. When feeling anxious/stressed question “*where does this anxiety/stress come from?*”

3. Shifting to another person’s point of view

- i. “*what is that person going through that could explain their actions towards me?*”

Shift & Persist

- Mrs. J went to the grocery store and a worker was very rude to her when she asked for help. This made Mrs. J very upset.
- She took a breath and thought about what she needed to make for dinner. (SHIFTED THE FOCUS OF ATTENTION). That helped her calm down.
- Then she thought about her grandmother, who faced very tough times. This shift allowed her to remind herself that across generations, people in her family have overcome discrimination and she will, too. (SHIFTING PERSPECTIVE- TO A HIGHER LEVEL)– (I.E., shifting up to see the situation from a different level).
- Then she looked a little closer at the person who had harassed her and saw how angry and beaten down he looked. This enabled her to see the situation from the other person's perspective and recognize that it was the problem of the other person (i.e., the other person's difficulties), and she had the strength to handle it (SHIFTING PERSPECTIVE – SHIFTING THE POINT OF VIEW).

Shift & Persist

- What would you have done in this situation?
- Has there been a time where you have been able to shift your focus and attention?
 - What happened?
 - How did you react?

Why talk about stress?

Talking about stress is important because you can:

- Recognize how much you're going through – it's a lot!
- Feel a sense of community by sharing with others
- Feel proud of how much you're doing
- Start to think about what sources of stress you **can** control and what you **cannot** control

Healthy Ways to Cope with Stress

Because stress can have such a big impact on health, learning to manage stress is important.

- Take care of yourself.
 - Eat healthy meals.
 - Exercise regularly, and do it with a buddy (learn more about this on session 4!)
 - Exercise reduces stress hormones and causes your body to release “happy hormones.”
 - Get plenty of sleep (7-9 hours of uninterrupted sleep per night).
 - Give yourself a break and ask for help and appreciation when you need it. Recognize where you have control and where you don't.
- Talk to others. Share your problems and how you are feeling with a family member, friend, or health provider.
- Stay connected to the present moment and reflect on how you are feeling.
 - Practice mindfulness, meditation, or use prayer
 - Practice gratitude/appreciation and joy

Discussion: What do you value, and how does this give you strength?

Identifying and focusing on your most important values can protect against the damaging effects of stress.



Giving Appreciation

Expressing gratitude or giving thanks can improve your relationship with your family and friends.

- It is important to tell your loved ones why you appreciate them.
 - “Thank you for cooking this delicious, healthy meal today.”
 - “Thank you for working hard today to provide for our family.”

Asking for Appreciation

- It is also important for you to share with them ways in which you would like to receive appreciation.
 - “It makes me happy when you tell me you love me.”

Mindfulness

- In many religions, we are asked:
 - To be more present in prayer
 - To have more control over our wandering minds and desires.
- Mindfulness focuses on the present and not worrying about the past or future.
- Mindfulness can help train our minds to become more **disciplined** and can help our regular worship and daily activities.

Practicing Mindfulness

- Notice when you begin to have thoughts/ feelings/ emotions
 - If someone offends you, notice how that makes you feel. Angry? Sad? Upset?

It is okay to feel this way.

Practicing Mindfulness

- Mindfulness gives you enough time to act on the positive emotions and get rid of the negative emotions
- Instead of reacting right away, stop to examine your emotions and the situation.
- Know that these feelings do not define you. They will pass.
- Instead of reacting with angry words that might hurt someone, try to respond calmly.
- This can help you to resolve the situation with a more positive outcome.

Mindfulness Discussion

How can you incorporate mindfulness, or mindful prayer into your day, especially in times of strong emotions or stress?



Creating SMART Health Goals

What is one thing you can do to reduce stress?

Create a SMART Plan to achieve your health goals:

- Specific: *What will I do? Where will I do it? How often will I do it?*
- Measurable: *How can I track it? What progress do I want to see?*
- Attainable: *What might get in the way of my plan? What can I do about it?*
- Relevant and Realistic: *Is it a priority for me? If it's not, change my goal.*
- Time-bound: *When will I do it? For how long?*

Next Session: Healthy Eating

- Please join us to learn about how to eat a heart healthy diet!
- I will call you to discuss your health goals, referral needs, and any other questions you might have.



NYU Grossman School of Medicine

Project ADHERE

Blood Pressure Education Program

Session 3: Healthy Eating (HTN+RD)

Addressing Disparities in Hypertension and Reducing Racial inequity through Engagement

As of February 6, 2024

Session Objectives

- Understand what a balanced meal is using the Plate Method
- Identify which foods will help you control your high blood pressure
- Understand food labels and how to use them to help you choose healthier foods
- Compare labels to reduce sodium (salt) in your diet
- Identify a healthy eating plan that you can incorporate into your daily life
- Learn how to overcome experiences of racial discrimination with food selection

Session 3: Overview

- The importance of lifestyle changes
- Healthy eating and the benefits of having a well balanced diet
- How eating healthy can help with:
 - Losing or maintaining weight
 - Feeling more energetic
 - Managing stress

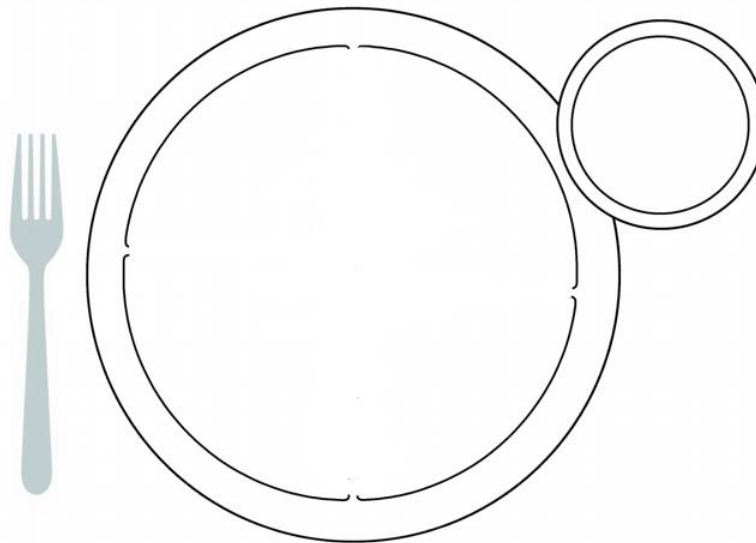
Discussion: Food is fuel for your body, mind, and soul.

What is your favorite food?

- Why is that particular food your favorite?
- How does eating your favorite food make you feel?

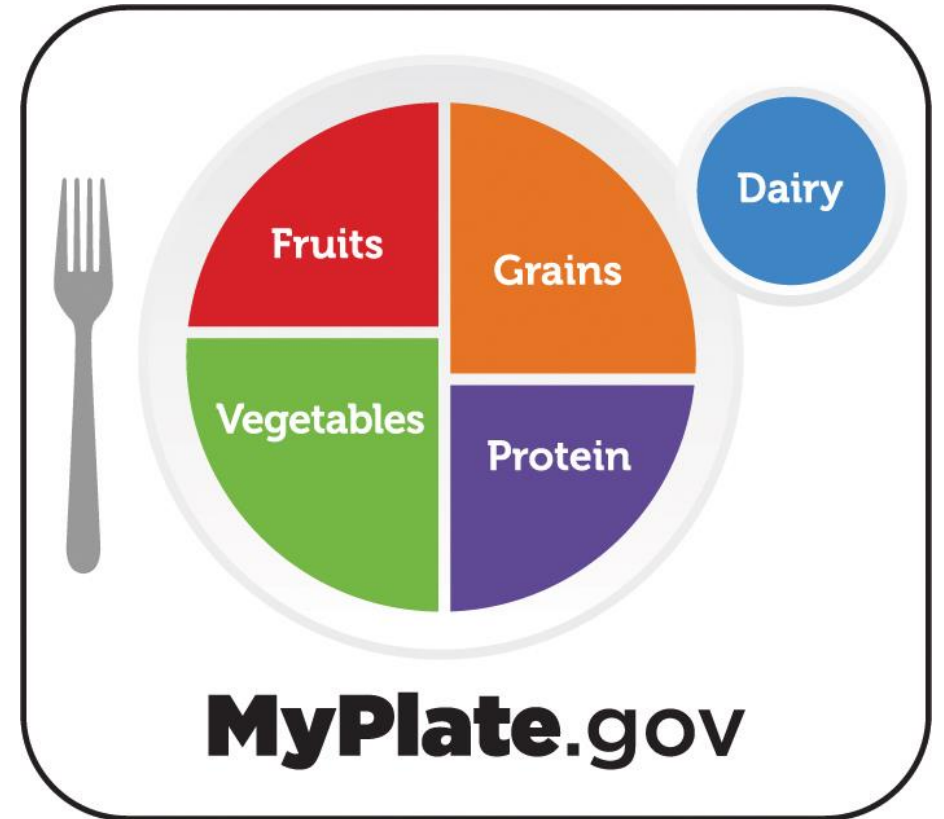
Exercise – Build Your Typical Meal Plate

What does a typical meal look like for you?



How to Build a Healthy Plate (Plate Method)

- Start with the right-sized plate or bowl.
- An adult plate should be 9 inches across, and a child's plate should be 7 inches across.
- Fill $\frac{1}{2}$ with fruits and vegetables
- Fill $\frac{1}{4}$ with a protein
 - lean meats (like grilled chicken breast and pork tenderloin), seafood (like skinless fish)
 - or vegetarian options (like beans, eggs or tofu)
- Fill $\frac{1}{4}$ with whole grains or starches



Fruit & Vegetables


- A healthy diet includes having fruits and vegetables every day
- Fruits and vegetables contain plenty of fiber which helps you feel full on fewer calories.
 - Sweet potatoes and collard greens are superfoods!

Keep in mind:

- Choose canned vegetables with low-sodium or no salt added
- Bake, steam, grill your vegetables - use very little oil
- Whole fruit over fruit juice
- Fruit for dessert



Lean Proteins

- Foods rich in proteins provide important nutrients and help you feel full
 - Choose lean proteins; they have less saturated fat, which is better for your heart and waistline.
 - Saturated fat raises your LDL (“bad”) cholesterol and increases your risk of heart disease.
 - Some lean proteins you can add to your diet:
 - Fish or shellfish
 - Plant-based: lentils, unsalted nuts, dried/canned beans,
 - Eggs
 - Chicken or turkey breast
- 
- A horizontal collage of various lean protein sources. From left to right, it includes a piece of raw salmon, a cooked shrimp, a lentil, a whole egg, and a piece of cooked chicken breast.



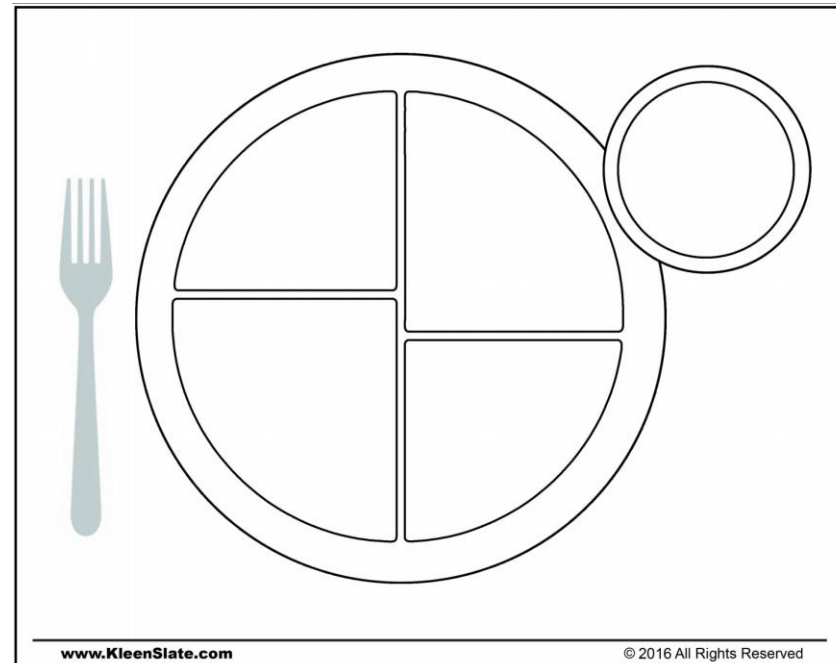
Whole Grains

- Whole grains make you feel fuller longer and lower your risk of heart disease.
- Keep in mind:
 - 100% whole wheat bread
 - Brown rice when possible
 - Oatmeal: Choose unsweetened and flavor with fresh fruit
 - Whole-wheat flour instead of white flour



Exercise – Build Your Next Meal Plate

How can you build your next meal plate?



Hydrating: Drinking water and healthy drinks

- Many sweet drinks are high in sugar and calories, including: sodas, sports drinks, energy drinks, juice, sweetened teas.
 - This can lead to weight gain which may increase blood pressure.
- Healthier options:
 - New York City Tap water: you can add slices of lemons or lime
 - Unsweetened tea- avoid adding sugar, or reduce the amount of sugar gradually
 - Sparkling water
 - Plain, fat free (skim) or low fat milk (1%) - consider these when adding them to coffee

Alcohol

- Drinking more than a moderate amount of alcohol can raise your blood pressure
- Moderate drinking is defined as:
 - Up to 1 standard drink per day for women
 - Up to 2 standard drinks per day for men



Salt (Sodium)

- Sodium is a mineral that helps keeps the balance of fluid on your body and can affect your blood pressure
 - Salt is a source of sodium
- Eating too much sodium can raise your blood pressure and increase your risk of heart attack and stroke
- Nutrition Facts labels make it easier to choose foods, sauces, and seasonings that are lower in salt (sodium)
- Read the nutrition label and try to limit your sodium to no more than 2,300 mg —about one teaspoon of salt per day



Reading Nutrition Labels

- Learning how to read and understand nutrition labels will help you make healthier choices

Nutrition Facts	
Serving Size 1 cup (239g)	
Servings Per Container 2	
Amount Per Serving	
Calories 100	Calories from Fat 15
% Daily Value*	
Total Fat 1.5g	2%
Saturated Fat 0g	0%
Trans Fat 0g	
Cholesterol 15mg	5%
Sodium 1200mg	50%
Total Carbohydrate 15g	5%
Dietary Fiber 1g	4%
Sugars 1g	
Protein 6g	

Start Here: Serving Size
Always check the serving size and number of servings in the container.

The amounts listed are per serving. If you eat this whole can, you are eating 2 servings (need to double everything / multiply by 2).

Reading Nutrition Labels

Nutrition Facts	
Serving Size 1 cup (239g)	
Servings Per Container 2	
Amount Per Serving	
Calories 100	Calories from Fat 15
% Daily Value*	
Total Fat 1.5g	2%
Saturated Fat 0g	0%
Trans Fat 0g	
Cholesterol 15mg	5%
Sodium 1200mg	50%
Total Carbohydrate 15g	5%
Dietary Fiber 1g	4%
Sugars 1g	
Protein 6g	

- Look for the amount of sodium
- Remember, you should try to limit your sodium to no more than 2,300 mg per day
- This can of soup has a lot of sodium—one serving has 50% of the recommended daily value for sodium

Cutting Back on Sodium

Too much salt can increase your blood pressure and risk for heart attack and stroke.

Which foods do you think are high in salt or sodium?

Foods High in Sodium – Avoid these!

Sliced Ham



Nutrition Facts		Amount/serving	% (DV)*	Amount/serving	% (DV)*
Serv size 2 oz (56g)		Total fat 1 g	2 %	Sodium 590 mg	25 %
		Sat fat 0 g	0 %	Potassium 150mg	4 %
		Trans fat 0 g		Total carb 2g	1 %
Servings Varied		Monounsaturat fat 0.5 g		Fiber 0 g	0 %
Calories 60		Polyunsaturat fat 0 g		Sugars 2 g	
Fat cal 10		Cholest 25 mg	8 %	Protein 9 g	18 %
*Percent Daily Values (DV) are based on a 2,000 calorie diet.		Vitamin A 0 %	*Vitamin C 0 %	*Calcium 0 %	*Iron 4 %

Potato Chips



Serving size	1 oz (28g/About 15 chips)	
Amount per serving		
Calories	160	
% Daily Value*		
Calories	160	
Fat	10g	13%
Saturated	1.5g	7%
Trans	0g	
Cholesterol	0mg	0%
Sodium	170mg	7%
Carbohydrates	15g	6%
Fiber	1g	5%
Sugars	less than 1g	
Protein	2g	
Vitamin D	0mc	0%
Vitamin C		6%
Calcium	10mg	0%
Iron	0.6mg	2%
Potassium	350mg	6%

Pickles



Nutrition Facts	
Usually 20 servings per container	
Serving size	about 1/3 pickle (28g)
Amount per serving	
Calories	0
% Daily Value	
Total Fat 0g	0%
Trans Fat 0g	
Sodium 330mg	14%
Total Carbohydrate 0g	0%
Total Sugars 0g	
Includes 0g Added Sugars	0%
Protein 0g	

Canned Soup



Nutrition Facts	
About 2.5 servings per container	
Serving size	1/2 cup (120mL) condensed soup
Amount per serving	
Calories	60
% Daily Value*	
Total Fat 2g	3%
Saturated Fat 0.5g	3%
Trans Fat 0g	
Polyunsaturated Fat 0g	
Monounsaturated Fat 0.5g	
Cholesterol 15mg	5%
Sodium 890mg	39%
Total Carbohydrate 0g	0%
Dietary Fiber <1g	4%
Total Sugars 0g	
Includes 0g Added Sugars	0%
Protein 3g	
Vitamin D 0mcg	0% • Calcium 10mg 0%
Iron 0.6mg	4% • Potassium 60mg 0%
*The % Daily Value (DV) tells you how much a nutrient in a serving of food contributes to a daily diet. 2,000 calories a day is used for general nutrition advice.	



Foods High in Sodium – Avoid these!

Hot Dog



Nutrition Facts			
Serv. Size 1 Hot Dog in a Bun (110g) Calories 310 Fat Cal. 150			
*Percent Daily Values (DV) are based on a 2,000 calorie diet.			
Amount / Serving	%DV*	Amount / Serving	%DV*
Total Fat 17g	26%	Total Carb. 28g	9%
Sat. Fat 7g	34%	Fiber 1g	3%
Trans Fat 1g		Sugars 4g	
Cholest. 35mg	11%	Protein 12g	
Sodium 760mg	32%		
Vitamin A 0%		Calcium 8%	
Vitamin C 4%		Iron 10%	

Frozen Meal



Nutrition Facts	
Serving Size 1 Meal (311g)	
Amount Per Serving	
Calories 250	Calories from Fat 60
% Daily Value*	
Total Fat 7g	11%
Saturated Fat 2.5g	13%
Trans Fat 0g	
Polyunsaturated Fat 1g	
Monounsaturated Fat 3g	
Cholesterol 45mg	15%
Sodium 570mg	24%
Potassium 620mg	18%
Total Carbohydrate 32g	11%
Dietary Fiber 4g	16%
Sugars 14g	
Protein 15g	22%

Frozen Pizza



Nutrition Facts	
4 servings per container Serving size 1/4 Pizza (149g)	
Amount per serving	
Calories	380
% Daily Value*	
Total Fat 17g	22%
Saturated Fat 9g	45%
Trans Fat 0g	
Cholesterol 45mg	15%
Sodium 710mg	31%
Total Carbohydrate 41g	13%
Dietary Fiber 2g	7%
Total Sugars 8g	
Includes 1g Added Sugars	3%
Protein 16g	30%
Vitamin D 0mcg	0%
Calcium 340mg	25%
Iron 2.5mg	15%
Potassium 310mg	6%
*The % Daily Value tells you how much a nutrient in a serving of food contributes to a daily diet. 2,000 calories a day is used for general nutrition advice.	

Healthy Cooking Tips

- Sautee, grill, steam or bake foods instead of frying
- Use healthy oils: Choose canola, soybean, peanut or olive oil instead of butter and shortening
- Use low-fat milk products: Cook with low-fat yogurt, buttermilk and fat-free evaporated milk instead of heavy creams
- Use less salt: Season with herbs and spices such as turmeric, cumin, coriander, bay leaf, mustard seed, green chili and fresh ginger and garlic
- Add vegetables to soups, stews and sauces

Eating Out

- Food servings are bigger today. Some restaurant entrees or fast-food meals have more than 1,500 calories—almost as many calories as you should have for the whole day.
- Almost 80% of the salt we consume comes from packaged food and restaurants, not from the salt shaker.

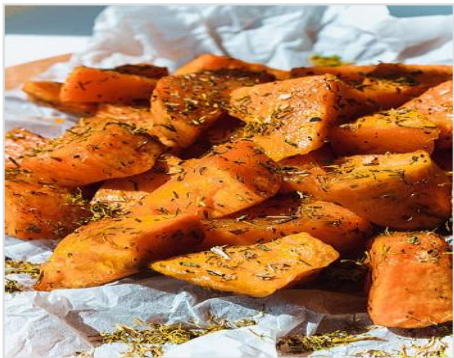


Tips When Eating Out

- Ask for low-sodium dressings, sauces or other toppings
 - Request to have them on the side so that you can control how much you add
- Ask for your food to be prepared with *no salt added*
- Pick healthier sides like salads or steamed vegetables
 - Limit portions of preserved and pickled vegetables, which may be higher in salt
- Share your meal with a friend, or take half home for later
- Look for items on the menu that are *steamed, grilled or broiled* instead of fried or sautéed
- Avoid foods that are deep-fried, or cooked in butter, clarified butter and creamy sauces

Emotional Eating

- Certain emotions— such as stress, boredom, loneliness, and depression make it easier for people to “slip” in their lifestyle change goals
- We often eat food – usually “comfort” or junk foods in response to feelings instead of hunger
- If you find yourself reaching for junk food, try a healthy snack or an activity (like a walk or game) instead.



Meal Time – Discussion

- How was meal time for you growing up?
- Did you have access to fresh produce in your neighborhood?
 - If not, consider going to the nearest neighborhood to purchase healthy foods if possible

What is your favorite food?

- Why is that particular food your favorite?
- How does eating your favorite food make you feel?

What does a typical Breakfast meal look like for you?

...Lunch? ...Dinner?

Healthy Eating Discussion

- What reasons do you have to make changes to your diet for better health?
- What are your food weaknesses? What do you eat frequently that might not be considered heart healthy?
- What things keep you from making changes to improve your health?
- Do you think your race/ ethnicity limits your access to healthy foods? if so, how?
- What can you do to overcome these barriers?

Cultural Foods

- Are you able to find fruits, vegetables and grocery items that you enjoy in your grocery store?
- Do you have to travel far to buy grocery items to make the meals you enjoy?
- Do any of the meals you love have a “bad rep”?
 - Why do you think that is?



Experiences: Supermarkets and Health Stores

- How do you feel when you go into the supermarkets in your neighborhood?
 - Outside of your neighborhood?
- How do you feel when you go to farmers markets in your neighborhood?
 - Outside of your neighborhood?
- What is your experience when going into health food stores?
- Tell me about a time you were able to shift your attention during these stressful situations (S+P)



Examples of Healthy Recipes

- Caribbean and African foods can also be added into American foods
- Jerk, curry (Salmon)
- Chicken salad (culturally diverse)
- Tropical style guacamole with corn, tomatoes, cooked broccoli, onions and a fruit. (example, mangoes)
- You can slow cook your chicken or beef stew and add steamed vegetables to it
- Jollof rice with plantains and steamed fish
- Baked tilapia, grilled chicken with African Spices
- Fufu and stew meat or fish (made with plantains, yams, and cassava) high in fiber, iron and vitamin C



Taking Care of You: Progressive Muscle Relaxation

What it is: Progressive muscle relaxation is a technique that helps you relax your body by tensing certain muscles and then relaxing them.

How it works: When you are stressed, you may be so tense that your body does not recognize what it feels like to be relaxed. Progressive muscle relaxation can help show you the difference between feeling tense and feeling relaxed.

How to do it:

- Find a quiet, private place and sit down in a comfortable position.
- Uncross your arms and legs and rest your feet gently on the floor.
- Take a deep breath and tense the muscles in your hands as hard as you can by making fists.
- Hold your breath for 5 to 10 seconds.
- Exhale as you release all the tension from your **fists**, relaxing them completely.
- Remain in this relaxed state for 15 to 20 seconds.
- Repeat this exercise, tensing and relaxing the other muscle groups in your body (**arms, shoulders, legs, and feet**).

Creating SMART Health Goals

What is one thing you can do to eat healthier?

Create a SMART Plan to achieve your health goals:

- Specific: *What will I do? Where will I do it? How often will I do it?*
- Measurable: *How can I track it? What progress do I want to see?*
- Attainable: *What might get in the way of my plan? What can I do about it?*
- Relevant and Realistic: *Is it a priority for me? If it's not, change my goal.*
- Time-bound: *When will I do it? For how long?*

Next Session: Being Physically Active

- Please join us to learn about how to make physical activity part of your daily routine.
- I will call you to discuss your health goals, referral needs, and any other questions you might have.

Additional Resources – Healthy Eating

- [Life's Essential 8, How to eat better \(heart.org\)](https://www.heart.org)
- [Understanding Food Nutrition Labels | American Heart Association](#)
- [healthy-eating-active-living-guide.pdf \(nyc.gov\)](#)

- [**Plan Your Plate:** Shifting to a Healthy Eating Style](#)
- [**Sweet Stuff:** How Sugars and Sweeteners Affect Your Health](#)
- [**The Skinny on Fat:** The Good, the Bad, and the Unknown](#)
- [**The Salty Stuff:** Salt, Blood Pressure, and Your Health](#)
- [**Rough Up Your Diet:** Fit More Fiber Into Your Day](#)
- [**Better Nutrition Every Day:** How to Choose Healthier Foods and Drinks](#)



NYU Grossman School of Medicine

Project ADHERE

Blood Pressure Education Program

Session 4: Being Physically Active (HTN+RD)

Addressing Disparities in Hypertension and Reducing Racial inequity through Engagement

As of February 6, 2024

Session Objectives

- Understand the benefits of different types of physical activities
- Learn how to incorporate physical activity into your daily routine to meet your health goals

Session 4 Overview

- Last session we discussed the importance of a healthy diet as a way to manage high blood pressure.
- Today we will focus on the benefits of being physically active
- A combination of a healthy diet and physical activity helps with weight control, your overall health, and stress management

Why is it important to be physically active?

- Control your blood pressure
- Prevent many chronic diseases
- Maintain a healthy weight
- Improve your mood
- Strengthen and protect bones, muscles and joints
- Sleep better



Physical Activity Discussion

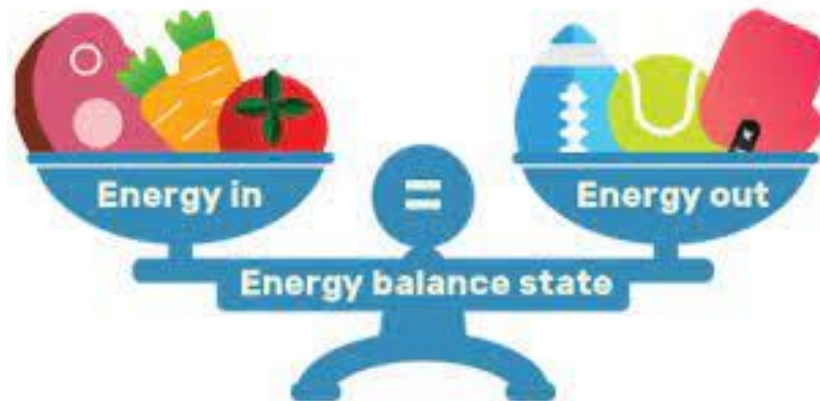
What do YOU do to stay active?

Do you experience racial/ethnic bias when trying to stay active?



Energy Balance

- **Healthy eating** and **being physically active** are important for a healthy lifestyle and lowering your risk of heart attack and other diseases
- These two behaviors that work together to keep your body in energy balance



Energy Balance and Calories

- When you eat food, you take in calories (energy).
 - Calories in food come from fat, carbohydrates (starches, sugar), protein, or alcohol.
- The number of calories in any food you eat or drink depends on what's in it.

Energy Balance and Physical Activity

- Calories also measure the energy you use up
- Your body uses calories to do basic functions necessary for just staying alive
 - like breathing, blood circulation, thinking, etc.
- The number of calories you use in a certain activity depends on several things, including the type of activity, the amount of time you are active, and how much you weigh.
 - In general, 1 mile of brisk walking (which takes most people about 15 - 20 minutes) uses about 100 calories.



How we lose weight

Choosing food with fewer calories

AND

being more physically active

= Burning more calories than you consume



How much physical activity do we need?

Adults should get 30 minutes per day,
at least five days a week.

- At least 150 minutes per week



Every day activities count too!

- Walking in your neighborhood or local park
- Pushing a stroller
- Cleaning and housework that gets your heart rate up
- Gardening
- Taking the stairs- an every day activity if you live in a walk up or an elevator building



Do you feel stressed when performing these everyday activities due to your race or ethnic background?

- It is important to discuss with your doctor what activities are safe for you.

Do a variety of activities.

- Do a variety of exercises to benefit your body in different ways and avoid getting bored
 - Aerobic activities (like brisk walking, running)
 - Muscle-strengthening activities (like pushups, lifting weights, resistance training)
 - Bone-strengthening activities (like jumping)
 - Balance and stretching activities (like yoga, stretching, martial arts)

Taking a quick exercise break?
Try one of these ideas!



Endurance
Endurance exercises improve the health of your heart, lungs, and circulatory system.

Flexibility
Stretching can improve your flexibility to make everyday activities easier.

Balance
Balance exercises help prevent falls and can improve balance.

Strength
Strength exercises can help you stay independent and prevent fall-related injuries.

➡ To learn more about exercise, visit: www.nia.nih.gov/exercise.

NIH National Institute on Aging

Build activity into your day

- Find yourself a walking buddy
 - The fresh air, exercise and time to have conversation can be a great stress-reliever
- You don't have to get all your physical activity at one time
 - Spread multiple 10-minute workouts throughout your day
- Take advantage of free or low-cost fitness classes online or in your neighborhood
- Buy your own weights, fitness bands, or yoga mat to use at home
- Take a walk as a family after a meal
 - You can count how many steps you walked together with a pedometer or cell phone app

Ways to be active?

- There are many ways to be active – even without going to the gym!
 - Brisk walking/running
 - Swimming
 - Biking
 - Playing basketball or a sport
 - Dancing
 - Taking an aerobics or Zumba class



Experiences

- What are your experiences when visiting parks or gyms in your neighborhood?
- Do you feel targeted by others due to your racial or ethnic background in these parks or gyms?
 - Tell me about a time you have shifted your focus when this has happened (s+p)
- Do you feel safe going to other neighborhoods for resources required for your wellbeing?
 - *This could be going to the gym, going for a run, going to a neighborhood park*

Barriers to Exercise

- What prevents you from exercising regularly?
 - Do you feel that your obligations in life prevent you from taking time in the day to exercise?
 - Do you feel comfortable exercising around other people in your neighborhood due to your racial or ethnic background?
- How can we address the barriers that prevent us from exercising?
- Is there anything else you would like to share about your ability or lack thereof to exercise in your environment?

Setting Physical Activity Goals

- Set a goal you can meet and write it down. When you meet a goal, reward yourself.
- You are more likely to stick to your goals if you choose activities you enjoy.
 - Do a variety of exercises to prevent boredom (cardio, strength training, stretching, balance).
- Exercise with a friend for emotional and physical support.

Sample Walking Program

Not sure how to begin? Use this walking guide to help you get started.

Tips: Walk with a friend for motivation.

Walk during your break.

Track your time and progress.

		Pace	Time Each Day	Number of Days	Total time For the Week	
Month 1	Week 1	Slow	10 minutes	4 days	40 min	It is good to start slow and for at least 10 minutes at a time. Pick up your pace after a few weeks.
	Week 2	Slow	10 minutes	4 days	40 min	
	Week 3	Slow	15 minutes	5 days	1 hr 15 min	
	Week 4	Slow-Brisk	20 minutes	5 days	1 hr 40 min	
Month 2	Week 5	Brisk	30 minutes	5 days	2 hrs 30 min	Work up to walking for at least 2 hours and 30 minutes each week.
	Week 6	Brisk	25 minutes	6 days	2 hrs 30 min	
	Week 7	Brisk	30 minutes	5 days	2 hrs 30 min	
	Week 8	Brisk	35 minutes	5 days	2 hrs 55 min	

NIH 2013. Sample Walking Program Guide.

Creating SMART Health Goals

What is one thing you can do to be more active each day?

Create a SMART Plan to achieve your health goals:

- Specific: *What will I do? Where will I do it? How often will I do it?*
- Measurable: *How can I track it? What progress do I want to see?*
- Attainable: *What might get in the way of my plan? What can I do about it?*
- Relevant and Realistic: *Is it a priority for me? If it's not, change my goal.*
- Time-bound: *When will I do it? For how long?*

Sample Exercise

Neck Exercise: improves flexibility and relieves tension in neck. (3 reps)

- Sit in your chair with your back firmly against it.
- Slowly, turn your head from left to right and hold the position for 10 seconds.
- Take deep, slow breaths while doing this exercise.



Sample Exercise

Toe stand: makes walking easier by strengthening calves and ankles. (5 reps)

- Remain standing, feet-shoulder width apart.
- Breathe out and slowly stand on your tiptoes and hold for 10 seconds.
- Breathe in as you slowly lower heels to the floor.
- Rest and repeat.



Breathing Exercise

We will end our session today with a 5 minute breathing exercise



Next Session: Heart Disease and Risk Factors

- Please join us to learn more about heart attack and stroke.
- I will call you to discuss your health goals, referral needs, and any other questions you might have.



NYU Grossman School of Medicine

Project ADHERE

Blood Pressure Education Program

Session 5: Heart Disease and Risk Factors (HTN+RD)

Addressing Disparities in Hypertension and Reducing Racial inequity through Engagement

As of January 30, 2023

Objectives

- Understanding heart disease and its risk factors
- Learning the warning signs of a heart attack and a stroke

Session 5 Overview

- Last session we discussed physical activity as a way to manage blood pressure
- Today we will focus on learning a little more about heart disease and its risk factors, heart attack and stroke.

Heart Disease among African Americans

- Heart disease is the leading cause of death for all Americans, but certain minority groups face a greater risk than others.
 - Hypertension (High Blood Pressure) is a major risk factor for heart disease
- Deaths from heart disease are higher in Black Americans than in White Americans and other ethnic groups. It also develops at a younger age in African Americans.
- Nearly 48% of African American women and 44% of African American men have some form of heart disease.

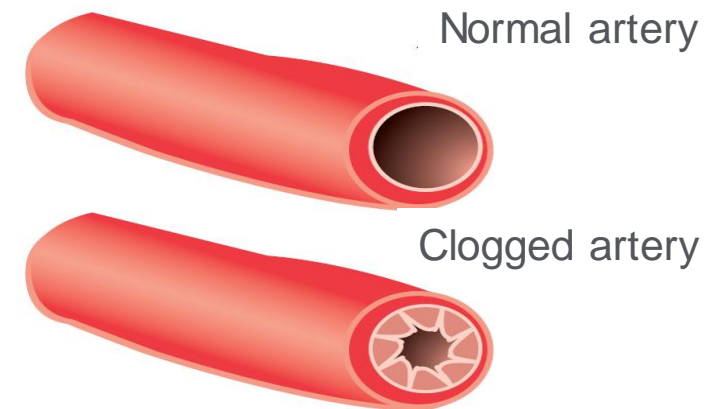
Heart Disease and African Americans

Below are the percentages of all deaths caused by heart disease in 2021, listed by ethnicity, race, and sex.¹

Race of Ethnic Group	% of Deaths
American Indian or Alaska Native	15.5
Asian	18.6
Black (Non-Hispanic)	22.6
Native Hawaiian or Other Pacific Islander	18.3
White (Non-Hispanic)	18.0
Hispanic	11.9
All	17.4

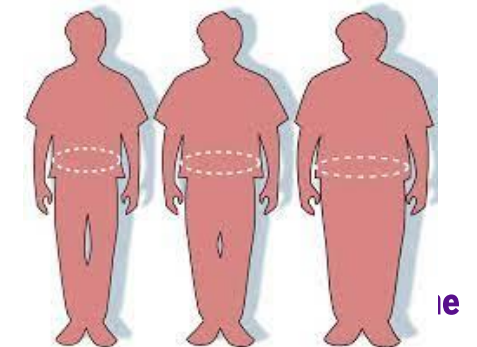
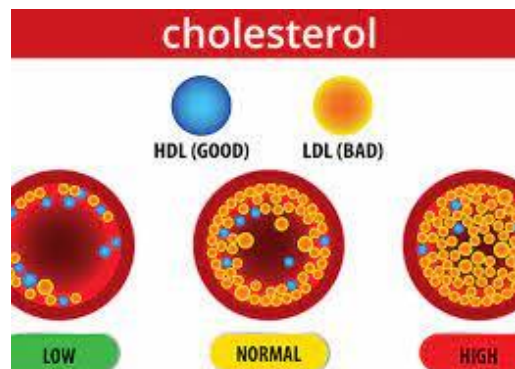
What is Heart Disease?

- The term “heart disease” refers to several types of heart conditions. The most common type of heart disease in the United States is coronary artery disease (CAD), which affects the blood flow to the heart. Decreased blood flow can cause a heart attack.
- The buildup makes the arteries more narrow, which makes it harder for the blood to flow through.
- If a blood clot forms, it can stop the blood flow which may lead to heart attack or stroke.



Heart Disease Risk Factors

- Some of the risk factors for heart disease include:
 - Cholesterol
 - Diabetes
 - Smoking
 - Obesity
 - Stress



What is a heart attack and stroke?

Heart Attack

- Happens when a part of the heart muscle doesn't get enough blood.
- Can occur when blood flow to the heart is blocked.
- Can lead to death.

Stroke

- Sometimes called a “brain attack”, occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts.
- Can occur when blood flow to the brain is blocked, causing brain cells to die.
- Can lead to disability and death.

Warning Signs of a Heart Attack

- Chest pain or discomfort
- Discomfort in other areas of the upper body
- Difficulty breathing
- Feeling lightheaded, breaking out in a cold sweat, or feeling like you are going to throw up

If you or someone you know has these symptoms, do not ignore these signs.
Seek immediate medical attention!

Dial 9-1-1

Warning Signs of a Stroke

The warning signs of a stroke happen suddenly.

A person may have one or more warning signs:

- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking because of dizziness or loss of balance
- Sudden severe headache

If you or someone you know has these symptoms, seek immediate medical attention!

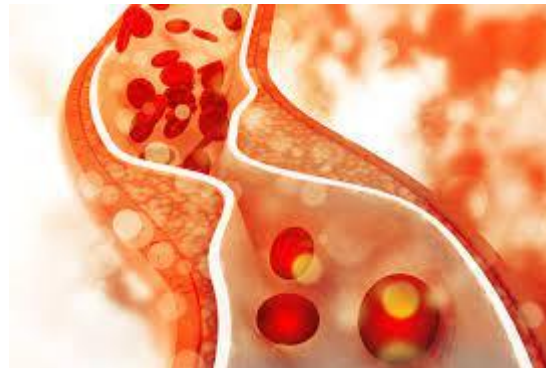
Dial 9-1-1

Discussion

- Have you experienced loss of friends/family due to a heart attack or stroke?
- How do these events affect your community?

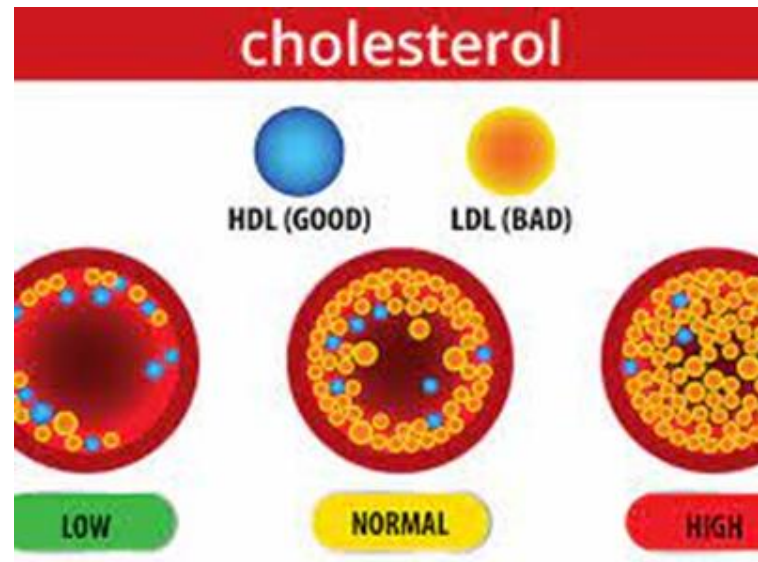
Cholesterol

- Cholesterol itself isn't bad. Cholesterol is just one of the many substances created and used by our bodies to keep us healthy.
- Some of the cholesterol we need is produced naturally (and can be affected by your family health history), while some of it comes from the food we eat.
- High levels of “bad” (LDL) cholesterol in the blood can build up in the inner walls of the arteries that feed the heart and brain, and can cause blockages
 - This increases the risk for coronary heart disease, heart attack, and stroke.



Cholesterol: 2 Types

- “Bad” Cholesterol (LDL) deposits fat and cholesterol in your blood vessels.
 - Remember: LDL = Lower is better!
- “Good” Cholesterol (HDL) cleans up fat and cholesterol from your blood vessels.
 - Remember: HDL = Higher is better!



Cholesterol and Diet

- Most high blood cholesterol comes from eating food with **trans fat and saturated fat**.
- **Limit** these foods containing **trans/saturated fats**:
 - Margarines / Clarified butter
 - Frozen meals
 - Fried foods
 - Pastries, cookies, and cakes
 - Meat (such as fatty beef and deli meats)
 - Whole milk and dairy products
 - Palm oil, coconut milk/oil
- **Choose** fats that are good for your heart, as part of a healthy diet.
 - Seafood and fish, such as salmon, trout, and herring
 - Olive and canola oils
 - Nuts (walnuts, almonds, pecans, peanut butter)
 - Avocados

What is Diabetes?

- The blood takes the glucose (from your food) to the cells of your body, where it is turned into the energy needed for daily life.
- Diabetes happens when the body does not produce enough insulin, or when the cells cannot use the insulin well (Known as “Type 2” Diabetes)
 - This means that the glucose cannot enter the cells and it builds up in the blood.
- People who have high levels of glucose in their blood have diabetes.
- Diabetes can lead to many health problems, including heart attack, stroke, blindness, nerve damage, and kidney problems.



Diabetes

- High blood pressure and diabetes often occur together.
- People with diabetes are more likely to have heart disease or a stroke than those without diabetes.
- Many people have diabetes or are at risk for developing diabetes, and don't know it.
 - Ask your doctor to check your blood sugar.
- Some people have trouble controlling their diabetes.
 - I can help you work with your doctor if you have diabetes and need help managing it.

Smoking

If you are a smoker, quitting smoking is the single most important thing you can do for your health. If you quit, you will live a longer and healthier life and improve the health of the people around you.

Smoking affects every part of the body and causes many health problems such as:

- Increase risk of lung cancer, heart disease and COPD
- Cause more severe asthma
- Put infants at risk for sudden infant death syndrome (SIDS)
- Many cancers, including lung cancer
- Heart disease and lung diseases, including chronic obstructive pulmonary disease (COPD)
- An increase in asthma attacks
- Impotence
- Premature birth/low-birth weight in babies

Discussion

- Within your community, do you feel like a lot of people smoke?
- How does smoking impact your community?

Smoking and Tobacco

All types of tobacco products are harmful.

- *Smoked tobacco*
- (e.g., cigarettes, cigars, pipes, loose tobacco)
- *Smoke-less tobacco*
- (e.g., chew, snuff, dissolvable tobacco)

Quitting tobacco can be very hard to do.

Cigarettes and tobacco contain nicotine, which is highly addictive.

It causes changes in the brain that make people want to use it more and more.

But the health benefits of quitting are worth it!

Let's find out...



Smoking: Benefits of quitting

Your Health Starts Improving the Minute You Quit Smoking.

- **In 20 minutes** your heart rate and blood pressure drops
- **In 24 hours** your risk of heart attack drops
- **In 2 days** your ability to taste and smell improves
- **In 2-3 weeks** your lung function and circulation improve and walking is easier
- **In 1 year** your risk of heart disease is cut in half
- **In 5 years**
 - Your risk of cancer of the mouth, throat, and esophagus drops by half
 - Your risk of stroke and heart disease begins to equal that of a non-smokers (in 5-15 years)
- **In 10 years** your risk of dying of lung cancer is about the same as a non-smokers

Also, Quitting Smoking Saves Money

- Cigarettes are very expensive. By quitting, a person who smokes one pack of cigarettes each day will save \$4,000 a year (maybe even more now due to inflation!)

Stress

- Stress may contribute to poor health behaviors linked to increased risk for heart disease and stroke, such as:
 - Smoking
 - Overeating
 - Lack of physical activity
 - Unhealthy diet
 - Being overweight
 - Not taking medications as prescribed

Stress Management

What can I do about stress?

- Fortunately, you can manage stress in ways such as:
 - Exercising regularly. It can relieve stress, tension, anxiety and depression. Consider a nature walk, meditation or yoga.
 - Making time for friends and family. It's important to maintain social connections and talk with people you trust.
 - Getting enough sleep. Adults should aim for seven to nine hours a night.
 - Maintaining a positive attitude.
 - Practicing relaxation techniques while listening to music.
 - Finding a stimulating hobby that can be fun and distract you from negative thoughts or worries.

Heart Disease, Risk Factors & Racial Discrimination

- Tell me about a time you felt stressed
 - Were you able to shift your attention?
 - What needed to happen in your environment to be able to do this?
- Are there stressors in your life that could be eliminated?
 - Tell me more

Breathing Exercise

We will end our session today with a 5 minute breathing exercise



Keep up the good work

You have worked hard over the last few months to improve your health, but don't stop now. Healthy living means making life-long changes, so keep it up!

You will sometimes run into problems but you can get back on track. Remember, you can always call me if you need someone to talk to!

Keep up with your healthy living goals!

- Use the Plate Planner Method to eat healthy meals
- Be sure to get 150 minutes of physical activity each week
 - 30 minutes a day for 5 days = 150 minutes
- Keep track of your blood pressure
- See your doctor regularly

You can do it!

- By controlling your diet, exercising more, and visiting the doctor regularly for check-ups, you CAN live a healthier life.
- Project ADHERE and NYU are resources for you throughout your journey to good health. Please don't hesitate to contact us if you have any questions or need assistance getting connected to care.
- Thank you for your commitment to better health for yourself, your family and your community!

End of Program Survey / Exit Interview

I will call you in a few weeks about completing an end of program follow-up survey.

You may also be invited to participate in an exit interview.

Thank you in advance for taking the time to share with us what you liked about the program and what can be improved.

Your feedback will help us to improve the program for the next cohort of patients.

Faculty Group Practice (FGP) Hypertension Initiative: Patient Packet

Patient Agreement

How can we help you keep your blood pressure healthy?

Taking steps to manage your blood pressure can lead to many great health benefits. For this reason, the Faculty Group Practices (FGPs) at NYU Langone Health are offering patients a special opportunity. Patients can participate in a blood pressure management program. Being a part of this program can help you and your doctors improve the way you manage your blood pressure. If you join the program, you will continue to see your regular doctors for your medical care.

What are the benefits of participating?

- You will receive a **free blood pressure monitor**. This way you can check your blood pressure at home. Check your blood pressure as discussed with your healthcare team.
- You will receive regular virtual visits with a dedicated care team. They will work with you to find ways to keep your blood pressure numbers within a healthy range.
- There will always be someone available to answer your questions.

What are the benefits of monitoring your blood pressure at home?

- You will have a better understanding of your blood pressure.
- You will also learn how to manage your blood pressure when you share the readings with your healthcare team.
- Sharing your home blood pressure readings with your provider will help them determine your “true blood pressure.” This is determined by showing if your blood pressure readings are different in the office than they are at home.
- You can be in control of your health by keeping track of your blood pressure. You may even feel more motivated to control your blood pressure by improving your diet, being more physically active and taking your medications as prescribed.

What will you be asked to do?

- You will receive your blood pressure monitor along with instructions on how to sync the monitor to your phone and check your blood pressure at home.
- You will check your blood pressure at home as directed by your provider.
- We will ask that you send your readings to the clinic weekly via the NYU app.



- You will participate in regular monthly virtual visits with a dedicated care team.

Patient Agreement

By signing this form, I understand that:

- I agree to participate in the FGP Hypertension Initiative.
- I will talk to a dedicated care team about my blood pressure readings.
- I will receive a home blood pressure monitor. I am aware that my readings will be transmitted from the monitor to my clinic via MyChart, where they will be securely stored into my Electronic Medical Record.
- The blood pressure monitor is **NOT AN EMERGENCY RESPONSE UNIT AND IS NOT MONITORED 24/7**. Call 911 for immediate medical emergencies.
- I will be the only person using the blood pressure monitor as instructed. I will not use the device for reasons other than my own personal health monitoring.
- I can only participate in this program with one Medical Provider at a time.
- I can withdraw my consent to participate in the FGP Hypertension Initiative at any time. I will be expected to return the blood pressure monitor/cuff if I no longer wish to participate or if I do not use it.

I have read and understood the information and consent to participate in the Blood Pressure Management program as stated above. I am aware that this consent is valid as long as I am in possession of the blood pressure monitor device.

Patient Name (print) _____ MRN _____

BP Monitor Serial Number _____

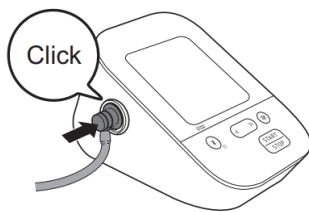
Patient Signature _____ Date _____

Guide to Using Your OMRON Blood Pressure Monitor (Model BP7250)

[\[Track My Blood Pressure Instructions for Apple iPhones/iPads\]](#)

[\[Track My Blood Pressure Instructions for Android Smartphones/Tablets\]](#)

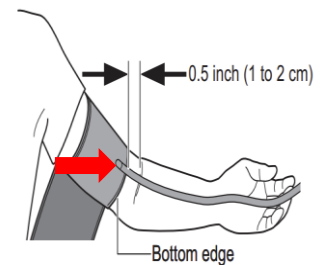
Follow these steps to place the arm cuff around your arm properly:



Plug the arm cuff into your monitor by inserting the air plug into the air jack securely until it clicks.



Place your hand through the cuff loop.



Pull the cuff until it reaches your upper left arm.

Make sure that the air tube is positioned on the inside of your arm and wrap the cuff securely, so it cannot move around your arm.



Your cuff will be on correctly, if you can only fit one finger between the cuff and your arm.

[Educational video helps train care teams and patients on how to properly self-measure blood pressure](#)

Blood Pressure (BP) Numbers: An Introduction

What is blood pressure?


- Blood pressure is the force of your blood pushing against the walls of your blood vessels.
- Systolic blood pressure shows how much pressure your blood uses against your artery walls when the heart beats. This is the top number in the reading.
- Diastolic blood pressure shows how much pressure your blood uses against your artery walls while the heart rests between beats. This is the bottom number in the reading.

What is high blood pressure?

- High blood pressure (HBP or hypertension) is when your blood pressure stays high over time.

What are Blood Pressure Categories?

- The American Heart Association (AHA) has created ranges, or categories, for blood pressure readings. They show what is normal, as well as ranges that are too high.
- See the categories in the chart below:

<div> Blood Pressure Categories  </div>			
BLOOD PRESSURE CATEGORY	SYSTOLIC mm Hg (upper number)		DIASTOLIC mm Hg (lower number)
NORMAL	LESS THAN 120	and	LESS THAN 80
ELEVATED	120-129	and	LESS THAN 80
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 1	130-139	or	80-89
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 2	140 OR HIGHER	or	90 OR HIGHER
HYPERTENSIVE CRISIS (consult your doctor immediately)	HIGHER THAN 180	and/or	HIGHER THAN 120

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heart.org/bplevels

What do these Blood Pressure Categories mean?

Category	Consistent BP Range	Treatment or Action
Normal	Below 120/80	Stick with heart-healthy habits like following a balanced diet and getting regular exercise.
Elevated	Systolic: 120-129 Diastolic: Less than 88	People with elevated blood pressure are likely to develop high blood pressure unless they take steps to control the condition. Speak with your healthcare provider about what you can do to prevent high blood pressure. This includes diet and exercise.
High Blood Pressure (Hypertension) Stage 1	Systolic: 130-139 Diastolic: 80-89	At this stage, doctors are likely to prescribe lifestyle changes. They may also add blood pressure medication. They would base this on your risk of a heart attack or stroke.
High Blood Pressure (Hypertension) Stage 2	140/90 mm Hg or higher	At this stage, doctors are likely to prescribe both blood pressure medications and lifestyle changes.
Hypertensive Crisis	Suddenly goes higher than 180/120 mm Hg	<p>This stage of high blood pressure requires medical attention. If your BP is in this high range, wait 5 minutes then test your blood pressure again.</p> <p>If your readings are still unusually high, contact your healthcare provider right away. You could be having a hypertensive crisis.</p>

Call 911 right away if:

Your blood pressure is higher than 180/120 mm Hg and you are experiencing signs of possible organ damage. Signs include chest pain, shortness of breath, back pain, numbness or weakness. You may also notice a change in vision or difficulty speaking. **Do NOT** wait to see if your pressure comes down on its own.

Langone Health. All rights reserved. Reviewed for health literacy. This information is not intended as a substitute for professional medical care. Always follow your health care provider's instructions.

DASH Diet

The DASH (Dietary Approaches to Stop Hypertension) Diet is a flexible lifelong approach to healthy eating. “Hypertension” means high blood pressure. The DASH diet was created to help lower blood pressure. This diet may also reduce your risk of getting other common diseases like cancer, diabetes, and heart disease.

- The DASH diet recommends having **MORE**:
 - Fruits and vegetables
 - Low-fat dairy foods
 - Eating more whole-grain foods
 - Skinless fish and poultry
 - Nuts and beans
 - Low-calorie and sugar free drinks like water, hot tea and coffee.
 - Vegetable oils for cooking
- The DASH diet recommends having **LESS**:
 - Foods high in saturated fat, cholesterol, and trans fats
 - Red meat
 - Sodium (salt)
 - Sugary drinks and sweets

What can I eat on the DASH Diet?

Choose foods from each of the food groups below each day. Try to get the recommended number of servings for each food group. The serving numbers are based on a diet of 2,000 calories a day. (Talk to your doctor if you are not sure about your calorie needs.) The DASH plan also recommends having under 2,300 mg of sodium a day.

If you don't have measuring cups, you can use your hands to measure portions.



Your fist is about 1 cup



Your palm is about 3 ounces



Your thumb tip is about 1 tablespoon, and your fingertip is about 1 teaspoon.

Here are some suggestions to help you get started:

Whole Grains: 6–8 Servings a Day

- ½ cup of dry, whole-grain cereal
- ½ cup of cooked brown rice, quinoa, or pasta



Vegetables: 4–5 Servings a Day

- 1 cup of raw, leafy green vegetables (for example, spinach or kale)
- 1 cup of corn
- ½ cup of cut up raw or cooked vegetables



Fruits: 4–5 Servings a Day

- 1 mango, orange, banana or apple
- ¼ cup dried fruit
- ½ cup of fresh, frozen or low-sodium canned fruit



Dairy Products: 2–3 Servings a Day

- 1 cup of low-fat milk or unsweetened yogurt
- 1.5 ounces of low-fat cheese



Lean Chicken, Meat and Fish: 6 or Fewer Servings a Day

- 1 ounce of cooked meat, chicken or fish
- 1 boiled egg



Nuts, Seeds and Beans: 4–5 Servings a Week

- 1/3 cup or 1 ½ ounces of unsalted peanuts
- 2 tablespoons of seeds
- ½ cup of cooked beans, peas, or lentils
- 2 tablespoons peanut butter



Fats and Oils: 2–3 Servings a Day

- 1 teaspoon of vegetable oil
- 2 tablespoons of salad dressing



Dessert: 5 or Fewer Servings a Week

- 1 cup of lemonade
- ½ sorbet or gelatin dessert



How do I read a food (or nutrition) label?

DASH is easy to follow and promotes a heart-healthy balanced eating style for a lifetime. Reading food labels is one of the best ways to stay on track with DASH. This can help you choose **heart healthy foods** that are part of the DASH diet. Look for the nutrition facts items below on food labels to follow your DASH diet:

1 **Start Here** →

2 **Check Calories**

3 **Limit these Nutrients**

4 **Get Enough of these Nutrients**

5 **Footnote**

Nutrition Facts

Serving Size 1 cup (228g)
Servings Per Container 2

Amount Per Serving
Calories 250 **Calories from Fat** 110

	% Daily Value*
Total Fat 12g	18%
Saturated Fat 3g	15%
Trans Fat 3g	
Cholesterol 30mg	10%
Sodium 470mg	20%
Total Carbohydrate 31g	10%
Dietary Fiber 0g	0%
Sugars 5g	
Protein 5g	
Vitamin A	4%
Vitamin C	2%
Calcium	20%
Iron	4%

6

Quick Guide to % DV

- 5% or less is Low
- 20% or more is High

* Percent Daily Values are based on a 2,000 calorie diet. Your Daily Values may be higher or lower depending on your calorie needs.

	Calories:	2,000	2,500
Total Fat	Less than	65g	80g
Sat Fat	Less than	20g	25g
Cholesterol	Less than	300mg	300mg
Sodium	Less than	2,400mg	2,400mg
Total Carbohydrate		300g	375g
Dietary Fiber		25g	30g

<http://www.foodpyramid.com/nutrition-facts-label>

EPIC CHW Documentation Protocol

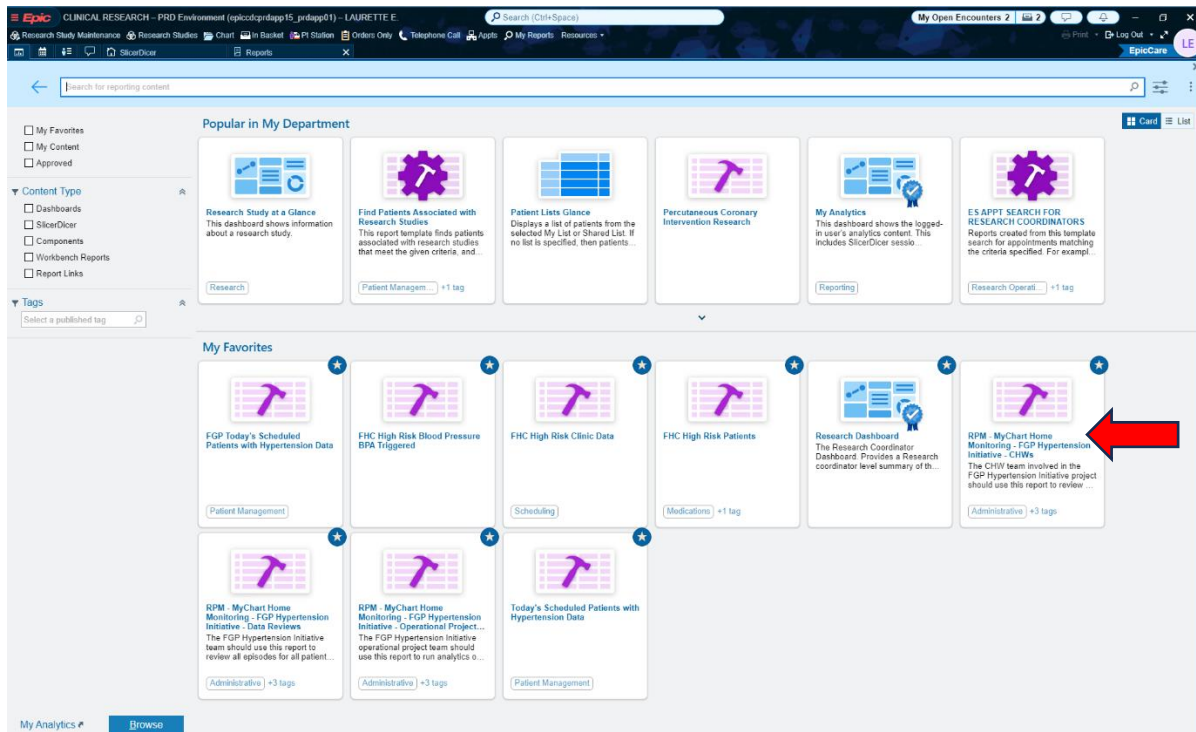
This protocol explains how to submit an encounter note to document CHW contact attempts with patients. This note is visible to all providers/staff on the patient's care team.

We submit an encounter note in the following scenarios:

- 1) For patients who were outreached via phone call and received some form of assistance (e.g., uploading BP readings, referrals, etc.)
- 2) For patients who were outreached via phone call but did not respond. Note: we want to document these contact attempts to keep the RPM program team up to date.
- 3) For patients who had a health session completed

Steps to Submitting Encounter Note

1. Open EPIC
2. Go to 'My Reports' located on the top bar
3. Run the 'RPM MyChart Home Monitoring – FGP Hypertension Initiative – CHWs' report



4. Select the patient you want to submit the onboarding report for and click on the 'Pt Outreach' button (note: only click once to highlight the row, you don't want to open their chart)

RPM - MyChart Home Monitoring - FGP Hypertension Initiative - CHWs [62556574] as of Wed 9/4/2024 12:13 PM

Detail List | Explore | Episodes by Status

Episode Creation Date	Episode Creator	Creation Dept. for FGP Hypertension Initiative Episode	Patient Name	MRN	Episode ID	SDOH Completed Date	Onboarding Completed?
08/14/2024	Azuka N Anyoku, MD	FGP LAURELTON - IM	Dulibre, Robert	1177357	21445...		
08/14/2024	Richard Joshua Shepard, DO	FGP ACWS INT MED	Watson, Rosemarie	1095513	21448...		Patient declined at this time. (FGP HTN ADDRESS BP BARRIERS OR CONCERNS TXT.3644) 67071 HL V. 1 1248999685
08/15/2024	Muneeb Khan, MD	FGP ACWS INT MED	Williamson, Cynthia	10212661	21454...		
08/16/2024	Azuka N Anyoku, MD	FGP LAURELTON - IM	Menozzi, Lena P	10216423	21467...		
08/16/2024	Azuka N Anyoku, MD	FGP LAURELTON - IM	Dorce, Guerline	15689224	21457...		
03/09/2024	Muneeb Khan, MD	FGP ACWS INT MED	Juela, Carlos	15445230	19636...		Patient agreed to measure blood pressure at home and completed onboarding. 67031 HL V. 1 1219762357
08/16/2024	David E Valentine, MD	FGP ACWS INT MED	Mentore, Michael	9169330	21458...		
08/16/2024	Azuka N Anyoku, MD	FGP LAURELTON - IM	Blackwood, Sonia	9029055	21470...		
08/19/2024	Obiora O Anyoku, MD	FGP LAURELTON - IM	Ornyelke, Justina	12689883	21484...		
08/20/2024	Obiora O Anyoku, MD	FGP LAURELTON - IM	Burrows, Vera O	10250503	21506...		
08/20/2024	Obiora O Anyoku, MD	FGP LAURELTON - IM	McLeod-Robinson, Sharon	9812326	21504...		
08/20/2024	Obiora O Anyoku, MD	FGP LAURELTON - IM	Heslop, Joyce A	14449906	21504...		Patient agreed to measure blood pressure at home and completed onboarding. 67074 HL V. 1 1240306083
08/20/2024	Azuka N Anyoku, MD	FGP LAURELTON - IM	Volsten, Nadine	9981703	21504...		Patient declined at this time. (FGP HTN ADDRESS BP BARRIERS OR CONCERNS TXT.3644) 67074 HL V. 1 12482294515
08/20/2024	Obiora O Anyoku, MD	FGP LAURELTON - IM	Ugonabo, John	12099604	21506...		
08/21/2024	Ina S Itzkovitz, MD	FGP ACWS INT MED	Mentore, Marley M	13568996	21514...		

Health Trends: Last 6 months. Patient-Entered Blood Pressure: 141/87 mmHg. Heart Rate (Patient-Entered): 71 bpm.

Recent Vitals (NOT Patient-Entered):

	8/16/2024	7/9/2024	7/9/2024	12/18/2023	2/13/2023
BP	120/84	122/8	121/1	130/8	131/6
Pulse	162/90	162/100	160/100	142/100	130/90
	75	—	76	75	97

Next 5 Visits: 9/4/2024 - 5/1/2027. The maximum number of appointments has been reached.

- Once the 'Patient Encounter Selection' page is open, click the 'Create an Encounter' button

Patient Encounter Selection

Mentore, Michael [9160330]

Create an Encounter | Show Filters

No contacts found.

Contacts loaded: 0.

- Once the 'Patient Encounter Creation' page is open, click the 'Accept' button to open the 'Call Initiation' page

7. Edit the 'Reason for Call' section accordingly. Click the 'Close' button to submit it.
 - a. Note: for the 'Reason for Call' section, you can enter 'FGP Hypertension Initiative' and select the 'Add' button twice to add it as a free text. Once added, you can enter your note in the 'Comments' section.

Clinical Research - PRD Environment (apicdgrpapp14_andrap01) - LAURETTE.E

Search (Click Space)

My Open Encounters | x1 | x2 | x3 | x4 | x5 | x6 | x7 | x8 | x9 | x10 | x11 | x12 | x13 | x14 | x15 | x16 | x17 | x18 | x19 | x20 | x21 | x22 | x23 | x24 | x25 | x26 | x27 | x28 | x29 | x30 | x31 | x32 | x33 | x34 | x35 | x36 | x37 | x38 | x39 | x40 | x41 | x42 | x43 | x44 | x45 | x46 | x47 | x48 | x49 | x50 | x51 | x52 | x53 | x54 | x55 | x56 | x57 | x58 | x59 | x60 | x61 | x62 | x63 | x64 | x65 | x66 | x67 | x68 | x69 | x70 | x71 | x72 | x73 | x74 | x75 | x76 | x77 | x78 | x79 | x80 | x81 | x82 | x83 | x84 | x85 | x86 | x87 | x88 | x89 | x90 | x91 | x92 | x93 | x94 | x95 | x96 | x97 | x98 | x99 | x100 | x101 | x102 | x103 | x104 | x105 | x106 | x107 | x108 | x109 | x110 | x111 | x112 | x113 | x114 | x115 | x116 | x117 | x118 | x119 | x120 | x121 | x122 | x123 | x124 | x125 | x126 | x127 | x128 | x129 | x130 | x131 | x132 | x133 | x134 | x135 | x136 | x137 | x138 | x139 | x140 | x141 | x142 | x143 | x144 | x145 | x146 | x147 | x148 | x149 | x150 | x151 | x152 | x153 | x154 | x155 | x156 | x157 | x158 | x159 | x160 | x161 | x162 | x163 | x164 | x165 | x166 | x167 | x168 | x169 | x170 | x171 | x172 | x173 | x174 | x175 | x176 | x177 | x178 | x179 | x180 | x181 | x182 | x183 | x184 | x185 | x186 | x187 | x188 | x189 | x190 | x191 | x192 | x193 | x194 | x195 | x196 | x197 | x198 | x199 | x200 | x201 | x202 | x203 | x204 | x205 | x206 | x207 | x208 | x209 | x210 | x211 | x212 | x213 | x214 | x215 | x216 | x217 | x218 | x219 | x220 | x221 | x222 | x223 | x224 | x225 | x226 | x227 | x228 | x229 | x230 | x231 | x232 | x233 | x234 | x235 | x236 | x237 | x238 | x239 | x240 | x241 | x242 | x243 | x244 | x245 | x246 | x247 | x248 | x249 | x250 | x251 | x252 | x253 | x254 | x255 | x256 | x257 | x258 | x259 | x260 | x261 | x262 | x263 | x264 | x265 | x266 | x267 | x268 | x269 | x270 | x271 | x272 | x273 | x274 | x275 | x276 | x277 | x278 | x279 | x280 | x281 | x282 | x283 | x284 | x285 | x286 | x287 | x288 | x289 | x290 | x291 | x292 | x293 | x294 | x295 | x296 | x297 | x298 | x299 | x300 | x301 | x302 | x303 | x304 | x305 | x306 | x307 | x308 | x309 | x310 | x311 | x312 | x313 | x314 | x315 | x316 | x317 | x318 | x319 | x320 | x321 | x322 | x323 | x324 | x325 | x326 | x327 | x328 | x329 | x330 | x331 | x332 | x333 | x334 | x335 | x336 | x337 | x338 | x339 | x340 | x341 | x342 | x343 | x344 | x345 | x346 | x347 | x348 | x349 | x350 | x351 | x352 | x353 | x354 | x355 | x356 | x357 | x358 | x359 | x360 | x361 | x362 | x363 | x364 | x365 | x366 | x367 | x368 | x369 | x370 | x371 | x372 | x373 | x374 | x375 | x376 | x377 | x378 | x379 | x380 | x381 | x382 | x383 | x384 | x385 | x386 | x387 | x388 | x389 | x390 | x391 | x392 | x393 | x394 | x395 | x396 | x397 | x398 | x399 | x400 | x401 | x402 | x403 | x404 | x405 | x406 | x407 | x408 | x409 | x410 | x411 | x412 | x413 | x414 | x415 | x416 | x417 | x418 | x419 | x420 | x421 | x422 | x423 | x424 | x425 | x426 | x427 | x428 | x429 | x430 | x431 | x432 | x433 | x434 | x435 | x436 | x437 | x438 | x439 | x440 | x441 | x442 | x443 | x444 | x445 | x446 | x447 | x448 | x449 | x450 | x451 | x452 | x453 | x454 | x455 | x456 | x457 | x458 | x459 | x460 | x461 | x462 | x463 | x464 | x465 | x466 | x467 | x468 | x469 | x470 | x471 | x472 | x473 | x474 | x475 | x476 | x477 | x478 | x479 | x480 | x481 | x482 | x483 | x484 | x485 | x486 | x487 | x488 | x489 | x490 | x491 | x492 | x493 | x494 | x495 | x496 | x497 | x498 | x499 | x500 | x501 | x502 | x503 | x504 | x505 | x506 | x507 | x508 | x509 | x510 | x511 | x512 | x513 | x514 | x515 | x516 | x517 | x518 | x519 | x520 | x521 | x522 | x523 | x524 | x525 | x526 | x527 | x528 | x529 | x530 | x531 | x532 | x533 | x534 | x535 | x536 | x537 | x538 | x539 | x540 | x541 | x542 | x543 | x544 | x545 | x546 | x547 | x548 | x549 | x550 | x551 | x552 | x553 | x554 | x555 | x556 | x557 | x558 | x559 | x560 | x561 | x562 | x563 | x564 | x565 | x566 | x567 | x568 | x569 | x570 | x571 | x572 | x573 | x574 | x575 | x576 | x577 | x578 | x579 | x580 | x581 | x582 | x583 | x584 | x585 | x586 | x587 | x588 | x589 | x590 | x591 | x592 | x593 | x594 | x595 | x596 | x597 | x598 | x599 | x600 | x601 | x602 | x603 | x604 | x605 | x606 | x607 | x608 | x609 | x610 | x611 | x612 | x613 | x614 | x615 | x616 | x617 | x618 | x619 | x620 | x621 | x622 | x623 | x624 | x625 | x626 | x627 | x628 | x629 | x630 | x631 | x632 | x633 | x634 | x635 | x636 | x637 | x638 | x639 | x640 | x641 | x642 | x643 | x644 | x645 | x646 | x647 | x648 | x649 | x650 | x651 | x652 | x653 | x654 | x655 | x656 | x657 | x658 | x659 | x660 | x661 | x662 | x663 | x664 | x665 | x666 | x667 | x668 | x669 | x670 | x671 | x672 | x673 | x674 | x675 | x676 | x677 | x678 | x679 | x680 | x681 | x682 | x683 | x684 | x685 | x686 | x687 | x688 | x689 | x690 | x691 | x692 | x693 | x694 | x695 | x696 | x697 | x698 | x699 | x700 | x701 | x702 | x703 | x704 | x705 | x706 | x707 | x708 | x709 | x710 | x711 | x712 | x713 | x714 | x715 | x716 | x717 | x718 | x719 | x720 | x721 | x722 | x723 | x724 | x725 | x726 | x727 | x728 | x729 | x730 | x731 | x732 | x733 | x734 | x735 | x736 | x737 | x738 | x739 | x740 | x741 | x742 | x743 | x744 | x745 | x746 | x747 | x748 | x749 | x750 | x751 | x752 | x753 | x754 | x755 | x756 | x757 | x758 | x759 | x760 | x761 | x762 | x763 | x764 | x765 | x766 | x767 | x768 | x769 | x770 | x771 | x772 | x773 | x774 | x775 | x776 | x777 | x778 | x779 | x780 | x781 | x782 | x783 | x784 | x785 | x786 | x787 | x788 | x789 | x790 | x791 | x792 | x793 | x794 | x795 | x796 | x797 | x798 | x799 | x800 | x801 | x802 | x803 | x804 | x805 | x806 | x807 | x808 | x809 | x810 | x811 | x812 | x813 | x814 | x815 | x816 | x817 | x818 | x819 | x820 | x821 | x822 | x823 | x824 | x825

8. Edit the 'Pt Outreach' section accordingly. Click the 'Close' button to submit it.
 - a. Note: for the 'Pt Outreach' section, you can enter 'Hypertension' as the topic you contacted the patient about. If you scheduled a follow-up call, you can also note that in the 'Next Contact' box.

The screenshot displays the EpicCare EMR interface for a patient named Laurrette Espinoza-Hernandez. The 'Pt Outreach' section is active, showing a list of contacts and a 'Track Pt Outreach' button. A red arrow points to the 'Track Pt Outreach' button. The 'Track Pt Outreach' section includes fields for 'Contacted via' (Telephone), 'Contacted about' (Hypertension), and 'Next contact'. The 'Reason for Call' section shows 'This is a test' and 'FGP Hypertension Initiative'. The 'Call Cannot be Completed' section shows 'New Reading' and 'No data found'. The 'Demographics' section is also visible.

10/18/2024 visit with Laurrette Espinoza-Hernandez for Patient Outreach

Contacts

Incoming Call Outgoing Call Other Show Permanent Comments My Quick Buttons

No contacts

You can use this button to the upper left to add an item to the list.

Reason for Call

This is a test 10/18/2024 This is a test

FGP Hypertension Initiative 10/18/2024 This is a test

Track Pt Outreach

Contacted via Telephone In Person Mail MyChart Telephone

Contacted about Add Hypertension

Next contact

Restore Close Previous Next

Call Cannot be Completed

New Reading

No data found.

Demographics

History

Medical History

Diagnosis Date Comment Source

Hypertension

Infertility male

Low sperm count

Surgical History

No past surgical history on file.

Family History

Problem Relation Age of Onset Comments Pedigree

Hypertension Father

Family Status

Relation Status

Mother Alive

Father Alive

COPO

Tobacco Use

Never smoked or used smokeless tobacco.

Vaping Use

Never used

Alcohol Use

No.

Drug Use

No.

Sexual Activity

Sexually active; Partners: Female.

Employment History

No employment history on file.

Family and Education

9. Once encounter note is finalized, simply exit out of the patient's account. The encounter note should now be posted on the patient's chart review.

Participant RBPM Set-up Support Form

○ To be filled out by a CHW

1. CHW facilitated patient receiving a remote blood pressure monitor + RBPM patient packet + project flyer
(if by mail, confirm address/update on RBPM Tracking Form in the research drive).

Encounter Type:

- In Person
- By Phone

Length of encounter: _____ minutes

Outcome:

- Complete - Via Mailing
 - BP Monitor number
 - Mailed by
 - Date mailed
 - Date materials were received by participant
- Complete - Via Pick-up at the clinic
 - BP Monitor number
 - Provided by
 - Date picked up
- Follow-up Required
- [IF follow-up required]:
 - [Schedule Follow-up call 1]:
 - Date: ____
 - Time: ____
 - Select follow-up needed (select all that apply):
 - Patient did not receive materials (Note: If patient did not receive materials by mail, check tracking number and follow-up with patient)
 - Other (describe) _____
 - [Begin Follow-up call 1]
 - Date
 - Time
 - Encounter type:
 - In-person
 - By phone
 - Text message
 - Follow-up call 1: Outcome
 - 1, Complete –
 - Via Mailing
 - BP Monitor number
 - Mailed by
 - Date mailed
 - Date materials were received by participant
 - 2, Complete - Via Pick-up at the clinic
 - BP Monitor number
 - Provided by
 - Date picked up
 - 2, In-process (additional follow-up required)
 - 3, Other (describe)
 - Follow-up call 1 notes: _____

Participant Forms for Pilot Study

Version 3.6.2024

- [IF additional follow-up required]:
 - [Schedule Follow-up call 2]:
 - Date: ____
 - Time: ____
 - Select follow-up needed (select all that apply):
 - Patient did not receive materials (Note: If patient did not receive materials by mail, check tracking number and follow-up with patient)
 - Other (describe) _____
 - [Begin Follow-up call 2]
 - Date
 - Time
 - Encounter type:
 - In-person
 - By phone
 - Text message
 - Follow-up call 2: Outcome
 - 1, Complete
 - Via Mailing
 - BP Monitor number
 - Mailed by
 - Date mailed
 - Date materials were received by participant
 - Via Pick-up at the clinic
 - BP Monitor number
 - Provided by
 - Date picked up
 - 2, In-process (additional follow-up required)
 - 3, Other (describe)
 - Follow-up call 2 notes: _____
- [IF additional follow-up required]:
 - [Schedule Follow-up call 3]:
 - Date: ____
 - Time: ____
 - Select follow-up needed (select all that apply):
 - Patient did not receive materials (Note: If patient did not receive materials by mail, check tracking number and follow-up with patient)
 - Other (describe) _____
 - [Begin Follow-up call 3]
 - Date
 - Time
 - Encounter type:
 - In-person
 - By phone
 - Text message
 - Follow-up call 3: Outcome
 - 1, Complete
 - Via Mailing
 - BP Monitor number
 - Mailed by
 - Date mailed

- Date materials were received by participant
 - Via Pick-up at the clinic
 - BP Monitor number
 - Provided by
 - Date picked up
 - 2, In-process (additional follow-up required)
 - 5, Do not call back – call limit reached
 - 3, Other (describe)
 - Follow-up call 3 notes: _____
- [IF additional follow-up required]:
 - [Schedule Follow-up call 4]:
 - Date: ____
 - Time: ____
 - Select follow-up needed (select all that apply):
 - Patient did not receive materials (Note: If patient did not receive materials by mail, check tracking number and follow-up with patient)
 - Other (describe) _____
 - [Begin Follow-up call 4]
 - Date
 - Time
 - Encounter type:
 - In-person
 - By phone
 - Text message
 - Follow-up call 4: Outcome
 - 1, Complete
 - Via Mailing
 - BP Monitor number
 - Mailed by
 - Date mailed
 - Date materials were received by participant
 - Via Pick-up at the clinic
 - BP Monitor number
 - Provided by
 - Date picked up
 - 2, In-process (additional follow-up required)
 - 3, Other (describe)
 - Follow-up call 4 notes: _____
- [IF additional follow-up required]:
 - [Schedule Follow-up call 5]:
 - Date: ____
 - Time: ____
 - Select follow-up needed (select all that apply):
 - Patient did not receive materials (Note: If patient did not receive materials by mail, check tracking number and follow-up with patient)
 - Other (describe) _____
 - [Begin Follow-up call 5]
 - Date
 - Time
 - Encounter type:

- In-person
 - By phone
 - Text message
- Follow-up call 5: Outcome
 - 1, Complete
 - Via Mailing
 - BP Monitor number
 - Mailed by
 - Date mailed
 - Date materials were received by participant
 - Via Pick-up at the clinic
 - BP Monitor number
 - Provided by
 - Date picked up
 - 2, In-process (additional follow-up required)
 - 3, Other (describe)
- Follow-up call 5 notes: _____
- [IF additional follow-up required]:
 - [Schedule Follow-up call 6]:
 - Date: ____
 - Time: ____
 - Select follow-up needed (select all that apply):
 - Patient did not receive materials (Note: If patient did not receive materials by mail, check tracking number and follow-up with patient)
 - Other (describe) _____
- [Begin Follow-up call 6]
 - Date
 - Time
 - Encounter type:
 - In-person
 - By phone
 - Text message
- Follow-up call 6: Outcome
 - 1, Complete
 - Via Mailing
 - BP Monitor number
 - Mailed by
 - Date mailed
 - Date materials were received by participant
 - Via Pick-up at the clinic
 - BP Monitor number
 - Provided by
 - Date picked up
 - 2, In-process (additional follow-up required)
 - 5, Do not call back – call limit reached
 - 3, Other (describe)
- Follow-up call 6 notes: _____
- Notes: _____

Participant Forms for Pilot Study

Version 3.6.2024

1. CHW provided assistance with remote BP monitoring set-up via Bluetooth:

Encounter Type:

- In Person
- By Phone

Outcome:

- Complete
 - Date completed
 - Provided by
 - Length of encounter: _____ minutes
- N/A – Patient did not need assistance setting up BP monitoring via Bluetooth, and CHW confirmed set-up is complete.
- Follow-up Required
- [IF follow-up required]:
 - [Schedule Follow-up call 1]:
 - Date: ____
 - Time: ____
 - Describe follow-up needed: ____
 - [Begin Follow-up call 1]
 - Date
 - Time
 - Encounter type:
 - In-person
 - By phone
 - Text message
 - Follow-up call 1: Outcome
 - 1, Complete
 - Date completed
 - Provided by
 - Length of encounter: _____ minutes
 - 2, In-process (additional follow-up required)
 - 3, Other (describe)
 - Follow-up call 1 notes: ____
- [IF additional follow-up required]:
 - [Schedule Follow-up call 2]:
 - Date: ____
 - Time: ____
 - Describe follow-up needed: ____
 - [Begin Follow-up call 2]
 - Date
 - Time
 - Encounter type:
 - In-person
 - By phone
 - Text message
 - Follow-up call 2: Outcome
 - 1, Complete
 - Date completed
 - Provided by

- Length of encounter: _____ minutes
 - 2, In-process (additional follow-up required)
 - 3, Other (describe)
- Follow-up call 2 notes: _____
- [IF additional follow-up required]:
 - [Schedule Follow-up call 3]:
 - Date: ____
 - Time: ____
 - Describe follow-up needed: _____
 - [Begin Follow-up call 3]
 - Date
 - Time
 - Encounter type:
 - In-person
 - By phone
 - Text message
 - Follow-up call 3: Outcome
 - 1, Complete
 - Date completed
 - Provided by
 - Length of encounter: _____ minutes
 - 2, In-process (additional follow-up required)
 - 5, Do not call back – call limit reached
 - 3, Other (describe)
 - Follow-up call 3 notes: _____
- [IF additional follow-up required]:
 - [Schedule Follow-up call 4]:
 - Date: ____
 - Time: ____
 - Describe follow-up needed: _____
 - [Begin Follow-up call 4]
 - Date
 - Time
 - Encounter type:
 - In-person
 - By phone
 - Text message
 - Follow-up call 4: Outcome
 - 1, Complete
 - Date completed
 - Provided by
 - Length of encounter: _____ minutes
 - 2, In-process (additional follow-up required)
 - 3, Other (describe)
 - Follow-up call 4 notes: _____
- [IF additional follow-up required]:
 - [Schedule Follow-up call 5]:
 - Date: ____
 - Time: ____

Participant Forms for Pilot Study

Version 3.6.2024

- Describe follow-up needed: _____
- [Begin Follow-up call 5]
 - Date
 - Time
 - Encounter type:
 - In-person
 - By phone
 - Text message
- Follow-up call 5: Outcome
 - 1, Complete
 - Date completed
 - Provided by
 - Length of encounter: _____ minutes
 - 2, In-process (additional follow-up required)
 - 3, Other (describe)
- Follow-up call 5 notes: _____
- [IF additional follow-up required]:
 - [Schedule Follow-up call 6]:
 - Date: _____
 - Time: _____
 - Describe follow-up needed: _____
 - [Begin Follow-up call 6]
 - Date
 - Time
 - Encounter type:
 - In-person
 - By phone
 - Text message
 - Follow-up call 6: Outcome
 - 1, Complete
 - Date completed
 - Provided by
 - Length of encounter: _____ minutes
 - 2, In-process (additional follow-up required)
 - 5, Do not call back – call limit reached
 - 3, Other (describe)
- Follow-up call 6 notes: _____
- Notes: _____

2. CHW demonstrated proper use of the blood pressure monitor

Encounter Type:

- In Person
- By Phone

Outcome:

- Complete
 - Remote Demonstration/Instruction
 - Date completed

- Method
 - Emailed
 - Mailed
 - Provided by
 - Length of encounter: _____ minutes
- In-Person Demonstration/Instruction
 - Date completed
 - Provided by
 - Length of encounter: _____ minutes
- Follow-up Required
- [IF follow-up required]:
 - a. [Schedule Follow-up call 1]:
 - i. Date: ____
 - ii. Time: ____
 - b. Describe follow-up needed: ____
 - c. [Begin Follow-up call 1]
 - i. Date
 - ii. Time
 - iii. Encounter type:
 - 1. In-person
 - 2. By phone
 - 3. Text message
 - d. Follow-up call 1: Outcome
 - i. 1, Complete
 - 1. Remote Demonstration/Instruction
 - a. Date completed
 - b. Method
 - i. Emailed
 - ii. Mailed
 - c. Provided by
 - d. Length of encounter: _____ minutes
 - 2. In-Person Demonstration/Instruction
 - a. Date completed
 - b. Provided by
 - c. Length of encounter: _____ minutes
 - ii. 2, In-process (additional follow-up required)
 - iii. 3, Other (describe)
 - e. Follow-up call 1 notes: _____
- [IF additional follow-up required]:
 - a. [Schedule Follow-up call 2]:
 - i. Date: ____
 - ii. Time: ____
 - b. Describe follow-up needed: ____
 - c. [Begin Follow-up call 2]
 - i. Date
 - ii. Time
 - iii. Encounter type:
 - 1. In-person
 - 2. By phone
 - 3. Text message

- d. Follow-up call 2: Outcome
 - i. 1, Complete
 - 1. Remote Demonstration/Instruction
 - a. Date completed
 - b. Method
 - i. Emailed
 - ii. Mailed
 - c. Provided by
 - d. Length of encounter: _____ minutes
 - 2. In-Person Demonstration/Instruction
 - a. Date completed
 - b. Provided by
 - c. Length of encounter: _____ minutes
 - ii. 2, In-process (additional follow-up required)
 - iii. 3, Other (describe)
 - e. Follow-up call 2 notes: _____
- o [IF additional follow-up required]:
 - a. [Schedule Follow-up call 3]:
 - i. Date: ____
 - ii. Time: ____
 - b. Describe follow-up needed: _____
 - c. [Begin Follow-up call 3]
 - i. Date
 - ii. Time
 - iii. Encounter type:
 - 1. In-person
 - 2. By phone
 - 3. Text message
- d. Follow-up call 3: Outcome
 - i. 1, Complete
 - 1. Remote Demonstration/Instruction
 - a. Date completed
 - b. Method
 - i. Emailed
 - ii. Mailed
 - c. Provided by
 - d. Length of encounter: _____ minutes
 - 2. In-Person Demonstration/Instruction
 - a. Date completed
 - b. Provided by
 - c. Length of encounter: _____ minutes
 - ii. 2, In-process (additional follow-up required)
 - iii. 5, Do not call back – call limit reached
 - iv. 3, Other (describe)
- e. Follow-up call 3 notes: _____
- o [IF additional follow-up required]:
 - a. [Schedule Follow-up call 4]:
 - i. Date: ____
 - ii. Time: ____
 - b. Describe follow-up needed: _____

- c. [Begin Follow-up call 4]
 - i. Date
 - ii. Time
 - iii. Encounter type:
 - 1. In-person
 - 2. By phone
 - 3. Text message
 - d. Follow-up call 4: Outcome
 - i. 1, Complete
 - 1. Remote Demonstration/Instruction
 - a. Date completed
 - b. Method
 - i. Emailed
 - ii. Mailed
 - c. Provided by
 - d. Length of encounter: _____ minutes
 - 2. In-Person Demonstration/Instruction
 - a. Date completed
 - b. Provided by
 - c. Length of encounter: _____ minutes
 - ii. 2, In-process (additional follow-up required)
 - iii. 3, Other (describe)
 - e. Follow-up call 4 notes: _____
- [IF additional follow-up required]:
 - a. [Schedule Follow-up call 5]:
 - i. Date: ____
 - ii. Time: ____
 - b. Describe follow-up needed: _____
 - c. [Begin Follow-up call 5]
 - i. Date
 - ii. Time
 - iii. Encounter type:
 - 1. In-person
 - 2. By phone
 - 3. Text message
 - d. Follow-up call 5: Outcome
 - i. 1, Complete
 - 1. Remote Demonstration/Instruction
 - a. Date completed
 - b. Method
 - i. Emailed
 - ii. Mailed
 - c. Provided by
 - d. Length of encounter: _____ minutes
 - 2. In-Person Demonstration/Instruction
 - a. Date completed
 - b. Provided by
 - c. Length of encounter: _____ minutes
 - ii. 2, In-process (additional follow-up required)
 - iii. 3, Other (describe)

Participant Forms for Pilot Study

Version 3.6.2024

- e. Follow-up call 5 notes: _____
 - [IF additional follow-up required]:
 - a. [Schedule Follow-up call 6]:
 - i. Date: _____
 - ii. Time: _____
 - b. Describe follow-up needed: _____
 - c. [Begin Follow-up call 6]
 - i. Date
 - ii. Time
 - iii. Encounter type:
 - 1. In-person
 - 2. By phone
 - 3. Text message
 - d. Follow-up call 6: Outcome
 - i. 1, Complete
 - 1. Remote Demonstration/Instruction
 - a. Date completed
 - b. Method
 - i. Emailed
 - ii. Mailed
 - c. Provided by
 - d. Length of encounter: _____ minutes
 - 2. In-Person Demonstration/Instruction
 - a. Date completed
 - b. Provided by
 - c. Length of encounter: _____ minutes
 - ii. 2, In-process (additional follow-up required)
 - iii. 5, Do not call back – call limit reached
 - iv. 3, Other (describe)
- Follow-up call 6 notes: _____
-
- Notes _____

1. What days and times are you available to participate in phone calls with the CHW?

Please check the days/write in the times below.

Day	☐ Sunday		☐ Monday		☐ Tuesday		☐ Wednesday		☐ Thursday		☐ Friday		☐ Saturday	
	From	To	From	To	From	To	From	To	From	To	From	To	From	To
	AM	AM	AM	AM	AM	AM	AM	AM	AM	AM	AM	AM	AM	AM
	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM

Notes:

Next meeting scheduled for: Date: mm/dd/yyyy

Time: __:__

- By Phone
- In person

- **Participant Referrals Form**
- *To be filled out by a CHW*

REDCap ID: _____

CHW Initials: _____

Encounter Date: mm/dd/yyyy

Encounter Type:

- In Person
- By Phone

Was this patient referred to the CHW by the nurse or practice?

- Yes
 - Referred by
 - Referral date:
 - Referral reason: _____
- No

Was there a referral need indicated by nurse SDOH screener?

Y/N

Referrals Needs

I would like to ask you some questions about how you are doing and if you need assistance with any referrals to community resources or services. Do I have your permission to proceed?

1. Have you needed help or had any problems with any of the following in the last 12 months?

If yes, specify if this is a current problem.

a. Getting healthcare / finding a doctor	Yes	Current	No
b. Refilling/getting my medication or anything Over-The-Counter (OTC)	Yes	Current	No
c. Emergency services (EMS, Fire, Police)	Yes	Current	No
d. Getting Internet/Wi-Fi access for home schooling, to access services, or apply for benefits	Yes	Current	No
e. Having a computer or smartphone to access services	Yes	Current	No
f. Legal assistance	Yes	Current	No
g. Childcare	Yes	Current	No
h. Enrolling children in school (with special accommodations if needed)	Yes	Current	No
i. Homeschooling (for children)	Yes	Current	No
j. Faith-based or spiritual care	Yes	Current	No
k. Other (please specify): _____	Yes	Current	No
l. None of the above	Yes	Current	No

Notes: _____

2. A. Does the participant need any referrals to social services / community resources/healthcare services?

- ☐ Yes
- ☐ No

C. If yes, describe assistance provided by the CHW, as well as any necessary next steps or follow-up:

Length of encounter: _____ minutes

Next meeting scheduled for:

Date: mm/dd/yyyy

Time: ____:____

- ☐ By Phone
- ☐ In person

Notes: _____

- **Participant Goal Setting Form**
- *To be filled out by a CHW*

REDCap ID: _____

CHW Initials: _____

Encounter Date: mm/dd/yyyy

Encounter Type:

- In Person
- By Phone

Participant's BP today: ____ / ____

1) Goal Setting:

A. Why is a healthy lifestyle important to you?

B. What does being healthy mean for you?

C. Have you tried to make healthy changes before? How did that work out? What did you learn?

D. Choose up to 5 goals from the list below that you would like to work on:

Hypertension Management Goals

- Take my medicine
- Lower my BP
- Maintain my BP

Diet/Exercise Goals

- Eat a healthy diet
- Lose weight
- Maintain weight
- Be physically active
- Exercise regularly

Smoking/Alcohol Goals

- Cut down on smoking
- Cut down on alcohol
- Quit smoking
- Quit drinking alcohol

Access Goals

- Access to healthcare
- Access to food
- Access to appropriate housing

- Access (other): Describe _____

Family Goals

- Get help for a family member
- Family goal (other): Describe _____

Employment Goals

- Job readiness skills
- Find/change job

Housing Goals

- Minor housing repairs
- Major housing repairs
- Find housing in a safe area
- Housing goal (other): Describe _____
- Safety

Other goals

- Find a regular doctor
- Improve my overall health
- Cope with stress
- Resolve legal problem
- Other: Describe _____

- E. Now rank the goals you have selected in order of importance, 1 being most important, 5 being least important, starting with the goal that is most important to you (use SMART goals). Write them in the box below.

Goal 1: _____

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #1?

Not	A		Somewhat		Very		Totally	
at all	Little		confident		Confident		Confident	
0	1	2	3	4	5	6	7	8

5a1. In what way, or how is this goal important to you?

Goal 2: _____

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #2?

Not	A		Somewhat		Very		Totally	
at all	Little		confident		Confident		Confident	

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

5a2. In what way, or how is this goal important to you?

Goal 3:

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #3?

Not at all	A Little	Somewhat confident				Very	Totally Confident		Confident	
0	1	2	3	4	5	6	7	8	9	10

5a3. In what way, or how is this goal important to you?

Goal 4:

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #4?

Not at all	A Little	Somewhat confident				Very	Totally Confident		Confident	
0	1	2	3	4	5	6	7	8	9	10

5a3. In what way, or how is this goal important to you?

Goal 5:

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

Participant Forms for Pilot Study

Version 3.6.2024

How confident am I to reach this goal #5?

0	1	2	3	4	5	6	7	8	9	10
	Not		A			Somewhat		Very		Totally
	at all		Little			confident			Confident	Confident

5a3. In what way, or how is this goal important to you?

[CHW to check in on prior referral need]

Length of encounter: _____ minutes

Next meeting scheduled for: Date: mm/dd/yyyy

Time: ____:____

- ☐ By Phone
- ☐ In person

- **Participant Progress Note**
- *To be filled out by a CHW*

REDCap ID: _____

CHW Initials: _____

Encounter Date: mm/dd/yyyy

Encounter Type:

- In Person
- By Phone

Participant's BP today: ____ / ____

Review the current goal-setting form with the participant.

Goal 1: _____

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

Goal 2: _____

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

Goal 3: _____

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

Goal 4: _____

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

Goal 5: _____

What will I do? _____

When will I do it? _____

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How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

1) **Check-in on previous short-term action plans** *Repeat for all plans:*

- a. How did it go with your plan to [Goals 1-5 above]?
- Success - Participant completed or exceeded the plan (go to question 3)
 - Partial Success – Participant completed the plan in part or it is on going
 - No success/Did not try - Participant did not complete any part of the plan
- b. If goal was “Partial Success” or “No Success/Did not try”: What challenge(s) are you facing? (Check all that apply)
- Plan was too hard
 - Lack of time/conflicted with schedule
 - Own illness/injury/pain
 - Weather related
 - Other: _____
- c. Describe solutions to address each challenge

2) Development of new short-term action plans

- **If “Success” (5/5 goals completed):** Great job achieving your goals! Let’s create a new plan for the next two weeks. What do you think about making some changes to be even healthier?
- **If “Partial Success” (1/5 – 4/5 goals completed):** Good try with your last plan. Let’s create a new plan for the next two weeks. What do you think about making some changes to improve your chance for better success this time? **(Rework to address barriers)**
- **If “No Success/Did not try” (0/5 goals completed):** I’m sorry it didn’t work out with your last plan. Let’s create a new plan for the next two weeks. What do you think about making some changes to improve your chance for better success this time? **(Re-work plan to address barriers)**

Over the next month, the participant will focus on the following goals:

Goal 1: _____

What will I do? _____

When will I do it? _____

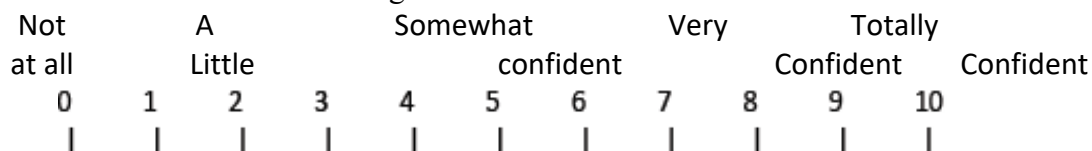
Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #3?



5a3. In what way, or how is this goal important to you?

Goal 2: _____

What will I do? _____

Participant Forms for Pilot Study

Version 3.6.2024

When will I do it? _____

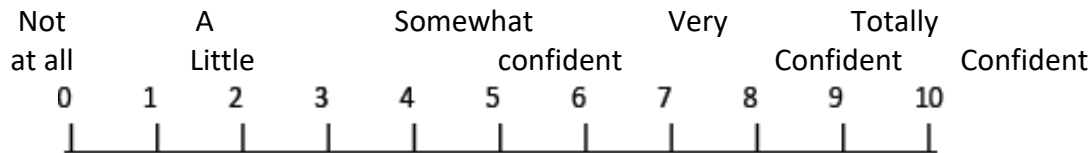
Where will I do it? _____

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What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #3?



5a3. In what way, or how is this goal important to you?

Goal 3:

What will I do? _____

When will I do it? _____

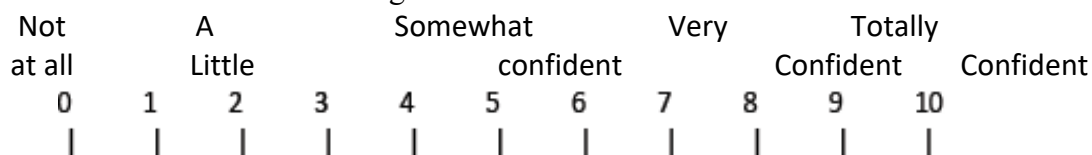
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What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #3?



5a3. In what way, or how is this goal important to you?

Goal 4:

What will I do? _____

When will I do it? _____

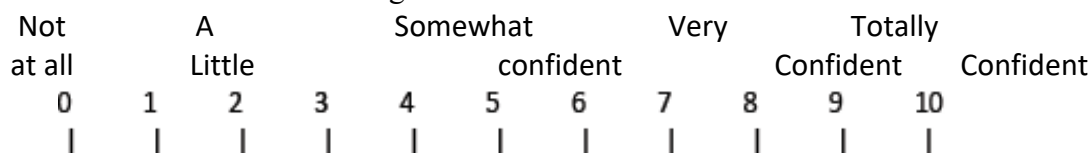
Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #3?



5a3. In what way, or how is this goal important to you?

Goal 5: _____

What will I do? _____

When will I do it? _____

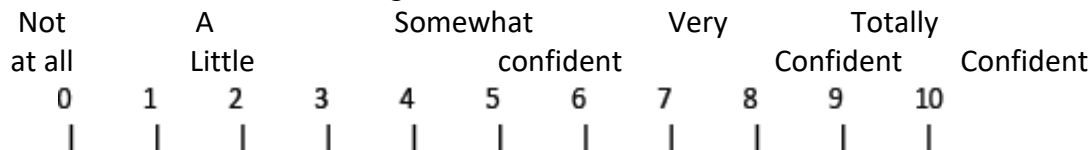
Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #3?



5a3. In what way, or how is this goal important to you?

Referrals Needs

2. A. Does the participant need any referrals to social services / community resources/healthcare services?

- ☐ Yes
- ☐ No

B. If yes, which kind (check all):

- ☐ Health Insurance- Medicaid/Medicare
- ☐ Primary care physician appointment scheduling
- ☐ Primary care physician referral
- ☐ Housing services
- ☐ Childcare/Child Education Services
- ☐ Food bank / SNAP access
- ☐ Unemployment Assistance
- ☐ Transportation Services (Access a Ride)
- ☐ YMCA/ Fitness center
- ☐ Other: _____

C. If yes, describe assistance provided by the CHW, as well as any necessary next steps or follow-up:

Length of encounter: _____ minutes

Next meeting scheduled for: Date: mm/dd/yyyy

Time: ____:____

- ☐ By Phone
- ☐ In person

Participant Encounter Form
To be filled out by a CHW

REDCap ID: _____

CHW Initials: _____

Encounter Date: mm/dd/yyyy

Encounter Type:

- ☐ In Person
- ☐ By Phone

Participant's BP today: ____ / ____

1. Encounter Purpose: *Check if relevant:*

- ☐ Participant requested support with home blood pressure monitoring
- ☐ Participant requested assistance with MyChart
- ☐ Participant requested other technology-related support
- ☐ Participant has very high or low blood pressure
- ☐ Participant requested health information on blood pressure control
- ☐ Participant requested health information on other conditions (please specify: _____)
- ☐ Participant requested doctor referral
- ☐ Participant requested help scheduling a PCP appointment
- ☐ Participant reported a new illness or diagnosis
- ☐ Participant reported a medical procedure
- ☐ Participant needs food bank information
- ☐ Participant requested unemployment assistance
- ☐ Participant requested housing assistance
- ☐ Participant needs other public assistance
- ☐ Other (please specify) _____

2. Describe what occurred or what was discussed. (eg. Patient called to ask about..., Patient was measured to have very high or low blood pressure etc.)

3. Describe the actions taken or recommendations provided by the CHW.

4. Describe the outcome(s).

5. Describe the follow-up plan.

Referrals Needs

6. A. Does the participant need any referrals to social services / community resources?

- ☐ Yes
- ☐ No

B. If yes, which kind (check all):

- ☐ Health Insurance- Medicaid/Medicare
- ☐ Housing services
- ☐ Childcare/ Child Education Services

Participant Forms for Pilot Study

Version 3.6.2024

- ☐ Food bank / SNAP Access
- ☐ Unemployment Assistance
- ☐ Transportation Services (Access a Ride)
- ☐ YMCA/ Fitness center
- ☐ Primary care physician referral
- ☐ Other: _____

C. If yes, describe assistance provided by the CHW, as well as any necessary next steps or follow-up:

Length of encounter: _____ minutes

Next meeting scheduled for: Date: mm/dd/yyyy

Time: ____:____

- ☐ By Phone
- ☐ In person

Notes _____

6. CHW Check In- Virtual Visit #1
To be filled out by a CHW

REDCap ID: _____

CHW Initials: _____

Encounter Date: mm/dd/yyyy

Encounter Type:

- ☐ In Person
- ☐ By Phone

Participant's BP today: ____ / ____

Review the current goal-setting form and/or most recent progress note with the participant.

Goal 1: _____

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

Goal 2: _____

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

Goal 3: _____

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

Goal 4: _____

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

Goal 5: _____

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

1) Check-in on previous short-term action plans *Repeat for all plans:*

- a. How did it go with your plan to [Goals 1-5 above]?
- Success- Participant completed or exceeded the plan (go to question 3)
 - Partial Success – Participant completed the plan in part or it is on going
 - No success/Did not try- Participant did not complete any part of the plan
- b. If goal was “Partial Success” or “No Success/Did not try”: What challenge(s) are you facing? (Check all that apply)
- Plan was too hard
 - Lack of time/conflicted with schedule
 - Own illness/injury/pain
 - Weather related
 - Other: _____
- c. Describe solutions to address each challenge

2) Development of new short-term action plans

- **If “Success” (5/5 goals completed):** *Great job achieving your goals! Let’s create a new plan for the next two weeks. What do you think about making some changes to be even healthier?*
- **If “Partial Success” (1/5-4/5 goals completed):** *Good try with your last plan. Let’s create a new plan for the next two weeks. What do you think about making some changes to improve your chance for better success this time? (Rework to address barriers)*
- **If “No Success/Did not try” (0/5 goals completed):** *I’m sorry it didn’t work out with your last plan. Let’s create a new plan for the next two weeks. What do you think about making some changes to improve your chance for better success this time? (Re-work plan to address barriers)*

Over the next month, the participant will focus on the following goals:

Goal 1: _____

What will I do? _____

When will I do it? _____

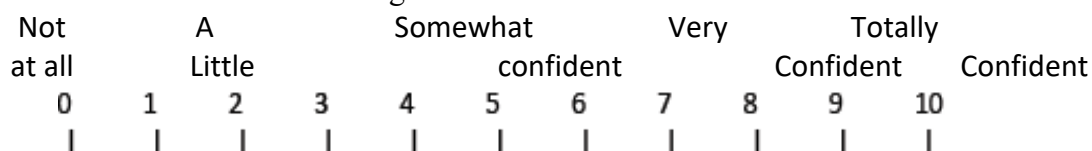
Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #1?



5a3. In what way, or how is this goal important to you?

Goal 2: _____

What will I do? _____

Participant Forms for Pilot Study

Version 3.6.2024

When will I do it? _____

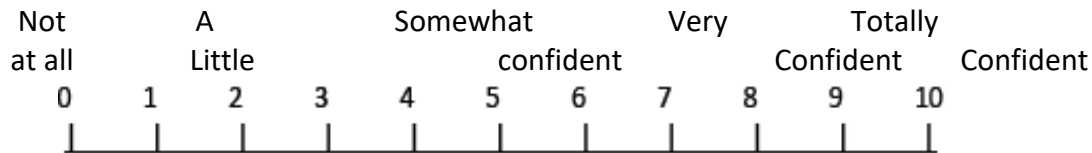
Where will I do it? _____

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What might get in the way of my plan? _____

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Goal 3: _____

What will I do? _____

When will I do it? _____

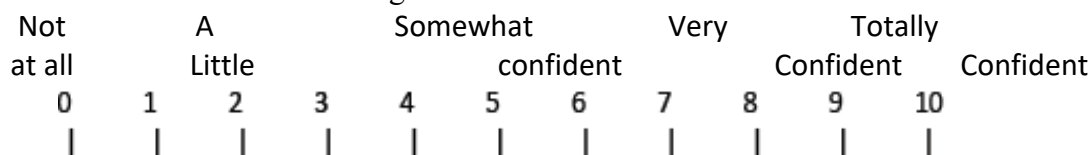
Where will I do it? _____

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What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #1?



5a3. In what way, or how is this goal important to you?

Goal 4: _____

What will I do? _____

When will I do it? _____

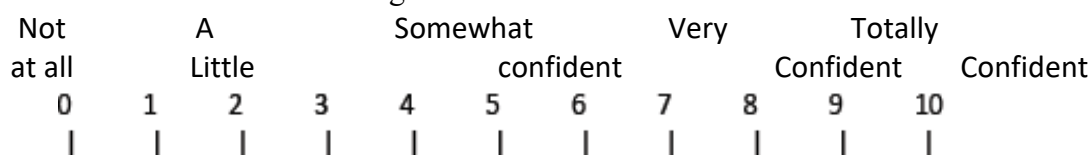
Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #1?



5a3. In what way, or how is this goal important to you?

Goal 5: _____

What will I do? _____

When will I do it? _____

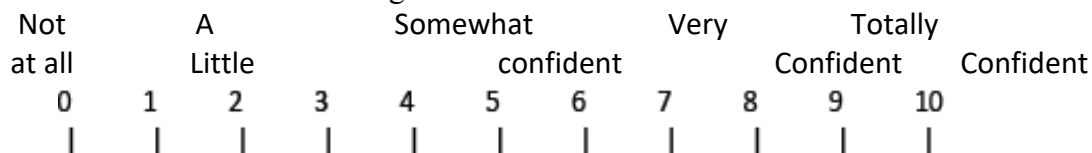
Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #1?



5a3. In what way, or how is this goal important to you?

One-on One Discussion Topic: [Medication Management]

1. Did the participant share labels or photos of their medications with the CHW today?

- ☐ No
☐ Yes

a. Did the CHW review medications with the participant? ☐ Yes ☐ No

2. Did the participant report any challenges with medication management? (select all that apply)

- ☐ No challenges
☐ Don't need it /feel fine
☐ Too complicated
☐ Too expensive
☐ Trouble remembering
☐ Makes me feel sick /side effects
☐ Can't understand/read label
☐ Embarrassed
☐ Other: _____

3. Did the participant report doing any of the following: (select all that apply)

- ☐ Skipping doses when feeling fine
☐ Adjusting doses
☐ Sharing medication with others
☐ None of the above

4. What recommendations did the CHW make to the participant? (select all that apply)

- ☐ Do not skip or stop taking medicine on your own Take as directed
☐ Do not lower dose on your own – Take as directed
☐ Do not share medication
☐ Talk to doctor about side effects, adjusting dosage, or other concerns about medication
☐ Take your medication at the same time every day
☐ Use a pillbox

- ☐ Ask doctor if there are lower-cost generic options
- ☐ Find out about refill options
- ☐ Have a healthy diet and regular physical activity to help medication work better
- ☐ Other: _____
- ☐ No recommendations made.

Shift and Persist/Racial Discrimination Discussion

- 1) Have you recently experienced a high stressful situation Yes/No
- a. If yes, were you able to shift your attention? Yes/No
- i. Can you tell me a little bit more about that?
- _____

Referrals Needs

1. A. Does the participant need any referrals to social services / community resources/healthcare services?
- ☐ Yes
 - ☐ No
- B. If yes, which kind (check all):
- ☐ Health Insurance- Medicaid/Medicare
 - ☐ Primary care physician appointment scheduling
 - ☐ Primary care physician referral
 - ☐ Housing services
 - ☐ Childcare/ Child Education Services
 - ☐ Food bank / SNAP access
 - ☐ Unemployment Assistance
 - ☐ Transportation Services (Access a Ride)
 - ☐ YMCA/ Fitness center
 - ☐ Other: _____
- C. If yes, describe assistance provided by the CHW, as well as any necessary next steps or follow-up:
- _____
- _____
- _____

Length of encounter: _____ minutes

Next meeting scheduled for: Date: mm/dd/yyyy Time: ____:____

- ☐ By Phone
- ☐ In person

7. CHW Check-In Visit Virtual Visit #2

○ To be filled out by a CHW

REDCap ID: _____

CHW Initials: _____

Encounter Date: mm/dd/yyyy

Encounter Type:

- In Person
- By Phone

Participant's BP today: ____ / ____

Review the current and/or most recent check-in goal-setting form with the participant.

Goal 1:

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

Goal 2:

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

Goal 3:

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

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Goal 4:

What will I do? _____

When will I do it? _____

Where will I do it? _____

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Goal 5:

What will I do? _____

When will I do it? _____

Where will I do it? _____

How often will I do it? _____

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1) Check-in on previous short-term action plans *Repeat for all plans:*

- a. How did it go with your plan to [Goals 1-5 above]?
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2) Development of new short-term action plans

- **If “Success” (5/5 goals completed):** *Great job achieving your goals! Let’s create a new plan for the next two weeks. What do you think about making some changes to be even healthier?*
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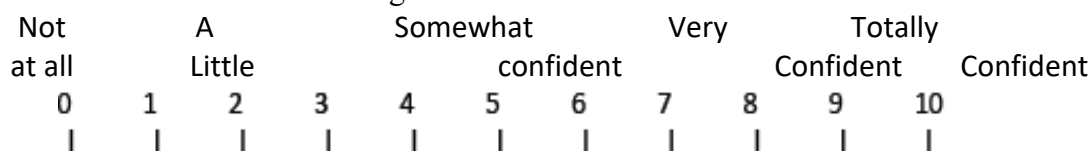
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What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #1?



5a3. In what way, or how is this goal important to you?

Goal 2: _____

What will I do? _____

Participant Forms for Pilot Study

Version 3.6.2024

When will I do it? _____

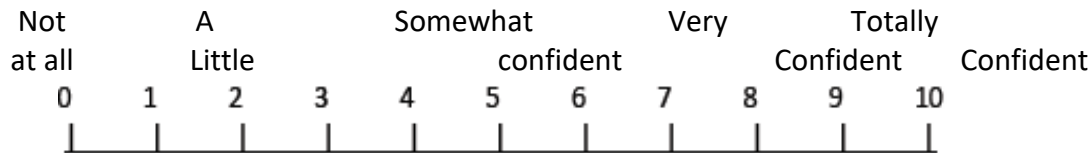
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5a3. In what way, or how is this goal important to you?

Goal 3:

What will I do? _____

When will I do it? _____

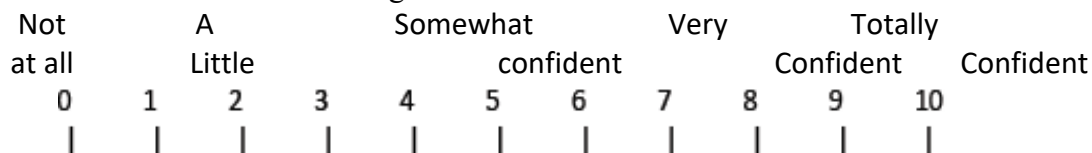
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5a3. In what way, or how is this goal important to you?

Goal 4:

What will I do? _____

When will I do it? _____

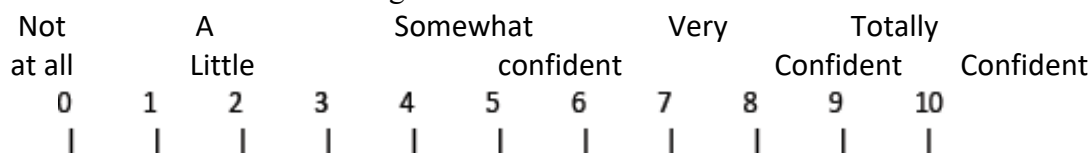
Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #1?



5a3. In what way, or how is this goal important to you?

Goal 5: _____

What will I do? _____

When will I do it? _____

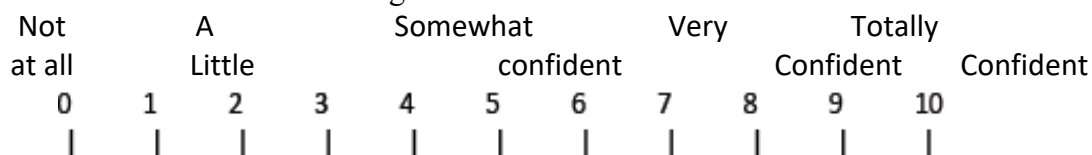
Where will I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What can I do about it? _____

How confident am I to reach this goal #1?



5a3. In what way, or how is this goal important to you?

Shift and Persist/Racial Discrimination Discussion

- 2) Have you recently experienced a high stressful situation Yes/No
- a. If yes, were you able to shift your attention? Yes/No
- i. Can you tell me a little bit more about that?

Referrals Needs

3. A. Does the participant need any referrals to social services / community resources or healthcare services?

- a. Yes
- b. No

B. If yes, which kind (check all):

- ☐ Health Insurance- Medicaid/Medicare
- ☐ Primary care physician appointment scheduling
- ☐ Primary care physician referral
- ☐ Housing services
- ☐ Childcare/ Child Education Services
- ☐ Food bank / SNAP access
- ☐ Unemployment Assistance
- ☐ Transportation Services (Access a Ride)
- ☐ YMCA/ Fitness center
- ☐ Other: _____

C. If yes, describe assistance provided by the CHW, as well as any necessary next steps or follow-up:

Check-in Discussion Topic: [Hypertension Management]

1. Describe what was discussed.

2. Describe the actions taken or recommendations provided by the CHW.

3. Describe the follow-up plan.

Length of encounter: _____ minutes

Next meeting scheduled for: Date: mm/dd/yyyy

Time: ____: ____

- ☐ By Phone
- ☐ In person

Script for FGP Hypertension Initiative Onboarding Follow-Up Call (TAU)

Program staff member to call patient within 24 hours after CHW introductory call is completed.

Greeting: Hi, my name is _____, calling from NYU Langone Health. Am I speaking with Mr./Ms. _____?

IF NO:

Is Mr./Ms. _____ available?

- IF STILL NO:
Please let them know NYU Langone Health called. My number is xxx-xxx-xxxx. I will reach out again and send a message via MyChart. Thank you!

IF YES:

Great! I'm following up on your recent visit with [provider's name], who recommended that you continue your high blood pressure care through the Hypertension Initiative's blood pressure monitoring program. I know you also had a chance to speak with [CHW's name], for a quick introduction to what the program's about. The purpose of my call is to go over program details and confirm whether you would like to enroll in this program. Is now a good time to talk?

- IF NO: No problem! Is there a better day/time for me to call back?
- IF YES: I'll call on [day] at [time]. Please feel free to reach me anytime at xxx-xxx-xxxx.
- If no further availability:* Feel free to call me anytime. Have a great day!

IF YES:

Great! Thank you for your willingness to hear more about the Hypertension Initiative! The goal of this program is to provide you with tools and support to manage your blood pressure. Let's go over the details and answer any other questions you may have.

Program Overview:

In this program, alongside our dedicated team and your provider, you'll be:

1. Monitoring your blood pressure from home with a device provided by NYU.

Confirm if pt received BP monitor during clinic visit / check RBPM tracking spreadsheet

Regularly checking your blood pressure at home can help you better understand your numbers and share important information with your provider and care team. You will use your monitor to take your blood pressure readings twice a day, Monday through Friday. In this program, our goal is to help you determine your true blood pressure, which may be different from when you take your blood pressure at the doctor's office. One way we can help you control your blood pressure is by learning about your blood pressure pattern. This is why we ask patients to regularly take their blood pressure in the morning and evening. If you have a high blood pressure reading, do not panic! We are to help and that is why you're joining this program – to lower it! You should make sure to upload ALL your blood pressure readings - even if they are high. Keep in mind that there is no such thing as being 'perfect' in this program. You can be a

Commented [EHL1]: Will provide more detailed instructions later during call.

work in progress on a journey to get healthier. The goal in this program is to teach you how to effectively manage your blood pressure.

2. Having monthly phone calls with a nurse case manager.

During your calls with a nurse, they will review your blood pressure readings and provide counseling on how to improve your blood pressure. They will also ask you a few questions about your basic needs to determine if you would benefit from referrals to community resources. If so, they will refer you to social and health services to help meet your needs.

This program is provided by NYU at no cost. The calls you'd have with your nurse would be billed like a regular doctor's visit and should be covered by your health insurance.

And that's basically it! If you choose to enroll in this program, please keep in mind that you would be agreeing to do your best to provide a minimum of 8 BP readings per week using the NYU monitor.

Verbal agreement: Now that you know this information, would you like to proceed with enrolling in this program?

IF NO: I'm sorry to hear that. We would really appreciate your feedback. Could you please provide a reason for why you do not want to enroll in this program? *Staff member to record on RBPM tracking spreadsheet and EPIC.

IF YES: Fantastic! We are so excited to work with you.

Have you had a chance to review the materials sent to your MyChart?

- IF YES: Great! These resources will be useful throughout the program.

IF NO:

For patients who received monitor during clinic visit: Can you log in to MyChart now? I'll guide you to the patient packet.

- IF YES: Great! Please log into your MyChart account and let me know when you're in.
 1. Go to 'Menu'.
 2. Scroll down and select 'To Do'.
 3. Look for 'Record Your Blood Pressure' and 'FGP Hypertension Initiative: Patient Packet'. If you don't see it, check 'Past Tasks.' If you're having trouble, I can email or mail the packet to you.
- If patient struggles: No problem, I can email or mail you the packet. I can also send it to your MyChart account. Which would you prefer?

For patients who will receive monitor in the mail: I'll include a printed copy in the package we'll mail to you.

- For Patients Awaiting BP Monitor by Mail:**

We'll mail you the blood pressure monitor package soon. As a reminder, you should take your readings **twice a day—once in the morning and again in the late afternoon—at least 4-5 days a week (Monday-Friday)**. You can follow the instructions on the patient packet to connect the monitor to your smartphone and MyChart for automatic uploads. Please keep in mind that you should be the only person using the blood pressure monitor.

For Patients with Monitor Already:

Have you set up the NYU Langone monitor?

IF YES: Excellent! Remember to take readings **twice daily (morning and late afternoon), 4-5 days a week (Monday-Friday)**. Please keep in mind that you should be the only person using the blood pressure monitor.

-

IF NO: Please refer to the patient packet for instructions on setting up your monitor. You'll be able to connect the monitor to your smartphone and MyChart for automatic uploads. Please keep in mind that you should be the only person using the blood pressure monitor.

Next Steps:

Once you start taking your blood pressure readings, a nurse from our team will call you monthly for health counseling sessions. They will also ask a few questions about your basic needs to help determine if referrals to social and health services may be helpful. If needed, a community health worker from our team will follow up with information and support.

Please note that while the program itself is free, your calls with the nurse are billed like a regular doctor's visit and should be covered by your insurance. During your first month in the program, you will get several calls from our team to ensure everything is set up for your success. We recommend saving our phone numbers in your contacts, so you know when we're calling you!

Do you have any questions?

- IF YES: Answer any questions.*
- IF NO: Thank you for your time! If anything comes up, you can call us at 646-501-3526 or email BPaction@nyulangone.org. Have a great day!

Remote Blood Pressure Monitoring – Mailing Protocol

Program staff member assigns ONE RBPM (Omron Model 7250) to each participant and completes the “RBPM tracking” spreadsheet found in the shared drive below:

R:\Address-BP\CHW Intervention\CHW Protocol\RBPM Set Up

Completing all information:

- Date Retrieved
- Participant ID -
- MRN Number
- Clinic Site (Site ID # Only)
- RPM Enrollment Date
- RBPM Serial Number
- Date Monitor Mailed
- NYU Staff member mailing package
- FedEx Tracking Number
- Date Delivered
- MyChart Messaging Status

Refer to “NYULH OptiFreight Logistics Shipping Instructions” document on how to use FedEx Ship Manager account to bill shipping charges to third party found in the shared drive below:

R:\Address-BP\CHW Intervention\CHW Protocol\RBPM Set Up

Staff member can use their FedEx Ship Manager Account to either request mailing box and shipping label to be delivered to 180 Madison Ave, print pre-paid shipping label at the office, or visit a nearby FedEx office to print shipping label and mail out in person.

The following items need to be included in the package:

1. Omron BP Monitor
2. Patient Letter
3. RBPM Patient Packet
4. Track My Blood Pressure Apple and Android Instructions for BP Monitor Set Up
5. Bubble wrap is also available in the office to make sure all materials are secured in the box. You can also ask FedEx for stuffing paper.

These documents are found in the Shared Drive under: R:\Address-BP\CHW Intervention\CHW Protocol\RBPM Set Up\RBPM Mailing Materials

- See next page for mailing options -

Mailing Instructions - choose either option to mail package.

1. Visiting FedEx store without Ship Manager Account (RECOMMENDED for CHWs)

1. Bring the BP monitor and printed materials to the FedEx store
2. Ask FedEx associate for assistance with shipping your package and tell them you have an account number for billing
 - i. Provide the NYU FedEx account number: *****
3. Provide the FedEx associate the recipient's address and phone number
4. Ask FedEx associate to select 'No signature required' for recipient
5. Provide the FedEx associate the ABP chart string information as the reference number:
 - i. Note: you will only be able to give them the chart string number, NOT department number. ABP chart string: *****
 - ii. Note: FedEx associates may be unable to do this. Please ask for a copy of the tracking number for our records.
6. FedEx associate should be able to enter all other relevant information.
7. FedEx associate will ask you to confirm sender and recipient information on the screen.
8. Once confirmed, FedEx associate will print pre-paid label to put on package. All set!

Once RBPM package has been mailed out, staff member should update the tracking sheet on the shared drive and notify the patient of their estimated delivery date via EPIC messaging (received as a MyChart message). Staff member should check FedEx tracking number to confirm that the package has been delivered. Once delivery is confirmed, they should send the patient another MyChart message to notify them and refer them to the set-up instructions included in the patient packet.

2. Using FedEx Ship Manager Account

- a. Log into FedEx Ship Manager account
- b. Go to 'Shipping' tab and select 'Create a Shipment'
- c. For 'Deliver To' page, enter the recipient's contact info and address
 - i. Note: Check off 'This is a residential address'
- d. For 'Packaging Details', select large box and enter 5 lbs for estimated weight
 - i. Note: boxes are subject to change, ask FedEx associate for recommended size
- e. For 'Service' page, select 'FedEx Express Saver' for standard shipping
 - i. Note: most packages are delivered within 2 days with this option
- f. For 'Service options' page, select 'No signature required' and enter the ABP chart string info under 'Add shipment references'
 - i. ABP Chart string: **** | Department: *****
- g. For 'Pickup/drop-off' page, select 'I'll drop off my shipment at a FedEx location'
 - i. Note: you could also select 'Schedule a new pick-up' and have FedEx pick up the package at the 180 Madison Ave office. There is a sign for FedEx drop-off area outside of the 7th floor door.
- h. Optional: for 'Notifications' page, you can enter your email address as shipper to be notified when package is delivered.
- i. For 'Billing details' page, this section should be auto-filled with the following information:
 - i. Bill transportation cost to: Third-party
 - ii. FedEx account number: *****

- j. Select the 'View Summary' button and check that information is correct
- k. Select 'Finalize' button and 'Download' button to print the label
 - i. Note: you can also follow these steps and print the label at the FedEx store, they have computers for this purpose.
- l. Visit FedEx store to drop off package with pre-paid label

IMPORTANT: make sure to enter chart string information in the reference information of the shipping label for OptiFreight Logistics and the Finance Department to reconcile this payment.

Post-mailing Instructions

Program staff member should send the patient a MyChart message once the blood pressure monitor package has been mailed and follow up with another message after delivery is confirmed.

MyChart message once package has been mailed:

Dear Mr./Mrs. _____,

This message is to notify you that the Faculty Group Practice (FGP) Hypertension Initiative at NYU Langone Health has mailed your blood pressure monitor (FedEx tracking number: _____). You should expect to receive it by _____.

Please refer to the instructions included in your package for guidance on setting up your monitor. If you need a larger cuff size, feel free to contact us to request an exchange.

If you have questions or concerns, you're welcome to reply to this message, call me at [xxx-xxx-xxxx] or email BPaction@nyulangone.org. We look forward to working with you!

Best,

[Program Staff Name]

MyChart message once package has been delivered:

Dear Mr./Mrs. _____,

We're reaching out to let you know that your blood pressure monitor from the Faculty Group Practice (FGP) Hypertension Initiative at NYU Langone Health has been delivered.

Please refer to the instructions included in your package for guidance on setting up your monitor. If you need a larger cuff size, feel free to contact us to request an exchange.

If you have questions or concerns, you're welcome to reply to this message, call me at [xxx-xxx-xxxx] or email BPaction@nyulangone.org. Welcome—we're glad to have you on board!

Best,

[Program Staff Name]

MyChart Activation Protocol

[Note: If patient is not reached or is reached only briefly during call but has to hang up, record contact attempt in **Contact Attempts Form**.

Follow call limit protocol as follows: CHW's to call patients a maximum of 6 times over a 2-week period as follows: 1) If voicemail is setup, CHWs will leave a message with their contact information after the first unanswered call, and will follow-up 2 more times if the call is not returned; 2) if voicemail is not setup, CHWs will call up to 5 more times over the 2-week period. If a patient answers the call and declines participation in the study, contact will be ended and the reason for decline recorded in the **Contact Attempts Form** and **Tracking Form**.]

If number is wrong or not in service, please check the "Do not call - wrong # / # not in service" on the MyChart activation form

MYCHART ACTIVATION SCRIPT

Good morning/afternoon, is this Mr./Mrs. ____?

[IF NO]

Is Mr./Mrs. ____ available?

[IF NO]

Is there a better time to reach them?

**update/schedule follow-up call in contact attempts form*

[IF YES]

My name is ____ and I work for NYU Langone Health. We are reaching out to NYU patients with upcoming appointments to help them set up a MyChart account. Are you familiar with MyChart? Have you used a patient portal before?

Based on our records, you do not have a MyChart set up. MyChart offers patients personalized and secure on-line access to portions of their medical records. It also enables you to securely use the Internet to help manage and receive information about your health. With MyChart, you can view your medications, test results, health summary and immunizations, as well as access other services such as requesting prescription renewals and communicating with your care team.

Would it be alright if I work with you now to set up your account? [yes/no/not interested]

[If "YES"] - Proceed with MyChart activation protocol, below

[If "NO"]- Is there a good time I can call you back so that we can set up your account?

*Can you confirm your phone number and email address? [update in the provided box in REDCap if differs from what is listed] **[If patient is not interested]: SKIP THIS QUESTION and move on to following question*

NYU employee schedules a follow-up call in **Contact Attempts Form**.

If “No/Not Interested” – *Could you please provide a reason why not?* (select drop-down menu item from REDCap question that most closely relates to patient’s answer. Update final outcome in **Tracking Form**)

MyChart Activation Protocol

Can you confirm your phone number and email address? [update in the provided box in REDCap if differs from what is listed]

Confirm if patient has an active email account.

Great! Do you have an active email address? [Yes/No]

[If “NO”] *I’m happy to schedule an in-person appointment with you to help you set up a Yahoo or Gmail account OR I can send you resources to guide you through setting up the email account on your own. Unfortunately, due to privacy concerns, I cannot help you sign up for an email account over the phone.*

Would you prefer to schedule an in-person appointment, or receive resources on how to sign up for an account independently?

(Select Encounter 1 Outcome: “Email setup in process – GO TO EMAIL SIGNUP FORM”; save and exit **MyChart Activation Form**; go to **Email Signup Form** and complete as prompted. When complete, save and exit **Email Signup Form**; return to **MyChart Activation Form** and fill out “Email Signup Outcome” question. Follow REDCap instructions to complete MyChart Activation with patient. Fill out final outcome in **MyChart Activation Form**, where prompted, and in **Tracking Form**).

[IF PATIENT REFUSES TO SIGN UP FOR EMAIL]: *“May I ask why you are not interested?”* (select drop-down menu item from REDCap question that most closely relates to patient’s answer. Update final outcome in **Tracking Form**)

[If “YES”]

Great! Are you currently by a computer, laptop, or a smartphone to follow a few simple steps? If so, please go to your browser and type <https://activation.nyulmc.org>. This is NYU’s site to set up your MyChart account. Please type in your first and last name followed by your date of birth as seen on the screen. Then press “CONTINUE”

Create Your MyChart Account

If you are a patient at NYU Langone, you can create an NYU Langone Health MyChart account to access your medical information. If you already have a MyChart account, [sign in](#).

Find Your Patient Record

To create a MyChart account, we first need to confirm that you have a patient record at NYU Langone. Please enter the following information to help us find your record.

First Name

Last Name

Date of Birth (MM/DD/YYYY)

Continue

By submitting this form, I attest that I am the individual whose information is being submitted to create an NYU Langone Health MyChart account. I consent and authorize NYU Langone to contact me about my healthcare by email, text message, or phone call. I understand that standard message and data rates may apply and communication frequency varies. I understand that I can change my communications preferences or opt-out of communications at any time through my NYU Langone Health MyChart account, by talking to my doctor's office, or texting HELP or STOP to 69854. Read more about our MyChart [terms and conditions](#) and [privacy policy](#).

Guide patients to follow the additional security verification to create account. Once account is created, remind the patient to:

- Keep their login information (username and password) secured/written somewhere safe so that they can go back for it if forgotten
- Their account contains private health information and should be treated as such. Remind them to not share their login information with anyone
- They are able to download the MyChart app to their iPhone. Access to MyChart is available via the NYU Langone Health mobile application for their Apple® or Android™ device. They must have an existing NYU Langone Health MyChart username and password to use the application. They can download the NYU Langone Health app in the iOS App Store or on Google Play.

If patients have specific questions about the use of MyChart, please follow the MyChart FAQs at the link below:

<https://mychart.nyulmc.org/mychart/Authentication/Login?mode=stdfile&option=faq&iid=int%5Fmychart%5Fhelp%5Ffaq>

[IF PATIENT REQUIRES FOLLOW-UP]: Schedule follow-up calls as instructed in REDCap until MyChart Activation is complete.

Update Final Outcome in **Tracking Form** when all steps are complete (ensure all other forms are complete).

FOLLOW UP SCRIPT

[If you'd like to send a quick follow up text or email (based on patient's preference) feel free to use the blurb below]:

Thank you so much for your interest in activating MyChart at NYU Langone. MyChart offers patients personalized and secure on-line access to portions of their medical records. Please go to <https://activation.nyulmc.org/> to get started on your activation set up. If you have any questions or would like assistance please reply to this email/text or give me a call at #####.

TAU CHW Referrals Protocol Light-touch CHW Implementation

Purpose: The protocol below is to be followed during the TAU phase to provide patients with any socio-economic determinants of health needs referrals as determined by NCM screening.

Once a patient reports an SDOH need upon completion by the screener delivered by the NCM, NCM will message via EPIC secure chat CHW team (CHWs, CHW manager) the patient's need + EHR. CHW team will respond to NCM to confirm that the message was received and need would be addressed.

Script:

CHW *"Hi this is [CHW name] calling from NYU Langone, is this [patient's name]?"*

"Hi, I am calling to follow up on the conversation that you had with your nurse [nurse name] from the HTN Initiative Program. I have some resources that you might find helpful, if you have time right now I can share those with you. Does that sound ok?"

CHW will proceed to share resources with patients regarding SDOH need and enter all pertaining information on the Referrals Form on REDCap. During the TAU phase, CHW will not assist the patient in filling out forms or contacting the organization themselves but rather encouraging the patient to connect with the resource/organization on their own.

Once sharing resources, contact information plus any other notes to the patient, CHW will let them know they would follow up.

"Do you have any questions for me at this time?"

If no

"Ok great, I will follow up with you in 2 weeks to see how everything is going. Does that sound ok? Wonderful, have a great rest of the day!"

If yes, please refer to FAQs below

Patients will receive a MyChart message with referral/resource and contact information sent by the CHW [please see draft of MyChart message]. CHWs will attempt to contact patient twice to provide referrals and for follow up. If after two contact attempts patient is not reached, CHW will let the NCM know that no referrals were provided directly but that a MyChart message was sent to the patient with the information.

FAQs – Light Touch Protocol

- 1. What if the patient needs additional help other than receiving resource name (i.e. filling out an application, contacting the organization/resource on their behalf, etc)? Can the CHW provide further assistance during the TAU phase?**
 - a. CHWs will not provide further assistance other than offering resource/referral information along with contact information during the TAU phase. If the patient still has the specific need and is enrolled once the site enters the PATCH phase, CHW will then be able to provide further assistance.
- 2. What if the patient would like the CHW to provide support in other areas- questions about HTN management, medications, RBPM support or other?**
 - a. Kindly let the patient know that at this time their nurse will be able to provide support and answer any questions. A reminder that all questions regarding medication should always be answered by their providers (PCP, nurse, pharmacist).
- 3. Where should the CHW document their interactions with the patient?**
 - a. All interactions regarding referrals should be documented on the Referral Form on REDCap. CHWs should also document all contact (whether successful or unsuccessful) to the patient on EPIC as a patient encounter. Please see “CHW EPIC Documentation” protocol for details

Subject: Follow Up from Your Call with [CHW's Name]: Resources

Hello [Patient's First Name],

Thank you for speaking with me today as part of your Remote Blood Pressure Monitoring Program with the FGP Hypertension Initiative at NYU Langone. We appreciate you sharing more about your current needs, and we're here to support you.

As discussed, here are the referrals we shared during the call:

- [Referral 1 – Name, Description, and Contact Info]
- [Referral 2 – Name, Description, and Contact Info]
- [Referral 3 – Name, Description, and Contact Info]

I will follow up with you in a few weeks to check in on how everything is going.

Take care,

[CHW's Name]

Subject: Resources

Hello [Patient's First Name],

We tried reaching you by phone as part of your Remote Blood Pressure Monitoring Program with the FGP Hypertension Initiative at NYU Langone. We understand that things can get busy, so we wanted to make sure you still receive the support you may need.

Below are some community resources that may be helpful based on your enrollment in the program:

1. [Referral 1 – Name, Description, and Contact Info]
2. [Referral 2 – Name, Description, and Contact Info]
3. [Referral 3 – Name, Description, and Contact Info]

If you have questions please call or text me at [CHW's Phone Number]. We're here to support your health and wellbeing.

Thank you,

[CHW's Name]

RBPM Set Up Protocol

1. CHW confirms through tracking information if RBPM has been received by the patient.
2. CHW calls participant to confirm receipt of HBPM

Good morning/afternoon Mr./Mrs. _____ this is [CHW name] and I am calling to confirm if you received the remote blood pressure monitor we sent to you? You should have received it on [confirm date from tracking information].

Yes/No

If No-

- Confirm participant's address one more time
- Ask participant to look around and ask any neighbors if they have seen the package
- Tell the participant to be on the lookout and you will confirm in 24h if they have received it.

If Yes- *Ok great. Have you had a chance to activate it yet with your smart phone and MyChart account?*

If Yes- *Great! Do you have any questions on how to take your BP or use your monitor?*

[Answer any questions participant may have]

If No- No problem, do you need any help activating it? If so, I can definitely walk you through the process so that your monitor is connected to the account. We can do this through the phone or through a video conference like Webex so I can show you step by step. Is right now a good time to walk you through it?

Follow step by step guide on how to connect RBPM to smartphone and MyChart found here:

R:\Address-BP\CHW Intervention\CHW Protocol\HBPM Set Up

3. CHW completes Participant RBPM Set-up Support Form on REDCap
4. Once RBPM is set up, CHW will ask participant to submit a BP reading to MyChart

You are all set with your remote blood pressure monitor! It is important to take your blood pressure readings daily, twice a day. Is this something you think you can do?

Is yes- *Great! This is an important step to manage your blood pressure!*

If No- *I understand it can be challenging to get into routine. Perhaps we can try taking a reading 4 days a week and work our way up. How does that sound? I can help you set up a routine or reminders if that would be helpful.*

I will be working with you throughout the program to set goals that will help you create a healthy lifestyle for a healthier heart. Sometimes when taking our blood pressure, the number may be a little

higher than we would like or expected. That is ok! There is no shame on where numbers currently stand, that's why we are here, to help you lower your blood pressure numbers. Regardless of what the reading is, please submit it on the app. Our nurse team, pharmacist and I are on your side and here to support you. As an additional reminder, it is important that the monitor is used for only personal use and not shared among family and friends since these are uploaded to your own medical chart.

As a next step, you will also be receiving a call within the next month from one of our nurses, and monthly thereafter. They are there to help you manage your hypertension and answer any questions you may have about your health. Do you have any questions for me?

[Provide any clarification requested by the patient]

Great! I suggest you save my phone number so that it is easier for us to communicate with each other. Congratulations for joining the hypertension initiative program! Have a great day!

Track My Blood Pressure

Instructions for Apple iPhones/iPads



Tips for Taking Accurate Blood Pressure Readings

- Relax, sit in a room with a comfortable temperature.
- Do not smoke, drink caffeinated beverages, or exercise within 30 minutes before measuring your blood pressure.
- Relieve your bladder (urinate) and ensure at least 5 minutes of quiet rest before reading.
- Sit in a comfortable chair. Have your back and your arm for reading supported.
- Keep your feet flat on the floor and your legs uncrossed.
- Place the arm cuff on your upper arm with the arm resting comfortably on a table. Keep hand open and relaxed. Make sure the cuff is on bare arm and not over clothing.



What should I do if I get a high blood pressure reading?

If you get a reading that is higher than normal, wait 5 minutes and take your blood pressure a second time. Often, the first reading is high and may not reflect your true blood pressure. Call your provider if your blood pressure remains high and you are concerned. If your second reading is greater than 180/110 mm Hg, **contact your provider right away.**

Call 911 if you have any of these symptoms:

- chest or back pain
- shortness of breath
- numbness/weakness
- changes to your vision
- trouble speaking

These symptoms can be signs of a medical emergency!

Track My Blood Pressure

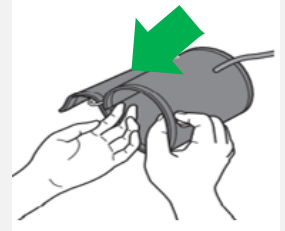
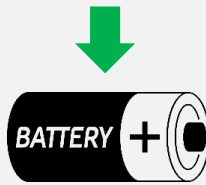
Instructions for Apple iPhones/iPads



Use the Track My Blood Pressure activity in the NYU Langone Health app to sync a blood pressure cuff via Bluetooth and send your readings to your care team.

Step 1 – Get your Blood Pressure Device Ready

- Install **batteries**
- **Connect tube** to the device
- Place **cuff on your arm**



Step 2 – Ensure Bluetooth is On

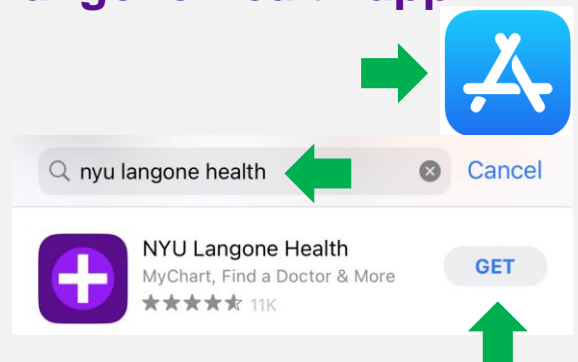
- Open the **Settings** app on your iPhone or iPad
- Tap **Bluetooth**
- **Toggle on** Bluetooth (if it is off)
- **Ensure your WIFI is on also**



Step 3 – Get or Update the NYU Langone Health app

Ask if they have the MyChart app downloaded. If yes, ask them to check for updates.

- Open the **App Store**® on your iPhone or iPad
- Search for **NYU Langone Health**
- Tap **Get** or **Update**
- Once installed, **open the app**



Track My Blood Pressure

Instructions for Apple iPhones/iPads



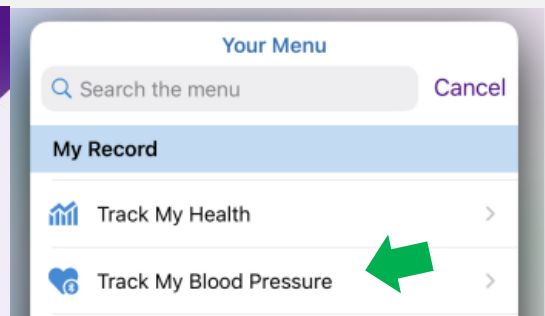
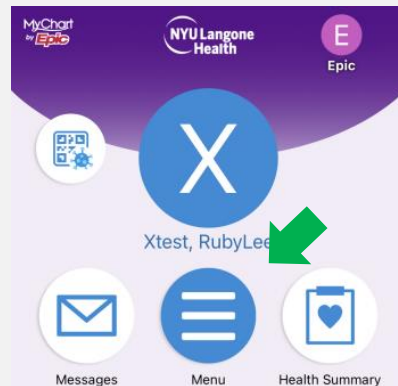
Step 4 – Log in or Create an Account

- **Log in** using your username and password
- *If you do not have an account yet with NYU, tap Create a MyChart Account and follow the prompts*
- *If you need help with a password reset call 866-262-6458*

A screenshot of the MyChart Login screen. At the top, it says "NYU Langone Health". Below that, there are two options: "MyChart Login" (highlighted with a green arrow) and "Continue as Guest". Under "MyChart Login", there are fields for "Username" and "Password" (with an eye icon to toggle visibility). Below the password field is a "Log In" button (highlighted with a green arrow). At the bottom, there are links for "Forgot Username or Password" and "Create a MyChart Account".

Step 5 – Open the Track My Blood Pressure Activity

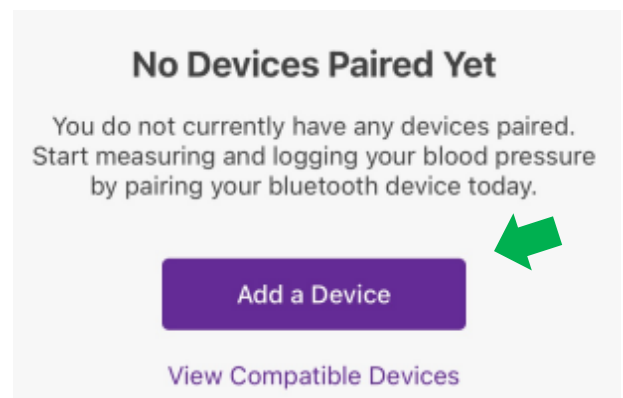
- Tap **Menu**
- Scroll down
- Tap **Track My Blood Pressure**



Step 6 – Sync your Blood Pressure Device

- Tap **Add a Device**

The following steps are specific to the Omron BP7250 blood pressure device. If you have a different model the steps may be slightly different, so follow the prompts.



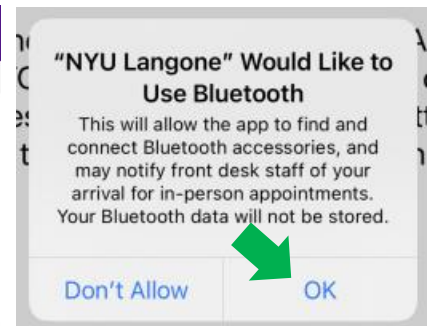
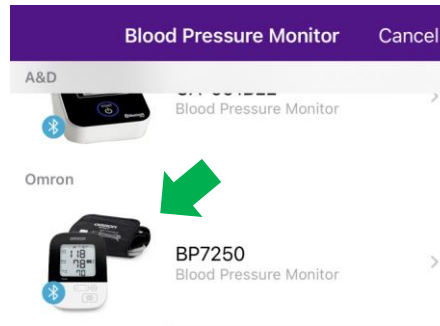
Track My Blood Pressure

Instructions for Apple iPhones/iPads

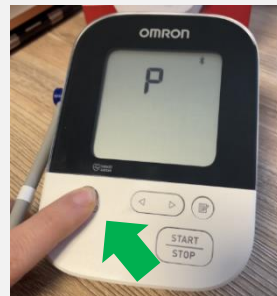


Step 6 – Sync your Blood Pressure Device (continued)

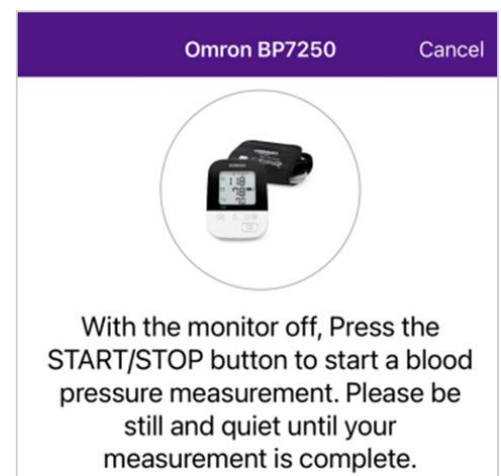
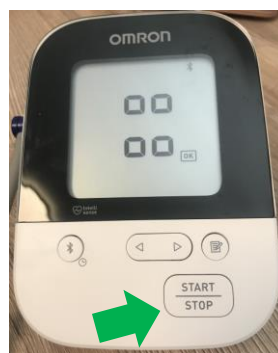
- Tap the picture of your device (BP7250)
- Tap **OK** to allow the app to use Bluetooth



- Press and **hold the Bluetooth button** on the blood pressure device until you see a “P”
- Tap **Pair** in the app



- Wait until you see four squares on the device, then press **Start/Stop** to turn it off.
- The app will immediately prompt you to take a reading (Continue on the next page)



Track My Blood Pressure

Instructions for Apple iPhones/iPads



Step 7 – Take Your First Reading

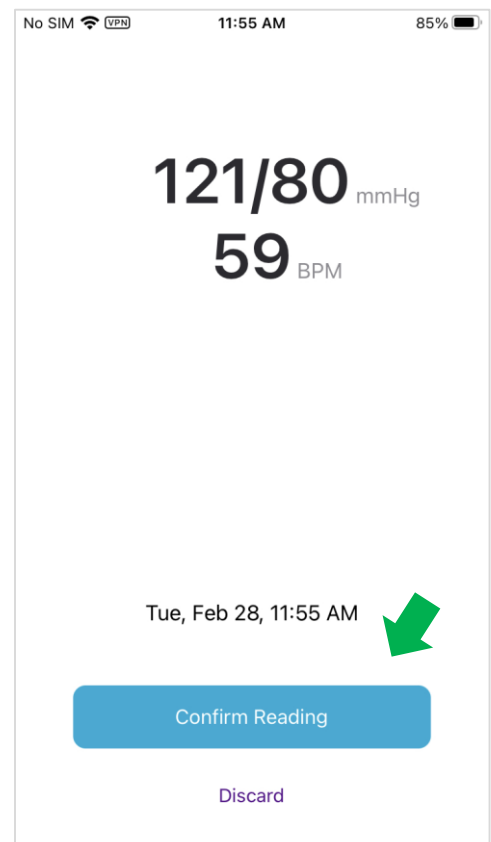
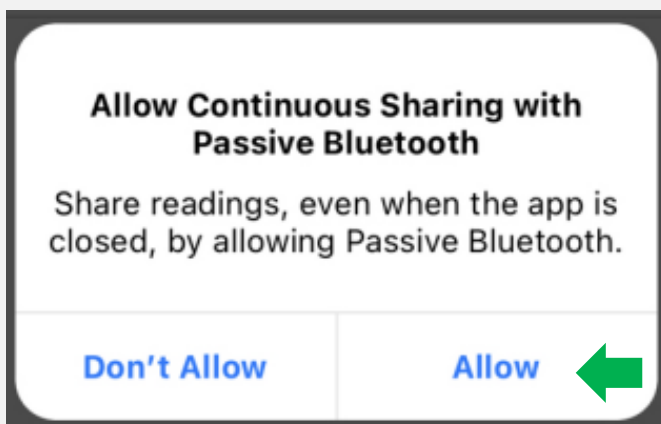
- Press the **Start/Stop** button on the monitor



- You will **feel the cuff inflate** and see the numbers changing on the blood pressure monitor
- Remain **quiet and still**



- Once your reading is complete, tap **Confirm Reading** in the app
- When prompted, **Allow** Continuous Sharing with Passive Bluetooth



Track My Blood Pressure

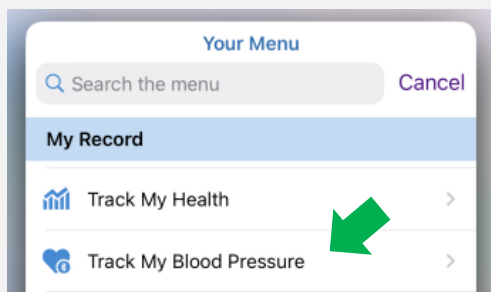
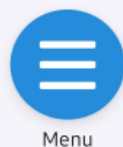
Instructions for Apple iPhones/iPads



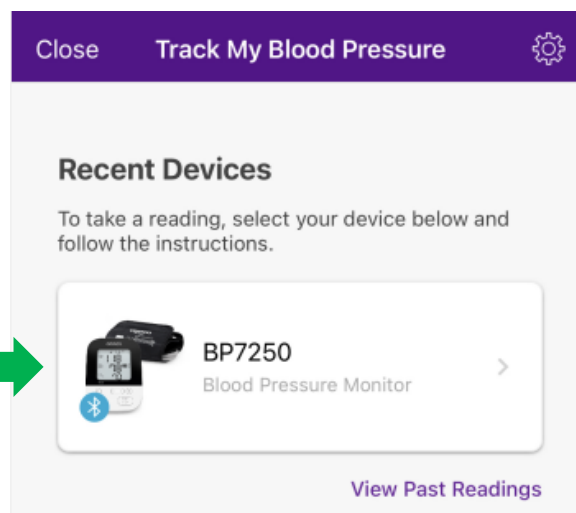
Step 8 – Take Subsequent Readings

Each time you take your blood pressure, follow these steps to ensure the reading is successfully sent to your care team.

- Tap **Menu**
- Scroll down
- Tap **Track My Blood Pressure**



- Tap the **picture** of your device under Recent Devices



- Press the **Start/Stop** button on your monitor to begin the measurement



- Once your reading is complete, tap **Confirm Reading** in the app



Discard

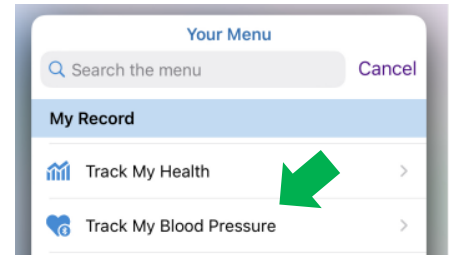
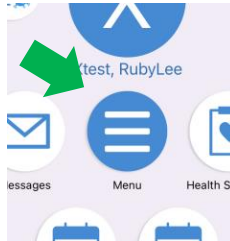
Track My Blood Pressure

Instructions for Apple iPhones/iPads

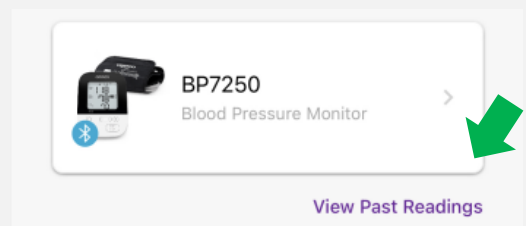


Review Your Past Readings

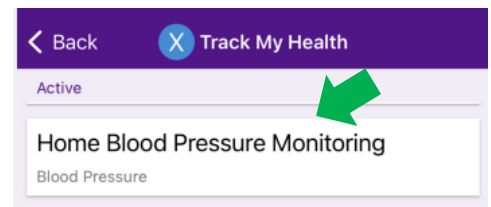
- Tap **Menu**
- Scroll down
- Tap **Track My Blood Pressure**



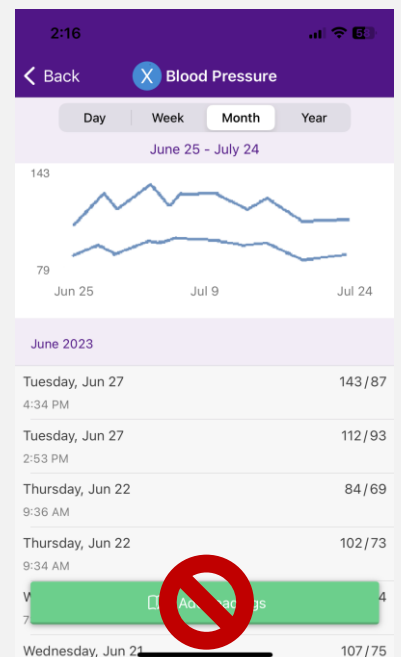
- Tap **View Past Readings**



- If you see a list, tap **Home Blood Pressure Monitoring**



- Tap on the graph to see a list of saved readings in table format



Do NOT use the green Add Readings button on this page. This button is for typing in readings manually, this is only for those that do not have a Bluetooth capable Blood Pressure device.

Track My Blood Pressure

Instructions for Android Smart Phones/Tablets



Tips for Taking Accurate Blood Pressure Readings

- Relax, sit in a room with a comfortable temperature.
- Do not smoke, drink caffeinated beverages, or exercise within 30 minutes before measuring your blood pressure.
- Relieve your bladder (urinate) and ensure at least 5 minutes of quiet rest before reading.
- Sit in a comfortable chair. Have your back and your arm for reading supported.
- Keep your feet flat on the floor and your legs uncrossed.
- Place the arm cuff on your upper arm with the arm resting comfortably on a table. Keep hand open and relaxed. Make sure the cuff is on bare arm and not over clothing.



What should I do if I get a high blood pressure reading?

If you get a reading that is higher than normal, wait 5 minutes and take your blood pressure a second time. Often, the first reading is high and may not reflect your true blood pressure. Call your provider if your blood pressure remains high and you are concerned. If your second reading is greater than 180/110 mm Hg, **contact your provider right away.**

Call 911 if you have any of these symptoms:

- chest or back pain
- shortness of breath
- numbness/weakness
- changes to your vision
- trouble speaking

These symptoms can be signs of a medical emergency!

Track My Blood Pressure

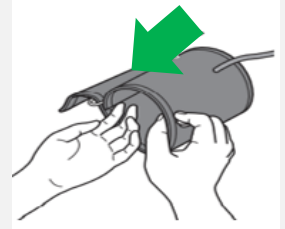
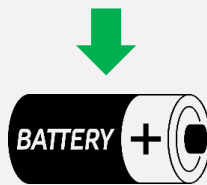
Instructions for Android Smart Phones/Tablets



Use the Track My Blood Pressure activity in the NYU Langone Health app to sync a blood pressure cuff via Bluetooth and send your readings to your care team.

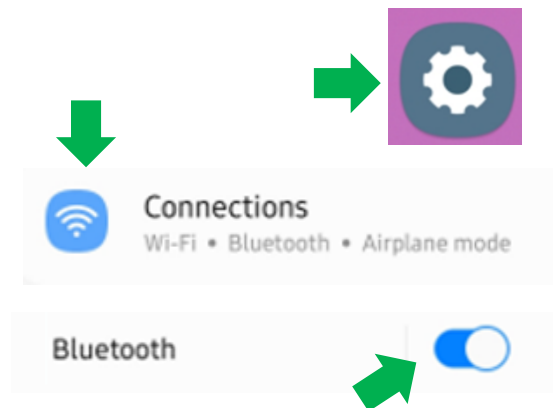
Step 1 – Get your Blood Pressure Device Ready

- Install **batteries**
- **Connect tube** to the device
- Place **cuff on your arm**



Step 2 – Ensure Bluetooth is On

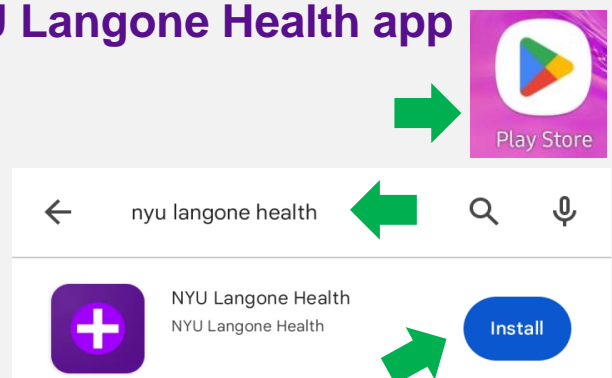
- Open the **Settings** app on your Android phone or tablet
- Tap **Connections**
- **Toggle on** Bluetooth (if it is off)
- **Ensure your WIFI is on also**



Step 3 – Install or Update the NYU Langone Health app

Ask if they have the MyChart app downloaded. If yes, ask them to check for updates.

- Open the **Google Play Store**® on your Android phone or tablet
- Search for **NYU Langone Health**
- Tap **Install** or **Enable > Update**
- Once installed, **open the app**



Track My Blood Pressure

Instructions for Android Smart Phones/Tablets



Step 4 – Log in or Create an Account

- **Log in** using your username and password
- *If you do not have an account yet with NYU, tap Create a MyChart Account and follow the prompts*
- *If you need help with a password reset call 866-262-6458*

NYU Langone Health

MyChart Login Continue as Guest

Username

Password

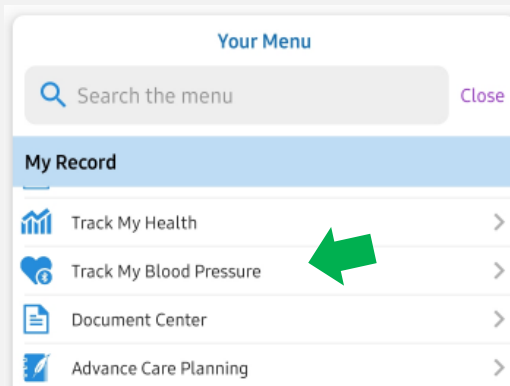
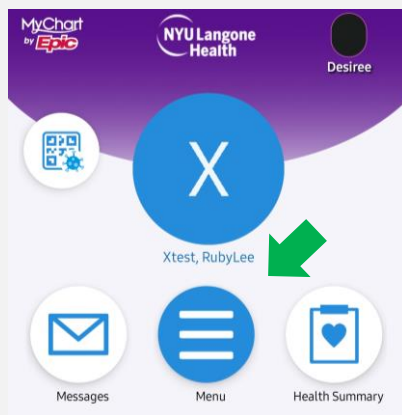
Log In

Forgot Username or Password

Create a MyChart Account

Step 5 – Open the Track My Blood Pressure Activity

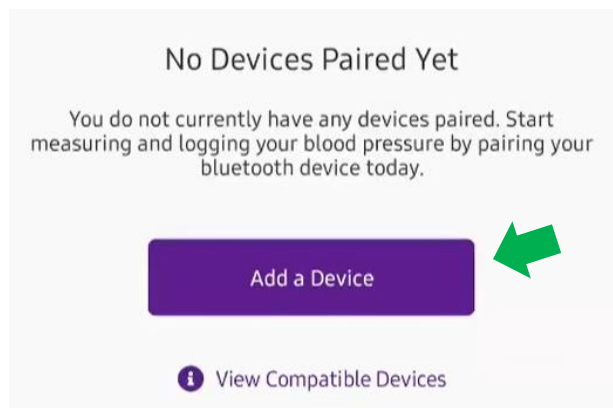
- Tap **Menu**
- Scroll down
- Tap **Track My Blood Pressure**



Step 6 – Sync your Blood Pressure Device

- Tap **Add a Device**

The following steps are specific to the Omron BP7250 blood pressure device. If you have a different model the steps may be slightly different, so follow the prompts.



Track My Blood Pressure

Instructions for Android Smart Phones/Tablets

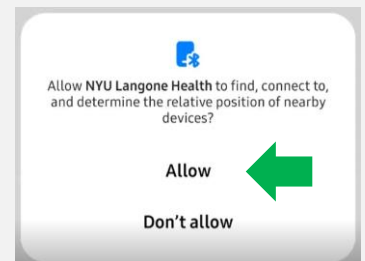
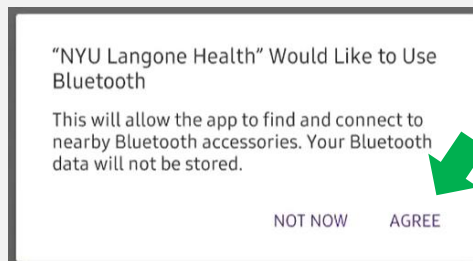


Step 6 – Sync your Blood Pressure Device (continued)

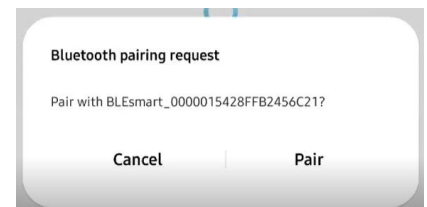
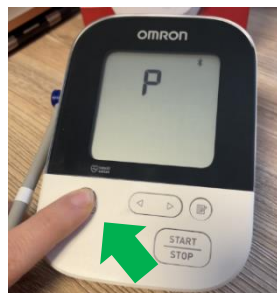
- Tap the **picture** of your device (**BP7250**)



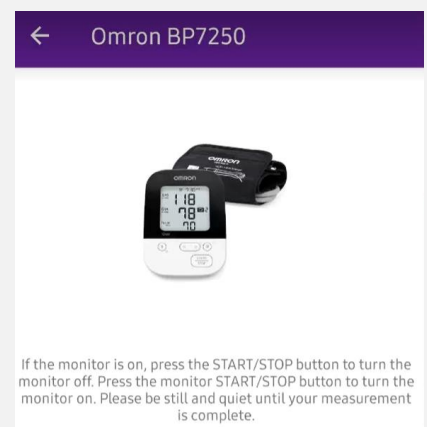
- Tap **Agree** and **Allow** to let the app find your device



- Press and **hold the Bluetooth button** on the blood pressure device until you see a “P”
- Tap **Pair** in the app



- Wait until you see four squares on the device, then press **Start/Stop** to turn it off.
- The app will immediately prompt you to take a reading (**Continue on the next page**)



Track My Blood Pressure

Instructions for Android Smart Phones/Tablets

Step 7 – Take Your First Reading

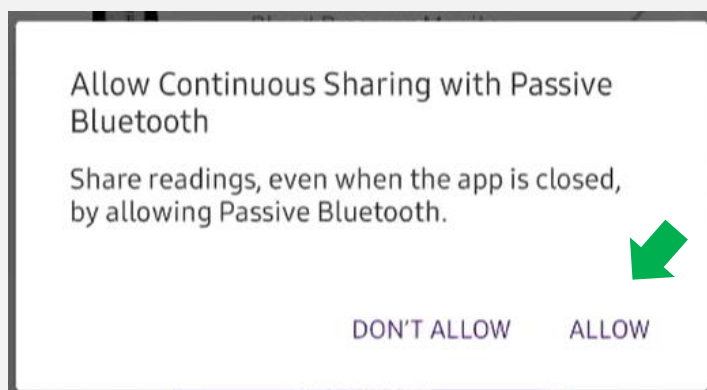
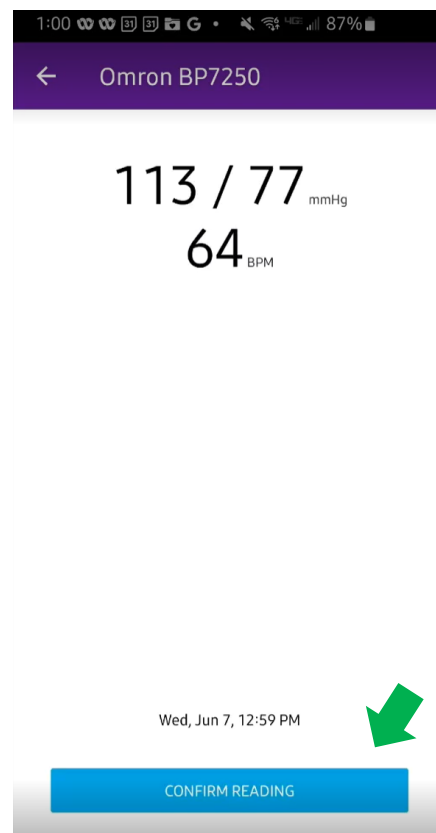
- Press the **Start/Stop** button on the monitor



- You will **feel the cuff inflate** and see the numbers changing on the blood pressure monitor
- Remain **quiet and still**



- Once your reading is complete, tap **Confirm Reading** in the app
- When prompted, **Allow** Continuous Sharing with Passive Bluetooth



Track My Blood Pressure

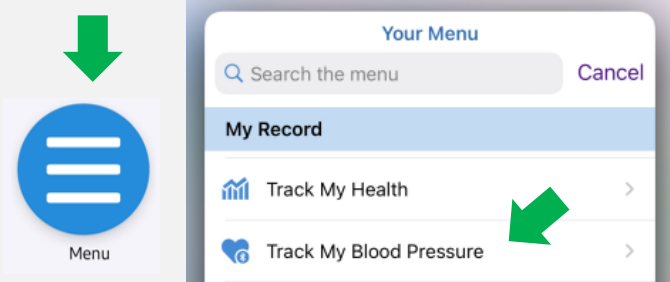
Instructions for Android Smart Phones/Tablets



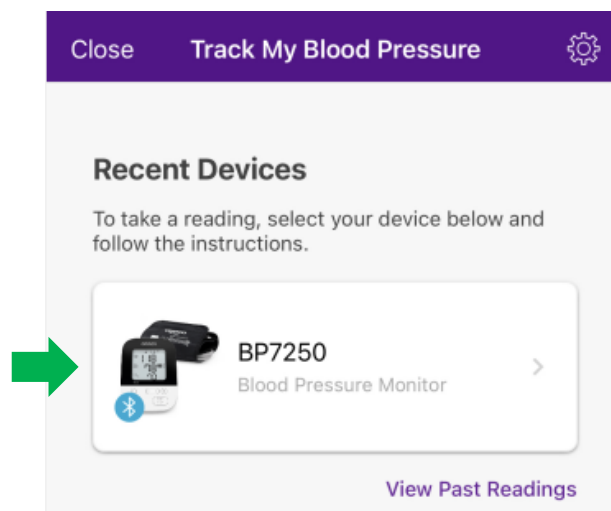
Step 8 – Take Subsequent Readings

Each time you take your blood pressure, follow these steps to ensure the reading is successfully sent to your care team.

- Tap **Menu**
- Scroll down
- Tap **Track My Blood Pressure**



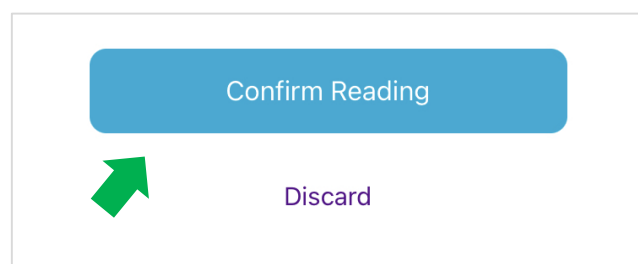
- Tap the **picture** of your device under Recent Devices



- Press the **Start/Stop** button on your monitor to begin the measurement



- Once your reading is complete, tap **Confirm Reading** in the app

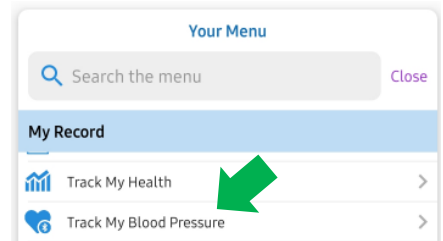
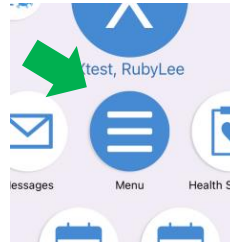


Track My Blood Pressure

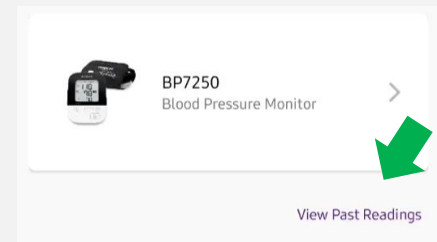
Instructions for Android Smart Phones/Tablets

Review Your Past Readings

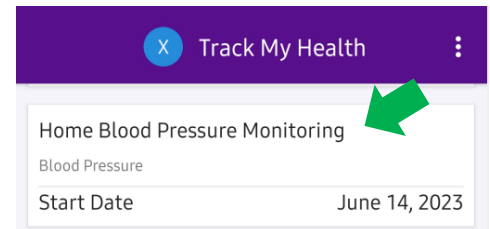
- Tap **Menu**
- Scroll down
- Tap **Track My Blood Pressure**



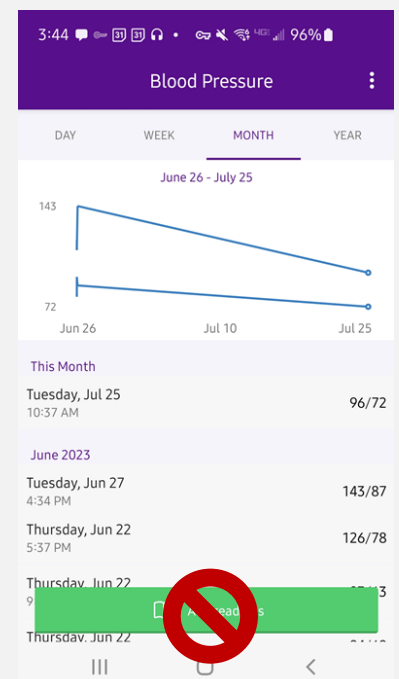
- Tap **View Past Readings**



- If you see a list, tap **Home Blood Pressure Monitoring**



- Tap on the graph to see a list of saved readings in table format



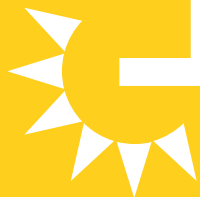
Do NOT use the green Add Readings button on this page. This button is for typing in readings manually, this is only for those that do not have a Bluetooth capable Blood Pressure device.



*Connecting New Yorkers with free and
low-cost health and social services*



www.hitesite.org



HITE About

The Health Information Tool for Empowerment (HITE) is a publicly available online directory of more than 6,000 health and social service organizations and programs located in New York City's five boroughs, Long Island, and Westchester. HITE lists organizations that provide free or low-cost services geared towards community health and well-being. Information in HITE listings is verified directly with program staff and is updated often to maintain accuracy.

HITE users include staff at health care and community-based organizations (CBOs), community advocates, school nurses and counselors, and other community members. HITE searches can assist with:

- Information and referral services
- Care and case management
- Care coordination
- Community advocacy and outreach
- Patient navigation
- Care transitions
- Benefit needs

Search services in HITE using the following categories:



Education &
Employment



Financial
Assistance



Food
Assistance



Health Care
& Medicine



Housing &
Homeless Services



Immigrant
Support



Mental Health &
Substance Abuse



Social Support
& Services



Youth & Family
Services

Refine your search

Searches can be refined by entering search criteria such as location, specific service, population, or language. Organizational listings include detailed information on location, services provided, hours of operation, languages spoken, intake procedures, and more. Users can create a personalized account to save resources for easy access.

Schedule a Demonstration

HITE staff provide free on-site or web-based presentations for hospitals, health centers, CBOs, public agencies, and provider networks and associations. Please contact HITE to schedule a demonstration at your organization.

Contact HITE

Contact HITE staff for general directory information, assistance using the website, to request presentations or materials, or to provide information about an organization already in or new to HITE.



(866) 370-HITE (4483)



hite@gnyha.org



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[Facebook \(@GNYHAHITE\)](#)



[LinkedIn \(@HITE\)](#)



[Subscribe to the Newsletter](#)



Please note that HITE is not affiliated with any of the organizations listed in the directory. For information about an organization, please contact them directly.

www.HITEsite.org

USER GUIDE

The screenshot shows the HITE website homepage. At the top is a purple navigation bar with the HITE logo and links for myHITE, Asylum Seeker Resources, Benefits Information, About us, and Contact. Below the navigation bar is a large banner image of a diverse group of people. Overlaid on the banner is the text "ONLINE RESOURCE DIRECTORY" and "connecting New Yorkers with free and low-cost health and social services". A search bar with the placeholder text "What service are you looking for?" and a purple "SEARCH" button is positioned below the banner. A red circle with the number "1" is next to the search bar. Below the banner is a section titled "BROWSE BY CATEGORY" which contains a grid of ten category buttons, each with an icon and a label. A red circle with the number "2" is next to the "Education & Employment" button. The categories are: Education & Employment, Financial Assistance, Food Assistance, Health Care & Medicine, Housing & Homeless Services, Immigrant Support, Mental Health & Substance Use, Social Supports & Services, Youth & Family Services, and Get the HITE newsletter.

1 What service are you looking for? **SEARCH**

BROWSE BY CATEGORY

2

- Education & Employment
- Financial Assistance
- Food Assistance
- Health Care & Medicine
- Housing & Homeless Services
- Immigrant Support
- Mental Health & Substance Use
- Social Supports & Services
- Youth & Family Services
- Get the HITE newsletter

The Health Information Tool for Empowerment (HITE) is a searchable online directory of more than 6,000 health and social service organizations and programs located in New York City's five boroughs, Long Island and Westchester. HITE lists organizations that provide low- or no-cost services to low-income, uninsured, and underinsured individuals and families. HITE is free of charge and anyone can use it to find health and social service organizations. HITE content and search functionality are mobile-ready and can be easily accessed on smartphones or tablets.

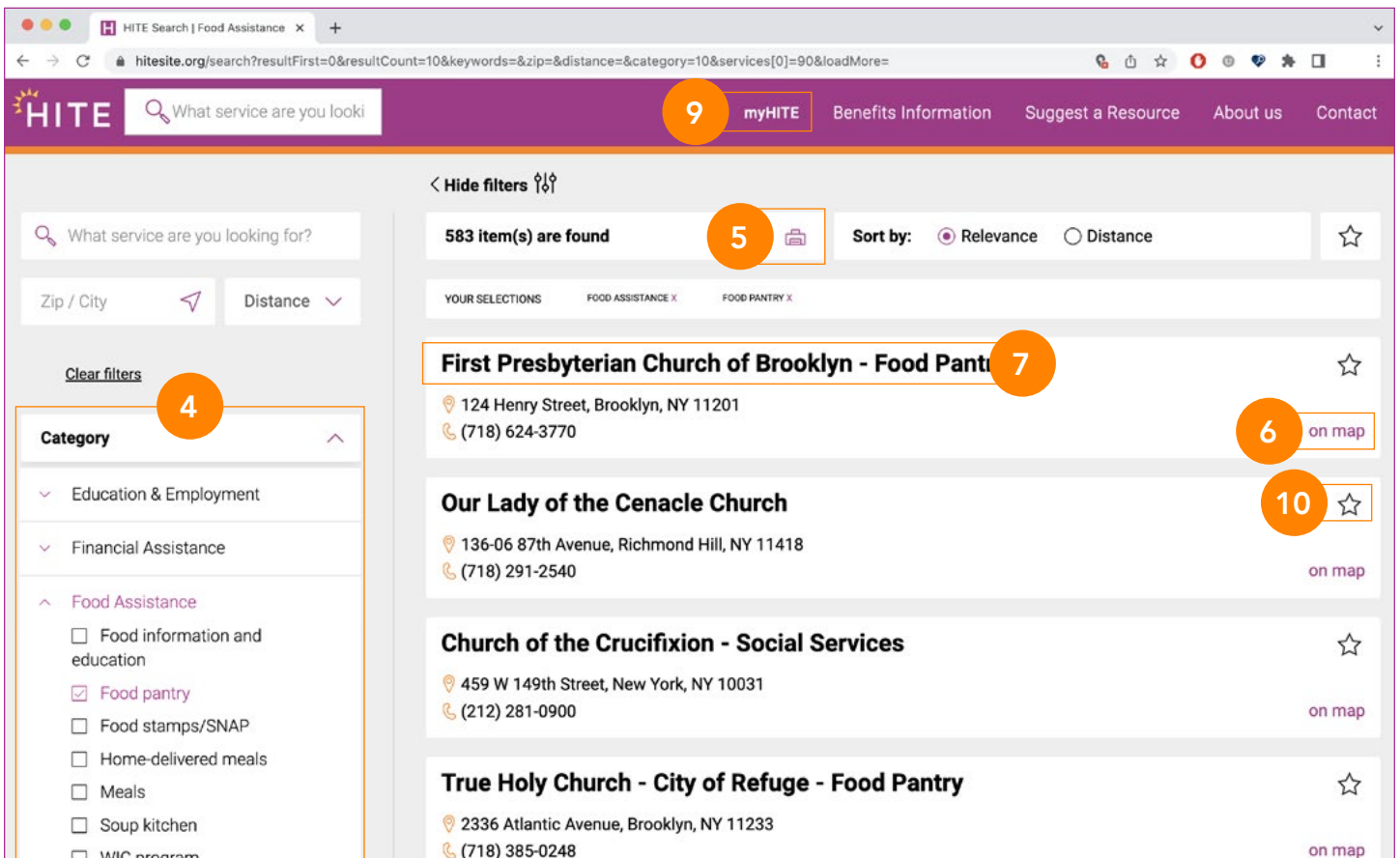
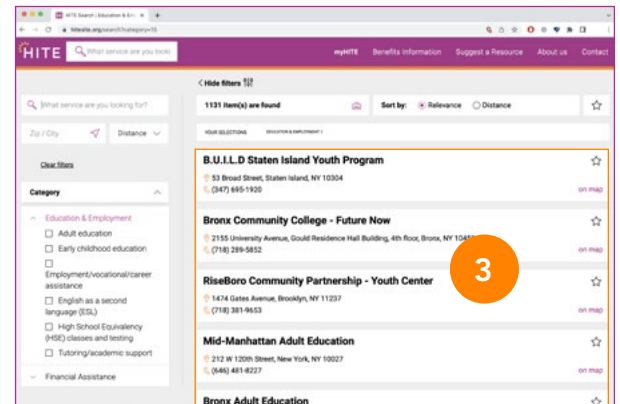
The following are recommended instructions with screen shots that demonstrate how to search for services, view resource details, and use the myHITE personalization feature.

SEARCH BY KEYWORD

- 1 From the homepage, type any keyword (ex: the service you seek, or an organization name). A list of suggested resources will populate as you begin typing. Select a resource from this list or click "search" to view all potential search results.

BROWSE FOR SERVICES

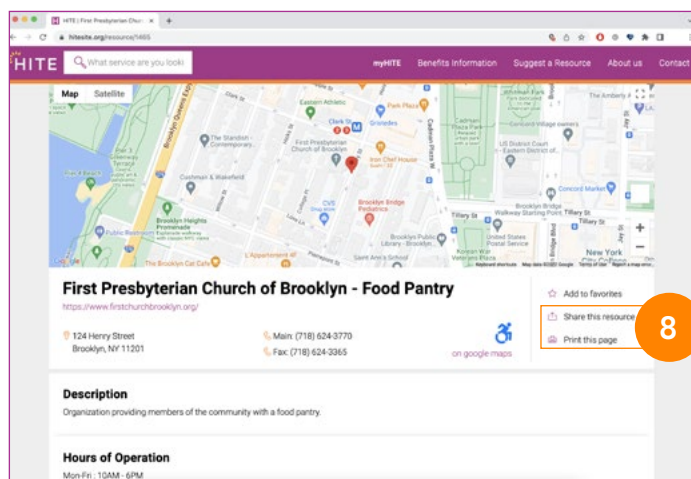
- From the homepage, start by clicking one of the category icons, which will bring you to a new page of all the resources in that category.
- Browse list of resources or enter additional search criteria on the left side of the screen. Start with a zip code and choose a distance, or type in the name of a borough/city/county.
- Click the 'Category' bar on the left side to view more specific services. Add age, populations, or language filters. Use the text box to find a specific service or term.



- Print the search results list for a client or colleague.
- Click the "on map" option to view the physical location of selected resources on a map. Map multiple resources at the same time to view their proximity to a preferred location.
- Click on a resource to view additional details, such as operating hours, services provided, languages spoken, and payment policies.

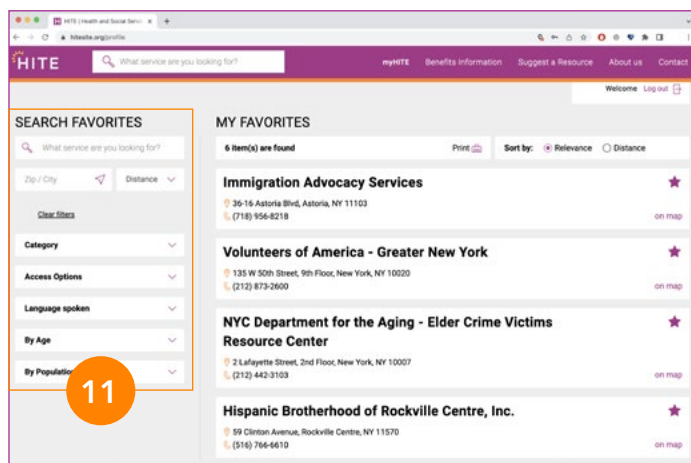
Share Resources

- 8 E-mail or print a resource page to share details with others.



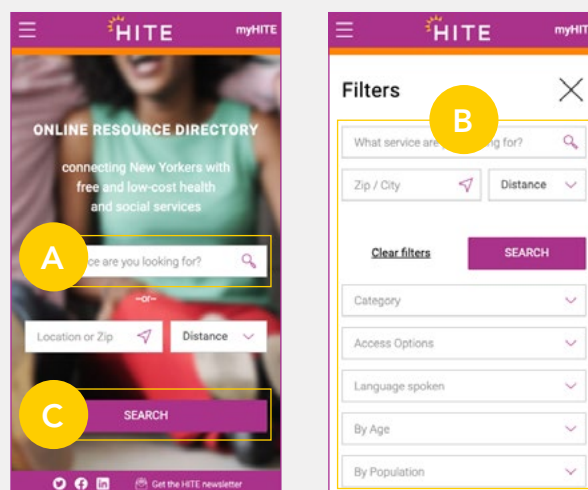
Save Favorites

- 9 Create a myHITE account to quickly and easily save commonly searched resources.
- 10 Once you're logged into myHITE, click the stars on the search results page or select "add to favorites" on the resource pages to add specific resources to your personalized myHITE account.



- 11 Search among your favorites within myHITE, just as you would in a regular search. Filter by category, age, population, and language, and sort by distance to a preferred zip code.

USING HITE ON A MOBILE DEVICE OR TABLET



Search by Keyword

- A From the homepage, type any keyword (ex: the service you seek, or an organization name). A list of suggested resources will populate as you begin typing. Select a resource from this list or click "search" to view all potential search results.
- B After submitting a keyword search, a list of filters will appear, followed by your search results. Scroll down or close the filters to view your initial search results.

Browse for Services

- C From the homepage, click "search."
- B Enter search criteria into the filters provided, such as zip code, category, age, or population, and click "search." Keyword searches can also be refined using the filters.



Contact HITE staff for general directory information, assistance using the website, to request presentations or materials, or to provide information about an organization already in, or new to HITE.

(866) 370-HITE (4483) | hite@gnyha.org | X: [@HITE_SITE](#) | Facebook: [@GNYHAHITE](#) | LinkedIn: [@HITE](#)

Please note that HITE is not affiliated with any of the organizations listed in the directory. For information about an organization, please contact it directly. HITE is a program of the Greater New York Hospital Association.

HEALTH INFORMATION TOOL FOR EMPOWERMENT (HITE)

Anika Yusuf (she/her)

Program Associate, HITE

Greater New York Hospital Association



About HITE (www.hitesite.org)

Publicly available site listing free or low-cost services

Available for free on any device with internet

6,000 resources in New York City, Long Island and Westchester

26,000 avg. users per month

Information verified twice annually through direct contact with listed organizations

HITE Users

Organizations using HITE

- Hospitals/health centers
- Schools
- Faith-based Organizations
- State/City agencies
- Community-based Organizations

Types of staff using HITE

- Social workers
- School counselors
- Case managers
- Community health workers

HITE Data Uses

Information
and referral
services

Community
needs
assessments

Community
resource
availability

Relationships with Organizations

Information
updates

HITE trainings
for staff

Community
meetings and
events

HITE Advisory
Group
participants

Connections
to member
hospitals

Case Study

Nancy is a single mother who has recently been diagnosed with hypertension during her routine health visit. She expresses that she is unsure of how to manage her hypertension.

The provider uses www.hitesite.org to find food information and educational resources that can help Nancy understand how to control her blood pressure.

For More Information

HITE Newsletter Sign up: <http://hitesite.org/>

HITE Materials: <http://hitesite.org/about>

Any questions, concerns, suggestions?

Please email:

Anika Yusuf ayusuf@gnyha.org

Subject Line: We're Here to Support Your Heart Health! Let's Connect!

Hello [Patients First Name],

We noticed we haven't been able to reach you by phone. As part of the Remote Blood Pressure Monitoring program with the Faculty Group Practice (FGP) Hypertension Initiative at NYU Langone Health (NYULH), a Community Health Worker (CHW) is available to help you connect your blood pressure monitor and support you in setting simple, healthy goals.

This program is designed to make it easier for you to manage your blood pressure from home and we're here to help every step of the way.

Please give us a call back at [CHW's phone number] or reply to this message to schedule a time that works best for you.

We look forward to connecting with you soon!

[CHWs Name]

[CHWs Phone number and email]

Pilot and PATCH 1st Introductory Community Health Worker Call

- CHW calls and introduces themselves as part of the patient's **NYU Healthcare Team**
- *We are giving a service, and our service is health*
 - We empower people to be their own advocates when we are not with them
- *As part of the FGP HTN Initiative you will be working with a team that **will be working with YOU** to help you manage and lower your blood pressure. Your team will consist of:*
 - *Community health workers* like myself who will be working with you to create healthy goals and together we will learn the best lifestyle and behavior changes to improve your health
 - *Pharmacists* that will help you manage your blood pressure medication
 - *Nurse* who will help you every month understand where your BP numbers stand and provide guidance in how to improve your health and wellbeing
 - *Our coordinator* who will make sure you are all set with our program regarding delivery of the monitor and any logistics needs.
 - After the nurse asks you about your basic needs, our research staff will follow up with you. They want to learn about your experience and how you felt being asked about your needs. Your feedback is very important and will help us improve our services at NYU Langone to better support you
- *Are you free for a few minutes for a quick face to face (zoom) chat and learn a little bit more about who we are?*
 - *Ok great. We sent you more information about who we are and the program to your NYU MyChart account. Did you have a chance to go over it?*
 - If yes, ask patient if they have any questions for you regarding the program
 - If not, ask patient if they prefer to have it sent either to their email or via text message
- For next steps, our coordinator will give you a call to confirm enrollment and provide details of your new BP monitor and delivery logistics
 - [confirm best time to call, provide Laurette's name and number so that they can save it and pick up her call]

TAU 1st Introductory Community Health Worker Call

- CHW calls and introduces themselves as part of the patient's **NYU Healthcare Team**
- *We are giving a service, and our service is health*
 - We empower people to be their own advocates when we are not with them
- *As part of the FGP HTN Initiative you will be working with a team that **will be working with YOU** to help you manage and lower your blood pressure. Your team will consist of:*
 - *Pharmacists* that will help you manage your blood pressure medication
 - *Nurse* who will help you every month understand where your BP numbers stand and provide guidance in how to improve your health and wellbeing
 - *Our coordinator* who will make sure you are all set with our program regarding delivery of the monitor and any logistics needs.
 - After the nurse asks you about your basic needs, our research staff will follow up with you. They want to learn about your experience and how you felt being asked about your needs. Your feedback is very important and will help us improve our services at NYU Langone to better support you
- *We sent you more information about who we are and the program to your NYU MyChart account. Did you have a chance to go over it?*
 - If yes, ask patient if they have any questions for you regarding the program
 - If not, ask patient if they prefer to have it sent either to their email or via text message
- For next steps, our coordinator will give you a call to confirm enrollment and provide details of your new BP monitor and delivery logistics
 - [confirm best time to call, provide Laurette's name and number so that they can save it and pick up her call]

Table 2: Implementation Strategies Activities & Trainings

Implementation Strategy	Conduct educational meetings	Hold meetings targeted toward different stakeholder groups (e.g., providers, administrators, other organizational stakeholders, and community, patient/consumer, and family stakeholders) to teach them about the clinical innovation							
Actions	Activities	Audience	Estimated Length/Timeline	Major Content	Training/ Activity Date(s)	Length of Training/Activity	Training/activity facilitated by	Site (if applicable)	Participants
Through 1-on-1 or group-based interactions (remotely or in-person) with patients, CHWs will support each of the components of PACE:		CHWs	6 h	<ul style="list-style-type: none">Review educational material and ease of delivery	Curriculum Mock Sessions: 5/24/23, 6/6/23, 6/7/23, 6/14/23, 6/21/23, 6/22/23, 6/28/23, 7/12/23, 7/19/23, 7/26/23, 8/9/23, 8/16/23, 2/6/24, 2/13/24, 2/20/24	1 hour each	Program Manager (Laura or Jennifer)	N/A	Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming)
NCM – CHWs support the adoption of NCM health educational and counseling by addressing barriers / providing strategies to improve adherence to counseling recommendations related to patient’s lived experiences (eg sharing resources on where to find healthy foods in their neighborhoods to support NCM healthy eating counseling)	1. Referrals Guide (CHW form)		1. 60m	<ul style="list-style-type: none">Review CHW forms and possible SDOH referrals neededReview CHW network of CBOs available around target neighborhoods	HiteSite 11/9/2023 (CHW form training pending) Referrals Training including their own internal network/knowledge. Community mapping? Communication between nurses and CHWs (in basket and secure chat); 3/21/24; Weekly 1h meeting with CHWs and NCMs to review EPIC workflow/communication	1 hour each	Program Manager (Laura); Program Coordinators (Claire and Laurette)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming)
	2. Goal Setting Training (CHW form)		2. 60m	<ul style="list-style-type: none">Review SMART goal setting skills	Goal Setting Form Training 3/28/24- S	1 hour	Program Manager (Laura); Program Coordinators (Claire and Laurette)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming)
	3. Deliver virtual group educational sessions to FBO and CBO partners		3. 5h	<ul style="list-style-type: none">Review group management skills in a virtual setting	Virtual Community Sessions: (Cohort 1) 2/2/2023, 2/7/2023, 2/9/2023, 2/14/2023, 2/16/2023, 2/21/2023, 2/23/2023; (Cohort 2): 11/14/2023, 11/16/2023, 11/21/2023, 11/28/2023, 12/5/2023, 12/12/2023;	1 hour each	Study CHWs: (Linda Thompson, Roger Abrams, Vallyn Fleming)	Virtual, Harlem Community Center	FBO and CBO partners
RBPM – eg. emphasizing importance of continual monitoring to support adoption and fidelity; educating patients on why RBPM is effective	1. RBPM set up guide	CHWs	1. 30m	<ul style="list-style-type: none">Review motivational interviewing skills to enhance behavior change	4/18/2023; FOCUS training (Aigna to confirm FOCUS content for CHWs) Tip sheets (need to demo); RBPM Set Up Training Refreshers: 3/14/24, 4/23/24	1 hour each	Program Manager (Laura); NYU FOCUS; Program Facilitator (Aigna Barber)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming)
	2. MI Training		2. 2 day training	<ul style="list-style-type: none">Learn to identify barriers to support continual adoption	12/21/2023	3h	Practice Implementation Manager (Franze de la Calle)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming); Program Manager (Laura De Jesus); Project Coordinator (Laurette Espinoza-Hernandez); Program Facilitator (Aigna Barber)
SDOH – eg. discussions and strategies for health behavior change that are tied to context of lived experience	1. Goal Setting Training (CHW form)	CHWs	1. 60m	<ul style="list-style-type: none">Review motivational interviewing skills to enhance behavior change	Goal Setting Form Training 3/28/24- S	1 hour	Program Manager (Laura); Program Coordinators (Claire and Laurette)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming)
	2. MI Training		2. 2 day training	<ul style="list-style-type: none">Review SMART goal setting skills	12/21/2023	3h	Practice Implementation Manager (Franze de la Calle)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming); Program Manager (Laura De Jesus); Project Coordinator (Laurette Espinoza-Hernandez); Program Facilitator (Aigna Barber)

Table 2: Implementation Strategies Activities & Trainings

Implementation Strategy	Prepare patients/consumers to be active participants:	Prepare patients/consumers to be active in their care, to ask questions, and specifically to inquire about care guidelines, the evidence behind clinical decisions, or about available evidence-supported treatments							
Actions	Activities	Audience	Estimated Length/Timeline	Major Content	Training/Activity Date(s)	Length of Training/Activity	Training/activity facilitated by	Site (if applicable)	Participants
Through 1-on-1 or group-based interactions (remotely or in-person) with patients, CHWs will support each of the components of PACE:		CHWs	6 h	<ul style="list-style-type: none"> Review educational material and ease of delivery 	Curriculum Mock Sessions: 5/24/23, 6/6/23, 6/7/23, 6/14/23, 6/21/23, 6/22/23, 6/28/23, 7/12/23, 7/19/23, 7/26/23, 8/9/23, 8/16/23, 2/6/24, 2/13/24, 2/20/24	1 hour each	Program Manager (Laura or Jennifer)	N/A	Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming)
NCM – preparing for upcoming primary care visits	1. Deliver virtual group educational sessions to FBO and CBO partners.		1. 5h	<ul style="list-style-type: none"> Review group management skills in a virtual setting 	Virtual Community Sessions: (Cohort 1) 2/2/2023, 2/7/2023, 2/9/2023, 2/14/2023, 2/16/2023, 2/21/2023, 2/23/2023; (Cohort 2): 11/14/2023, 11/16/2023, 11/21/2023, 11/28/2023, 12/5/2023, 12/12/2023; Harlem Community Sessions: Start date 10/22/2022 offered bi-weekly until March 2023	1 hour each	Study CHWs: (Linda Thompson, Roger Abrams, Vallyn Fleming)	Virtual, Harlem Community Center	FBO and CBO partners
	2. Record educational sessions for future dissemination.		2. 6h	<ul style="list-style-type: none"> Learn logistics of a virtual presentation 	TBD	1 hour each	Study CHWs: (Linda Thompson, Roger Abrams, Vallyn Fleming)	N/A	FBO and CBO partners as needed; Study Participants as needed
RBPM – Troubleshooting technology-related barriers to remote BP monitoring	1. RBPM set up guide;	CHWs	30 min	<ul style="list-style-type: none"> Learn steps on how to set up RBPM and corresponding applications 	4/18/2023; FOCUS training (Aigna to confirm FOCUS content for CHWs) Tip sheets (need to demo); RBPM Set Up Training Refreshers: 3/14/24, 4/23/24	1 hour each	Program Manager (Laura); NYU FOCUS; Program Facilitator (Aigna Barber)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming)
	2. Patient Portal Set-up Guide			<ul style="list-style-type: none"> Learn steps on how to set up the NYU MyChart Patient Portal, including email address 	MyChart Activation/REDCap training meetings dates: 9/9/22, 4/20/23, 4/27/23, 8/15/23, 8/23/23, 9/1/23, 9/20/23, 10/18/23, 10/19/23, 2 trainings on 10/20/23, 11/10/23, 11/20/23 --cc updated 11/16/23	1 hour each	Program Manager (Laura) / Program Coordinator (Claire, Laurette)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming)
SDOH – eg. discussions and strategies to enhance self-efficacy and healthcare efficacy in clinical encounters with primary care team (eg understanding and asking physicians about blood pressure readings; asking questions about medication changes); addressing transportation and other logistical barriers to care	1. Referrals Guide (CHW form)	CHWs	1. 60m	<ul style="list-style-type: none"> Review CHW forms and possible SDOH referrals needed Review CHW network of CBOs available around target neighborhoods 	HiteSite 11/9/2023 (CHW form training pending) Referrals Training including their own internal network/knowledge. Community mapping? Communication between nurses and CHWs (in basket and secure chat); 3/21/24; Weekly 1h meeting with CHWs and NCMs to review EPIC workflow/communication	1 hour each	Program Manager (Laura); Program Coordinators (Claire and Laurette)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming)
	2. Goal Setting Training (CHW form)		2. 60m	<ul style="list-style-type: none"> Review SMART goal setting skills 	Goal Setting Form Training 3/28/24- 5	1 hour	Program Manager (Laura); Program Coordinators (Claire and Laurette)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming)
	3. MI Training		3. 2 day training	<ul style="list-style-type: none"> Review motivational interviewing skills to enhance behavior change 	12/21/2023	3h	Practice Implementation Manager (Franze de la Calle)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming); Program Manager (Laura De Jesus); Project Coordinator (Laurette Espinoza-Hernandez); Program Facilitator (Aigna Barber)
	5. Data entry training (Participant forms)			<ul style="list-style-type: none"> Review SMART goal setting skills 	3/28/24, 4/16/24, 4/18/24	3h	Program Manager, Project Coordinators		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming)

Table 2: Implementation Strategies Activities & Trainings

Implementation Strategy	Support patients/ consumers to enhance uptake and adherence:	Develop strategies with patients to encourage and problem solve around adherence							
Actions	Activities	Audience	Estimated Length/Timeline	Major Content	Training/Activity Date(s)	Length of Training/Activity	Training/activity facilitated by	Site (if applicable)	Participants
Through 1-on-1 or group-based interactions (remotely or in-person) with patients, CHWs will support each of the components of PACE:	1. Goal Setting Training (CHW form)	CHWs	1. 60m	<ul style="list-style-type: none"> Review SMART goal setting skills 	Goal Setting Form Training 3/28/24- 5	1 hour	Program Manager (Laura); Program Coordinators (Claire and Laurette)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming)
	2. MI Training		2. 2 day training	<ul style="list-style-type: none"> Review motivational interviewing skills to enhance behavior change 	12/21/2023	3h	Practice Implementation Manager (Franze de la Calle)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming); Program Manager (Laura De Jesus); Project Coordinator (Laurette Espinoza-Hernandez); Program Facilitator (Aigna Barber)
NCM – CHWs will support patients to enhance uptake and adherence to NCM counseling/health education recommendations	3. Deliver virtual group educational sessions to FBO and CBO partners		3. 5h	<ul style="list-style-type: none"> Review educational material and ease of delivery 	Virtual Community Sessions: (Cohort 1) 2/2/2023, 2/7/2023, 2/9/2023, 2/14/2023, 2/16/2023, 2/21/2023, 2/23/2023; (Cohort 2): 11/14/2023, 11/16/2023, 11/21/2023, 11/28/2023, 12/5/2023, 12/12/2023; Harlem Community Sessions: Start date 10/22/2022 offered bi-weekly until March 2023	1 hour each	Study CHWs: (Linda Thompson, Roger Abrams, Vallyn Fleming)	Virtual, Harlem Community Center	FBO and CBO partners
RBPM – eg. trouble shooting technology-related barriers to RBPM and emphasizing importance of continual monitoring	RBPM Set up Guide	CHWs	30m	<ul style="list-style-type: none"> Learn to identify barriers to support continual adoption 	4/18/2023; Focus emphasis on RBPM adherence (3x a week) Tip sheets focused on NCM communication; RBPM Set Up Training Refreshers: 3/14/24, 4/23/24	1 hour each	Program Manager (Laura); NYU FOCUS; Program Facilitator (Aigna Barber)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming)
				<ul style="list-style-type: none"> Learn steps on how to set up RBPM and corresponding applications 	4/18/2023; FOCUS training (Aigna to confirm FOCUS content for CHWs) Tip sheets (need to demo); RBPM Set Up Training Refreshers: 3/14/24, 4/23/24	1 hour each	Program Manager (Laura); NYU FOCUS; Program Facilitator (Aigna Barber)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming)
3. SDOH – CHWs will support patients to “connect the dots” once referral information is shared by NCM; this may include addressing literacy issues, accessing referral locations, navigating to referral locations, completing applications, and facilitating direct contact with referral locations in target communities	1. Referrals Guide (CHW form)	CHWs	2 h	<ul style="list-style-type: none"> Review CHW forms and possible SDOH referrals needed Review CHW network of CBOs available around target neighborhoods 	HiteSite 11/9/2023 (CHW form training pending) Referrals Training including their own internal network/knowledge. Community mapping? Communication between nurses and CHWs (in basket and secure chat); 3/21/24; Weekly 1h meeting with CHWs and NCMs to review EPIC workflow/communication	1 hour each	Program Manager (Laura); Program Coordinators (Claire and Laurette)		Study CHWs (Linda Thompson, Roger Abrams, Vallyn Fleming)



Epic Secure Chat – Rover

May 8, 2023 - This information is proprietary and should not be reproduced or redistributed.

Secure Chat is an easy, efficient way to facilitate communication between users of all roles. The conversations can be about general information, or they can be patient-specific.

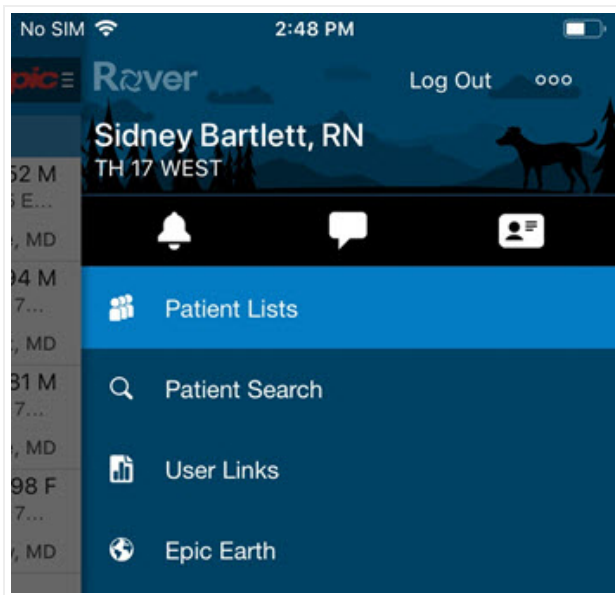
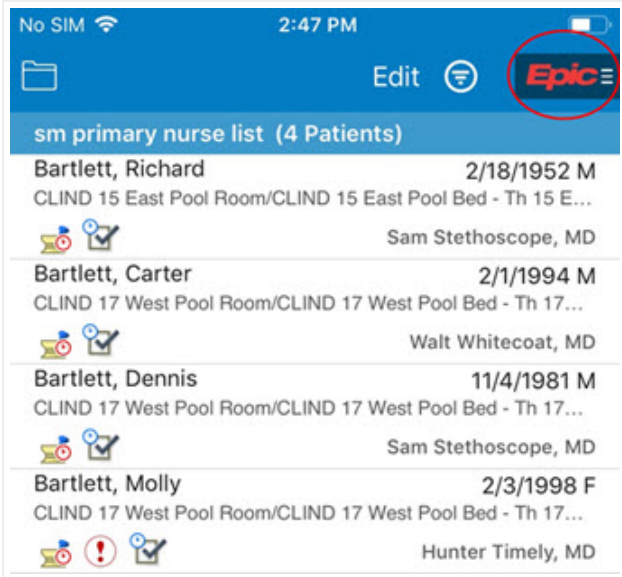
Note: All messages are not part of the patient's legal medical record and are auto-purged every 7 days.

Please see this important related policy here: <https://nyumc.ellucid.com/documents/view/5935>

Accessing Secure Chat in Rover

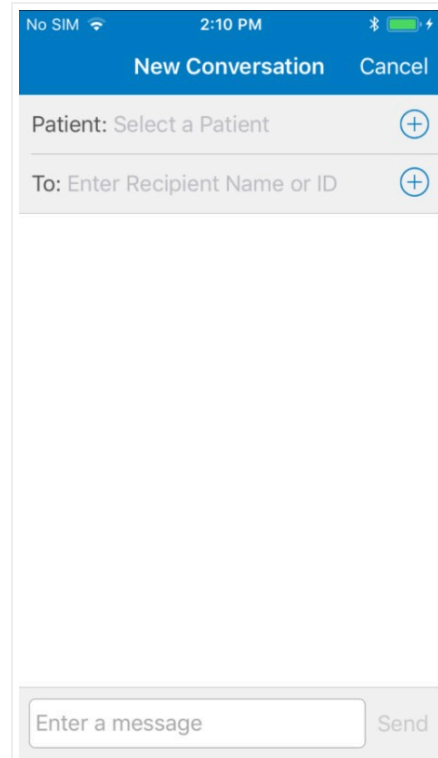
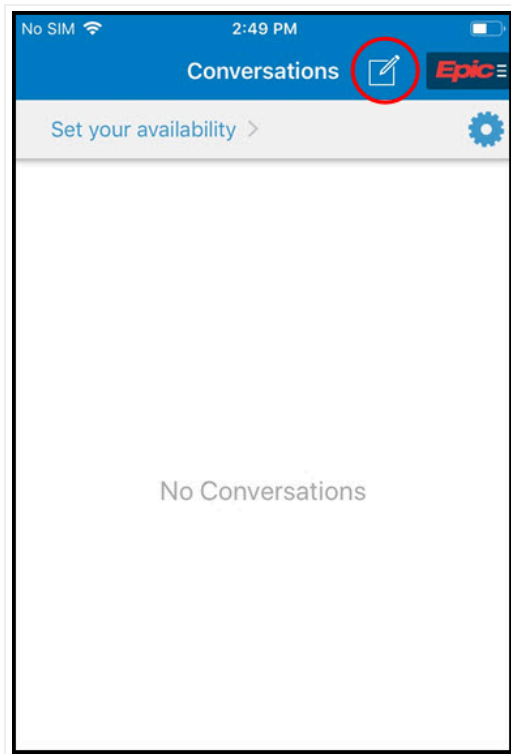
Note: Open an MCIT Help Desk ticket and notify your nursing leadership immediately if CMC device is missing, lost, or malfunctioning.

Secure Chat can be accessed from the Rover menu button.



Starting Conversations


Within Secure Chat you have the ability to create new conversations as well as access previous conversations. To begin a new conversation, tap on the pencil icon in the top right hand corner.

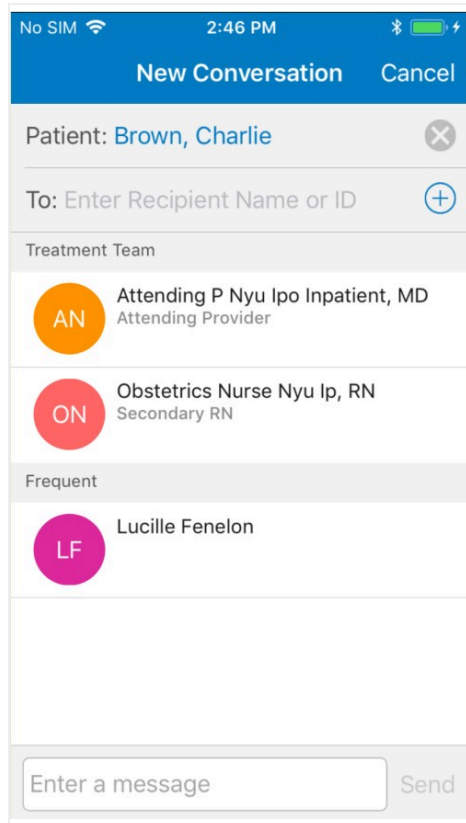
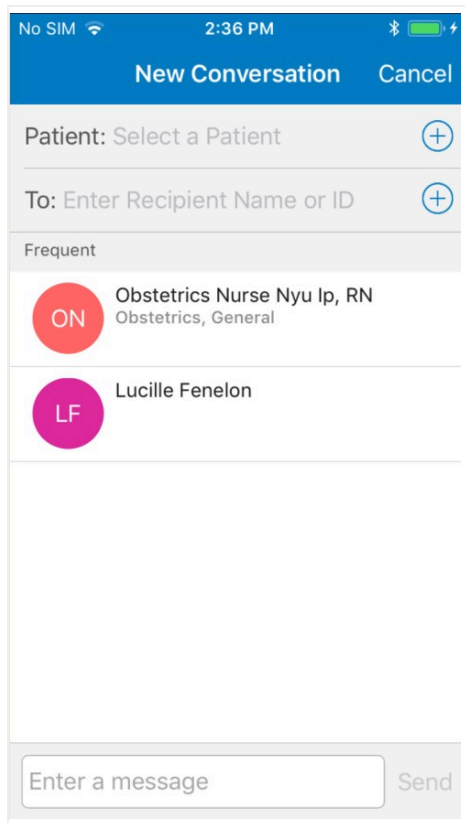


In the new conversation menu, select the patient you would like to discuss. If the conversation is not about a specific patient, leave the "Patient" field blank. If your message is about a patient, enter the patient's name or MRN in the **Patient** field.

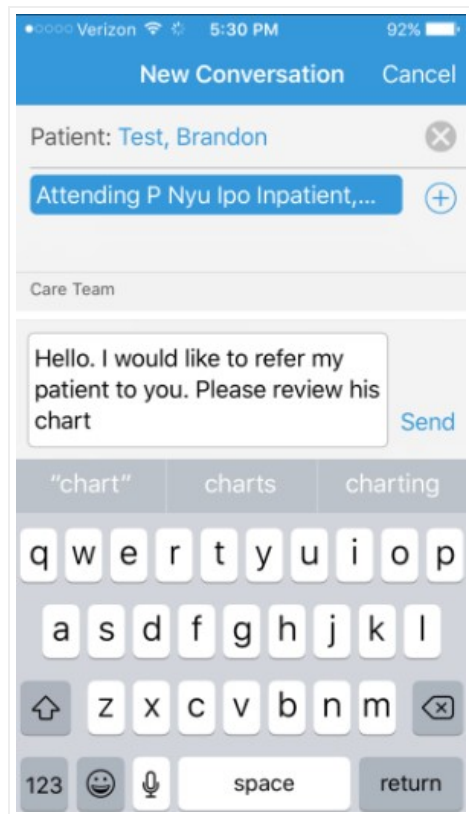
- In the **To** field, enter the recipient's name.

- If the intended recipient is greyed out with a  lock icon and an error **"Unable to Add User [name] does not have the required security to join conversations about a patient"**, or **"Unable to Add User [name] does not have the required security to participate in chat"**, the sender must contact the Help Desk referencing the user whom they cannot add in the conversation.


- If the intended recipient is greyed out with a  lock icon and an error **"Unable to Add User [name] uses a mobile application to chat but has not logged in recently"**, the intended recipient has to login to the mobile application (Rover, Haiku or Canto) to chat. The error occurs when users have been not logged in to the applicable mobile application for the last thirty (30) days. Note that this error message should not occur if the intended recipient has the ability to chat both in Hyperspace and mobile application (Rover, Haiku or Canto).

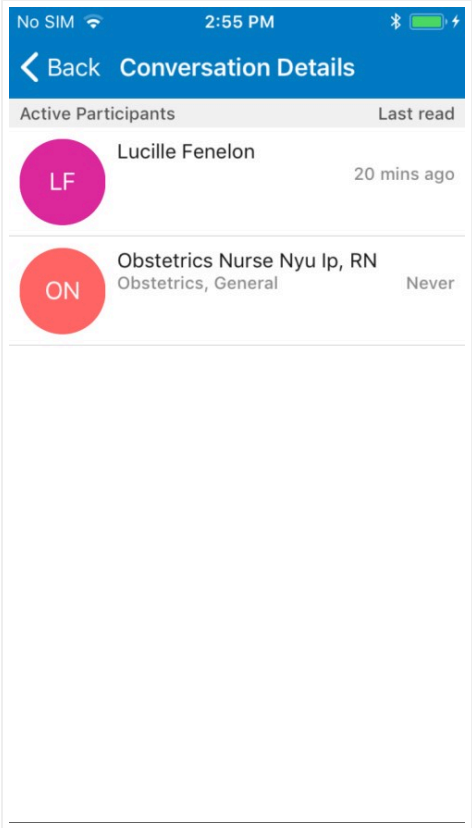
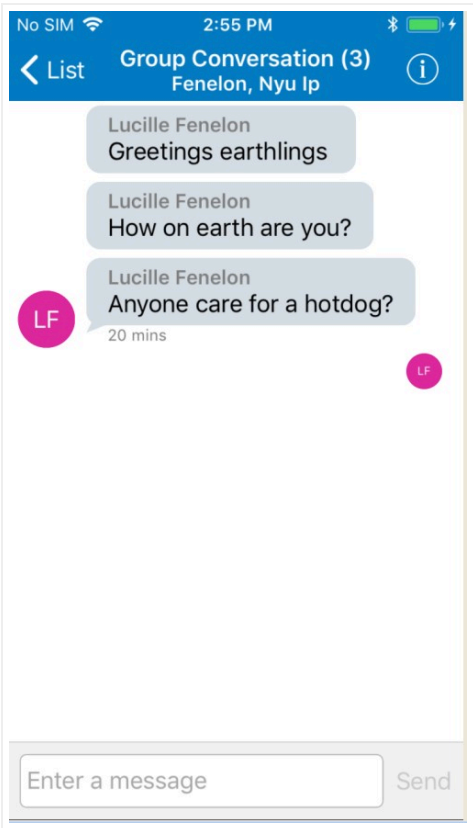


Once you have selected your recipients, tap on the Enter a Message field, type your message then tap Send.

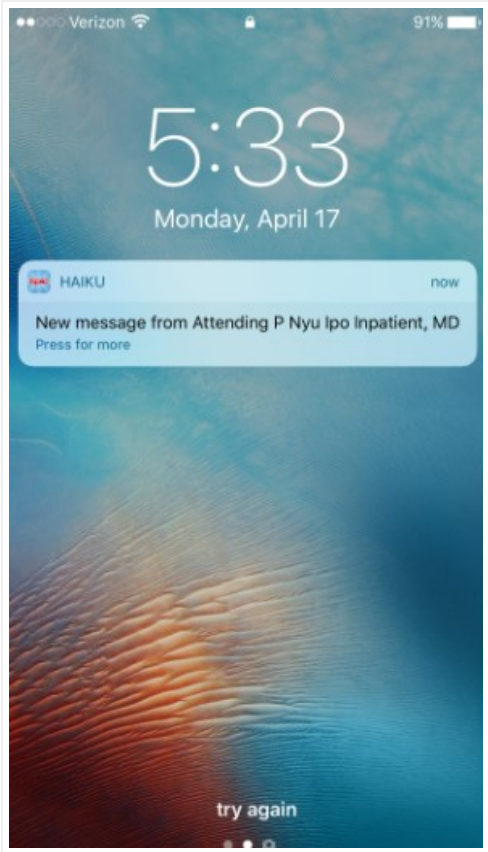




From within the conversation, you can tap the  icon on the top right corner, to see when a recipient last checked in on this message. You can tap on the patient header to open the chart.




When you receive a new message you will also receive a banner indicating that a new message has arrived, as long as you are still logged into Rover or the system has timed you out.



FindHelp Resources

Resources for FindHelp are available at the link below through the NYU Langone Inside Health.

- Tip sheets: [FindHelp Reference Links](#)
- Slides:  [Using FindHelp Final.pptx](#)
- [Recording](#) link

Actions to Decrease Disparities in Risk and Engage in Shared Support for BP Control (ADDRESS-BP) in Blacks Community Engagement Handbook for Community Health Workers (CHWs)

COMMUNITY ENGAGEMENT TRACKING

All community engagement (health fairs, community events, hypertension monitoring trainings and sharing of heart health educational packages) are tracked in spreadsheet on the NYU shared drive. Each event will have a record of:

- Date
- Purpose
- Location/Partner Organization
- Number of Contacts with community during the event (i.e., # of community members screened (BP), provided educational materials, provided verbal education, provided referrals, etc
- CHW in attendance
- Number of health education packets shared (if applicable)
- Number of volunteers trained (for hypertension monitoring training)

Spreadsheet will be updated once event is completed.

[Community Engagement Tracking\Community Engagement Tracking.xlsx](#)

For every event, CHWs will collect information from volunteers/community members through sign-up sheets to closely monitor attendance.

PRIMARY CARE REFERRALS

During community events, CHWs may ask community members if they have a primary care provider they can go to when discussing their hypertension, questions about their medication or if their blood pressure reading is out of range (per protocol below, immediate medical attention should be recommended if BP is above 180/110). If the community member does not have a primary care provider and is in need of a referral, CHW will confirm type of health insurance (Medicaid/Medicare) in order to provide guidance. If community member does not have health insurance, CHW will provide appropriate SDoH referral to meet their needs.

BLOOD PRESSURE SAFETY PROTOCOL

Events of Special Interest

Blood Pressure Monitoring Safety Protocols

Following American Heart Association guidelines, patients will be asked to take their BP twice (morning and evening), 3 days a week for one week prior to their visit with the NCM using a validated home blood pressure monitor. Blood pressure values from the monitor will be automatically uploaded via Bluetooth to the patient's medical record and monitored by the NCM and their primary care provider. Dr. Ogedegbe, an MPI and hypertension specialist, will also review out of range BP values and provide consultation to the participating NCMs and primary care providers. Building upon our past work, we will implement a BP safety monitoring protocol for high and low blood pressure readings.

As per the protocol, adapted from the NYCDOHMH, immediate medical attention should be recommended if a participant's BP is **180/110 or above (either number)**.

Participants who upload very high BP readings will be strongly encouraged to seek immediate medical attention by the NCM. Participants will be asked if they are experiencing any unusual symptoms at the moment: severe headache, feeling light-headed/dizzy, unusual difficulty breathing, numbness, confusion, unusual vision loss, chest pain, unusual nausea (ie. warning signs of heart attack or stroke). The protocol for participants who are experiencing any of these symptoms will follow the standard clinic guidelines and include the follow scenarios:

- a) Experiencing symptoms and the participant is onsite at the doctor's office: The participant will immediately see the PCP, or receive a same day appointment.
- b) Experiencing symptoms and the participant is offsite: The participant will be advised to go to the emergency room. If the participant requests someone to accompany them to the doctor/emergency room, a study team member may accompany the participant if available. Study team members will notify the participant's doctor's office immediately and provide the doctor's office with an update on whether participant sought medical care or refused.
- c) No symptoms and the participant is onsite at the doctor's office: The participant will be advised by clinic staff to see the doctor and notify doctor/staff immediately.
- d) No symptoms and the participant is offsite: The NCM will advise the participant to sit, breathe deeply, and relax for 10 minutes and re-take the BP reading. If the reading still falls in the very high range, the participant will be advised to seek immediate medical care—either a same day appointment at their doctor's office, an urgent care center, or the emergency room. The NCM will notify the doctor's office immediately and provide the

doctor's office with an update on whether participant decided to seek medical care or refused.

For participants who upload **low BP (90/60) or lower** they will be asked if they are experiencing the following symptoms: dizziness, headache, vision changes, shortness of breath, or chest pain.

- a) Experiencing symptoms: The participant will be advised to go to the emergency room. The NCM will notify the doctor's office immediately and provide the doctor's office with an update on whether participant decided to seek medical care or refused.
- b) No symptoms: The NCM will advise the participant to recheck their BP after resting in a quiet, dark room for 10 minutes.
 - I. If the BP reading improves (110/70 or higher), the participant will be advised to continue to monitor their BP at home.
 - II. If the BP reading remains the same and symptoms listed above occur, the participant will be advised to recheck their BP. If the BP reading improves but:
 - i. Systolic BP (SBP)>90 but <110 AND Diastolic BP (DBP)>60 but <70 OR SBP<90 or DBP<60 the NCM will advise the participant to contact their doctor's office and stop taking antihypertensive medications until the appointment. Participants should continue to monitor their BP at home.

A NCM will follow-up with the participant within 24 hours. Staff will be instructed to document the incident and follow-up call on the appropriate follow-up form/call log.

Participants with elevated BP >180 systolic BP or >110 diastolic BP or with low BP (90/60) or lower with symptoms will be asked to provide the study team with a signed document attesting that they sought care or refused to seek care, and the reasons why.

INCENTIVES

In order to attract community members during health fairs and events, CHWs are encouraged to offer small incentives including pens, keychains, small bags, folders for materials, etc. Incentives can be obtained through NYU's brand store.

Packing List

To all community events and health fairs CHWs must bring:

- 2 Blood Pressure Monitors
- XL BP cuff
- iPad for tracking sign ups (community members or volunteers)
- Heart Health Education packets

- NYU Langone Tabledoth
- Community Incentives
- Keep On Track Training Manuals (for Hypertension Management Training)
- All CHWs must have their NYU Employee ID

Subject Line: Reminder to Upload Your Blood Pressure Readings

Hello [Patients First Name],

We noticed that we haven't received your blood pressure readings as part of the Remote Blood Pressure Monitoring program with the Faculty Group Practice (FGP) Hypertension Initiative at NYU Langone Health (NYULH).

If you haven't started uploading yet—or if it's just been a while—we encourage you to begin again. Regularly uploading your readings help your care team track your progress and support your blood pressure goals.

Having technical issues with your monitor? We have resources to help you set up monitor and upload readings. Just reply to this message or call us at 646-501-3526 for more information.

Thank you for being part of the Hypertension Initiative. We look forward to continuing our work together!

Sincerely,

FGP Hypertension Initiative

Subject Line: Reminder to Upload Your Blood Pressure Readings

Hello [Patients First Name],

We noticed that we haven't received your blood pressure readings as part of the Remote Blood Pressure Monitoring program with the Faculty Group Practice (FGP) Hypertension Initiative at NYU Langone Health (NYULH).

If you haven't started uploading yet—or if it's just been a while—we encourage you to begin again. Regularly uploading your readings help your care team track your progress and support your blood pressure goals.

Need help with your monitor or uploading your readings? A Community Health Worker (CHW) from our team can assist you. Just reply to this message or call us at 646-501-3526 to get connected.

Thank you for being part of the Hypertension Initiative. We look forward to continuing our work together!

Sincerely,

FGP Hypertension Initiative

[Patient's Full Name]

[Address Line 1]

[City, State ZIP]

[Insert Date]

Subject: Congratulations on Graduating from the Remote Blood Pressure Monitoring Program with the FGP Hypertension Initiative at NYU Langone!

Dear [Patient's First Name],

Congratulations on successfully completing the Remote Blood Pressure Monitoring (RBPM) Program! Your hard work and commitment to monitoring your blood pressure has paid off, and we are thrilled to celebrate this important milestone in your journey toward a healthy heart.

Your official graduation date is [Graduation Date].

Because you've done such a great job managing your blood pressure, you have now graduated from the program. This means you will no longer be able to upload your blood pressure readings to your NYU MyChart account. However, your blood pressure monitor is yours to keep, please continue to use it regularly as part of your healthy routine.

You're not alone in this next chapter. You can continue to work with me, your Community Health Worker, for up to 30 more days after your graduation date. During this time, I'm here to support you, answer any questions, and help you stay on track with your health goals.

On behalf of the entire team, thank you for allowing us to be part of your care. You should be incredibly proud of your dedication and the steps you've taken to improve your health. Keep up the great work and continue making heart-healthy choices every day.

Congratulations!

[CHWs Name]