Harnessing the Power of Team-Based Care and Self-Measured Blood Pressure Monitoring to Improve Hypertension Control at Community Health Centers

December 12, 2025

Housekeeping

- Welcome!
- Let’s get to know each other - Take a moment to introduce yourself in the chat!
- **Please change your name to your full First and Last Name**
- **Please add your Health Center/Organization Name next to your name!**

Speakers

Andrew Moran, MD, MPH

Associate Professor of Medicine, Columbia University

Director, Global Hypertension Control, Resolve to Save Lives

Kelsey Bryant, MD, MPH, MS

Assistant Professor of Medicine

Certified Hypertension Specialist

Mount Sinai

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Associate Professor of Medicine

Co-Director, Columbia Hypertension Center

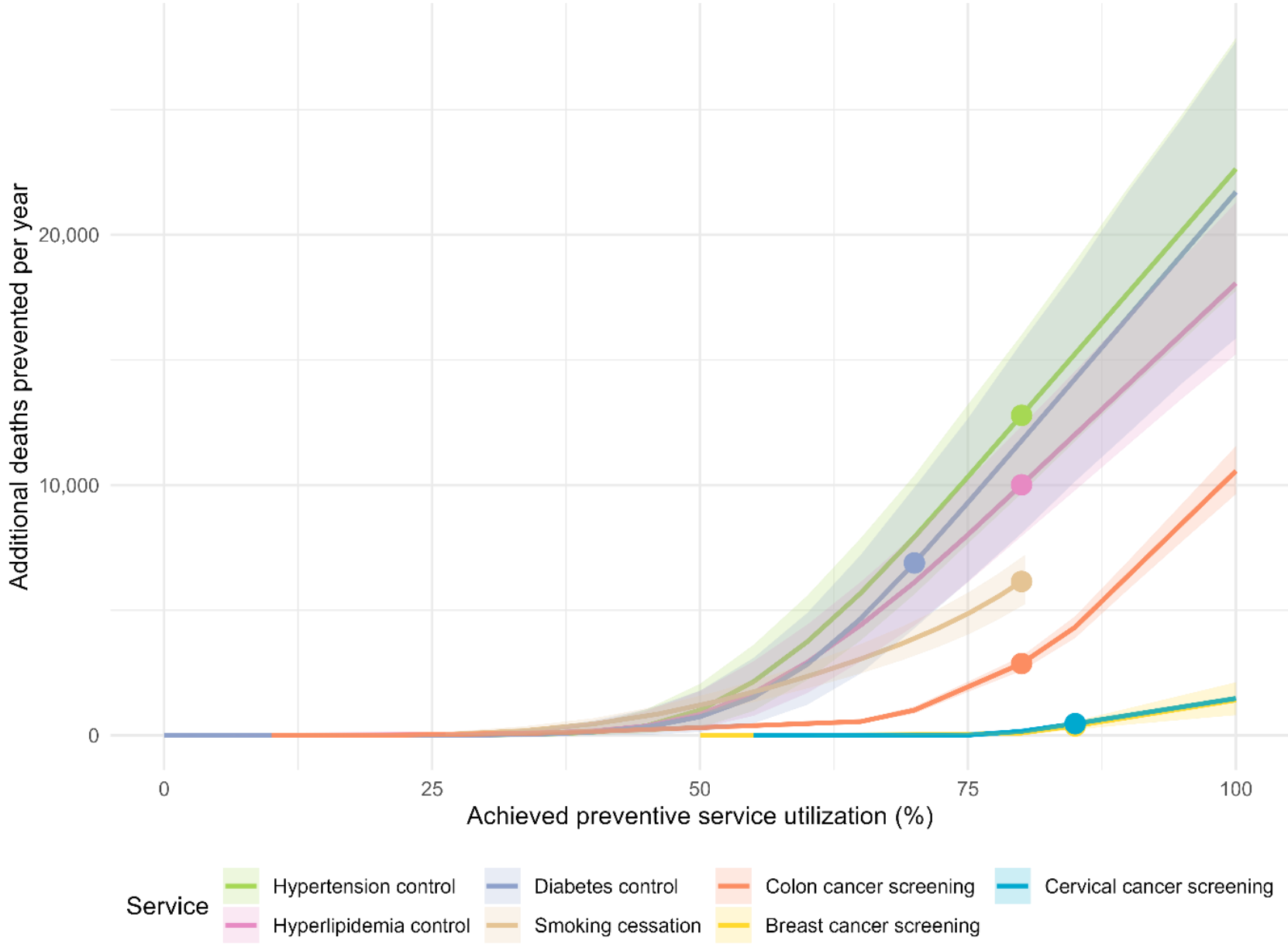
Columbia University Irving Medical Center

Part One: Team-based Care

Dr. Andrew Moran

Hypertension control = lives saved

Of all primary care preventive services, **hypertension control saves the most lives**



Pilla S. et al. under review

Hypertension in the NY State community health centers*

UDS Data Five-Year Summary

Age and Race/Ethnicity | Patient Characteristics | Services | Clinical Data | Cost Data

Clinical Data	2020	2021	2022	2023	2024
Controlling High Blood Pressure *	60.46%	62.56%	66.40%	67.85%	69.74%

- Overall, within NY adults with HTN treated in participating centers (1.3 million adults); **HTN control is ~70%**
- This estimate does not account for people without healthcare access or not accessing their care
- **HTN control around 65% is typical for health systems where the system and clinicians are working toward a goal BP <140/90 mmHg**
- In our prior session, we saw that health care providers and clinicians reaching >80% control (<140/90) have **average systolic BP <120 mmHg in their hypertension patients**

2025 US HTN guidelines: recap of main messages from September CHCANYS webinar

- **Spread the news, and motivate patients to take their daily medicines: HYPERTENSION TREATMENT PREVENTS DEMENTIA**
- **GO FOR IT!** Overcome inertia and **treat SBP <130 mmHg** in HTN patients as long as no side effects or polypharmacy concerns. **Target mean systolic BP of 120 mmHg** at provider and clinic levels
- **Ensure access to dual drug single pill combinations** in formularies, pharmacy shelves—for Stage 2 HTN patients
- **Implement and improvise on Team-Based HTN Care**
- **Advocate in Albany** to increase scope of practice and reimbursement for non-physician workers (PAs, NPs, clinical pharmacists, community health workers)

An Update to Guidelines: team-based care in 2025

2025 ACC/AHA Hypertension Guidelines, Section 5.4 *Plan of Care for Hypertension*

Recommendations for Plan of Care for Hypertension Referenced studies that support the recommendations are summarized in the Evidence Table.		
COR	**LOE**	**Recommendations**
Team-Based Care		
1	**A**	1. For adults with uncontrolled hypertension, a team-based care approach is recommended to achieve and maintain BP control.[1–4]

What is team-based hypertension care?

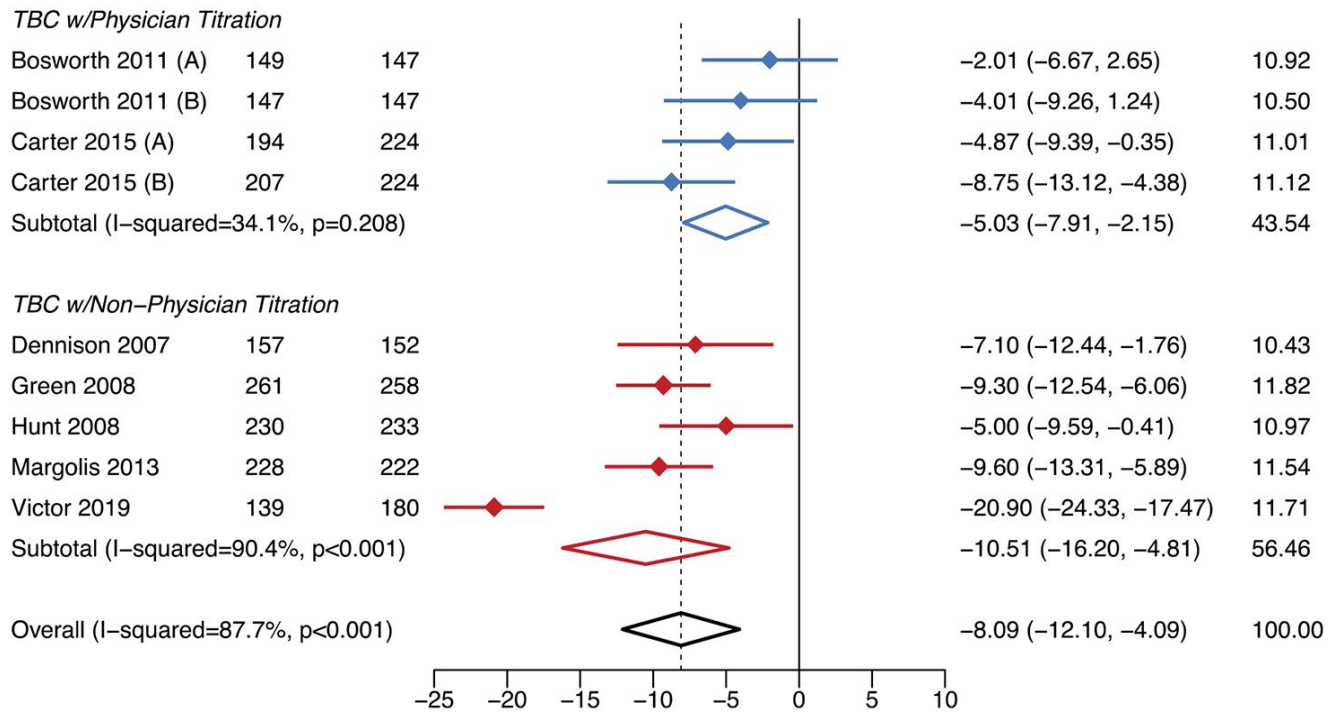
- **ACC/AHA 2025:** *"a health systems-level organizational intervention"*
- Incorporates a **trained multidisciplinary team**, including physicians, nurse practitioners, physician assistants, nurses, pharmacists, dieticians, social workers, and community health workers
- Each **team members' roles delineated**, allowing the primary care clinician to focus on complex issues while other team members address medication management, patient education, lifestyle modification, and social determinants of health

Team-based care: the evidence

- 19 studies comprising 5993 participants
- 12-month systolic BP change versus usual care:
  - **-5.0** (-7.9 to -2.2) mm Hg for team-based care (TBC) with **physician** titration
  - **-10.5** (-16.2 to -4.8) mm Hg for TBC with **nonphysician** titration*

Physician-led TBC

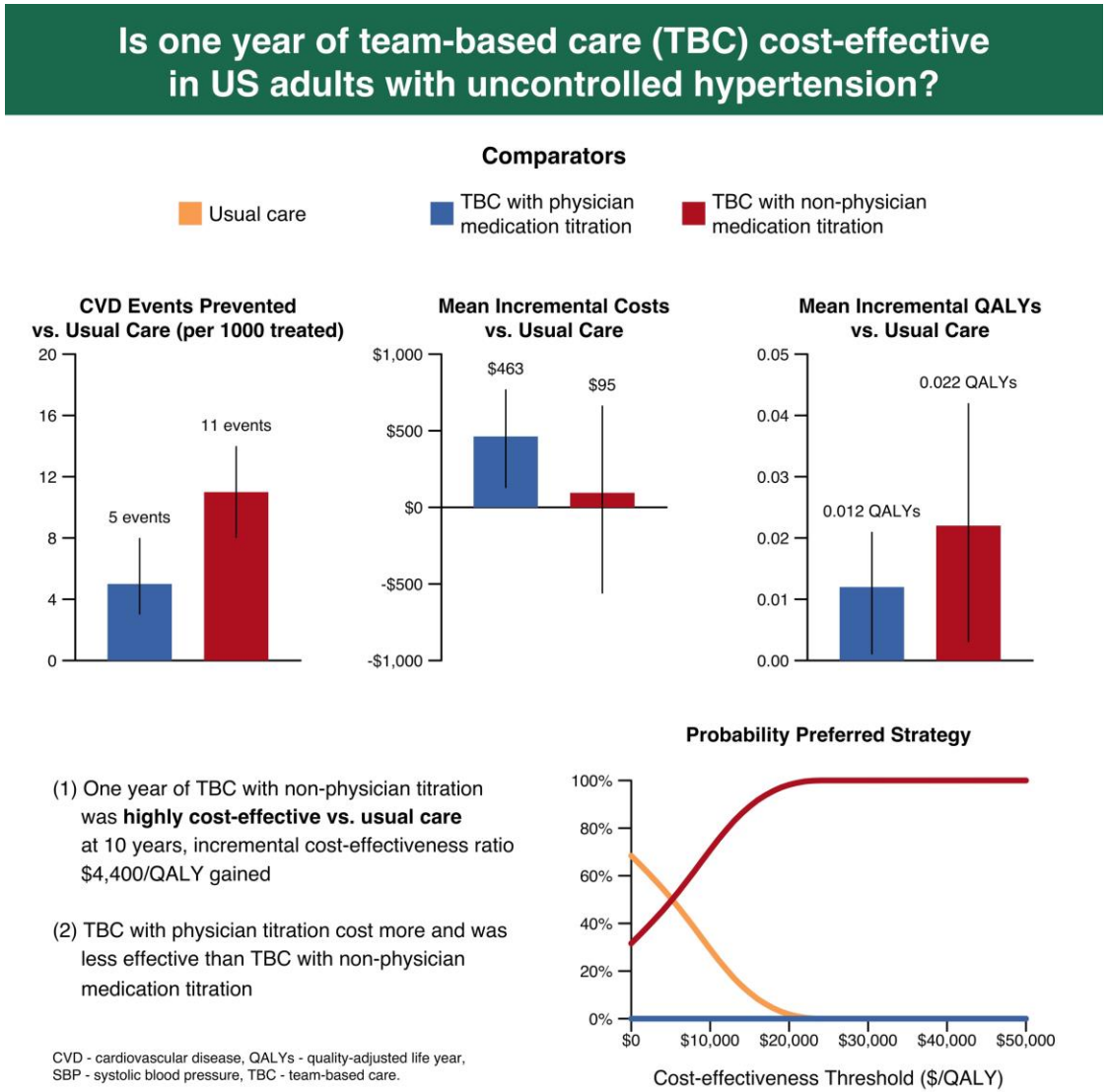
Non-physician-led TBC



Bryant, KB et al., Hypertension, 2023

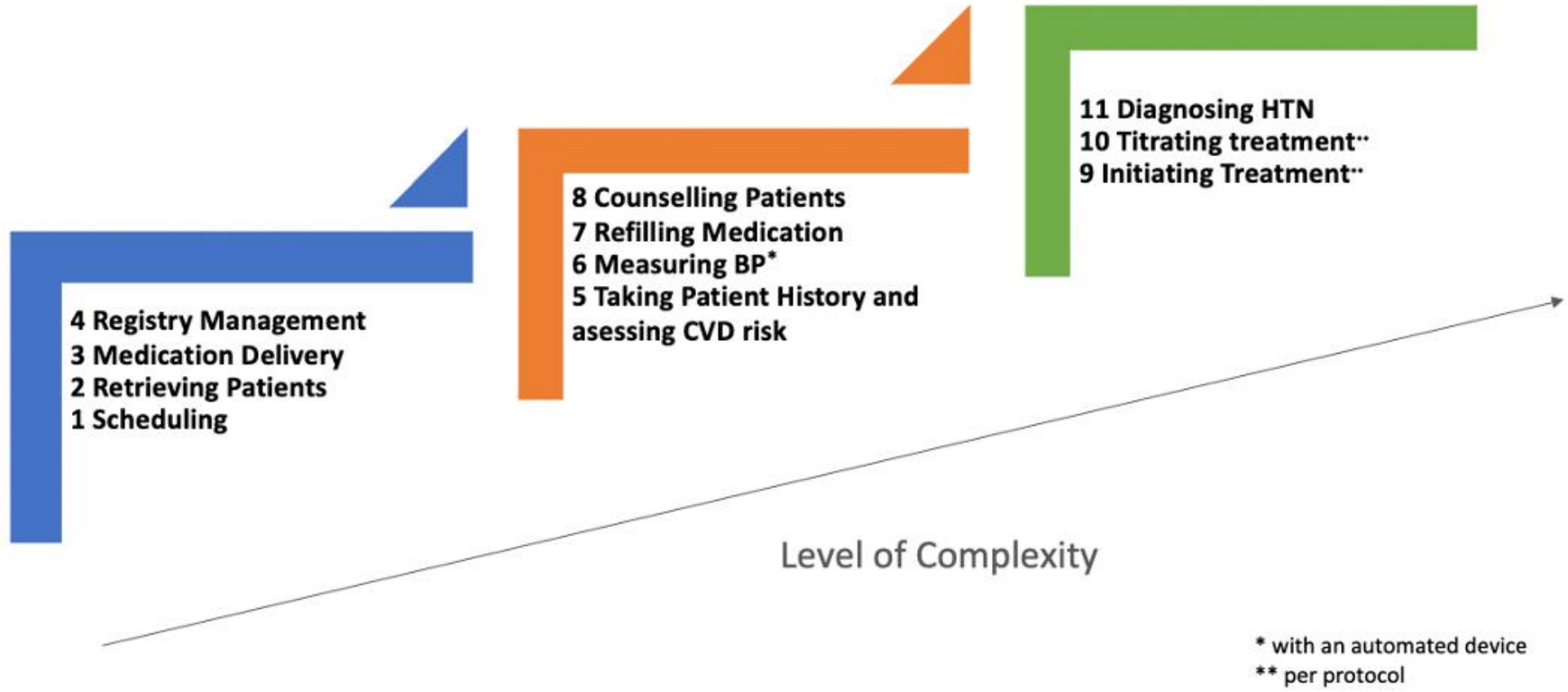
Cost-effectiveness of team-based HTN care

- Relative to usual care at 10 years, TBC with nonphysician titration was estimated to cost $95 and cost-effective ($4400/quality-adjusted life year gained)
- TBC with physician titration was estimated to cost more and gain fewer quality-adjusted life years than TBC with nonphysician titration



Bryant, KB et al., Hypertension, 2023

Team-based care conceptual framework for hypertension management

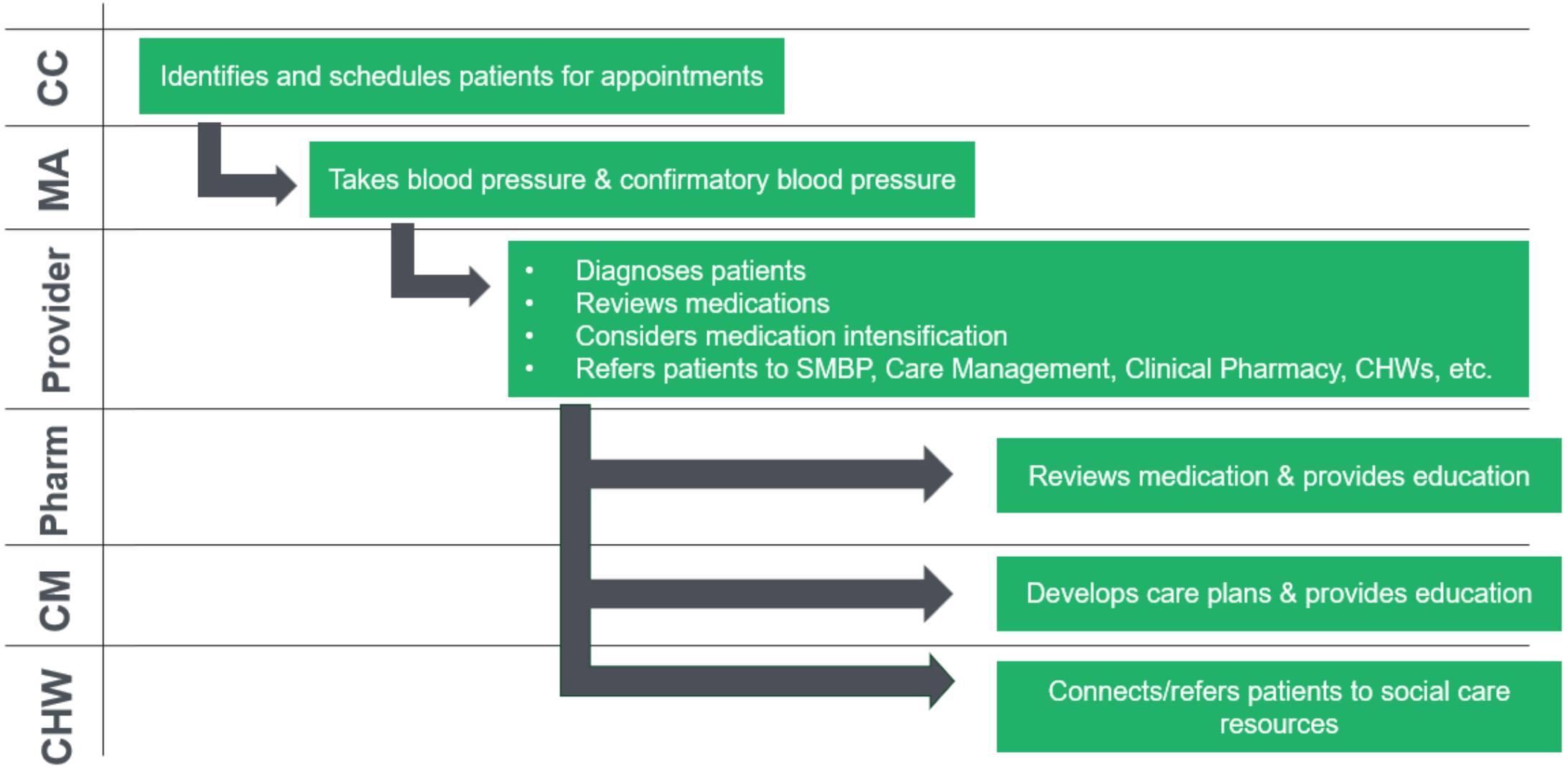


*Ogunbge O. et al., Determining the frequency and level of task-sharing for hypertension management in LMICs: A systematic review and meta-analysis. eClinicalMedicine, 2022.

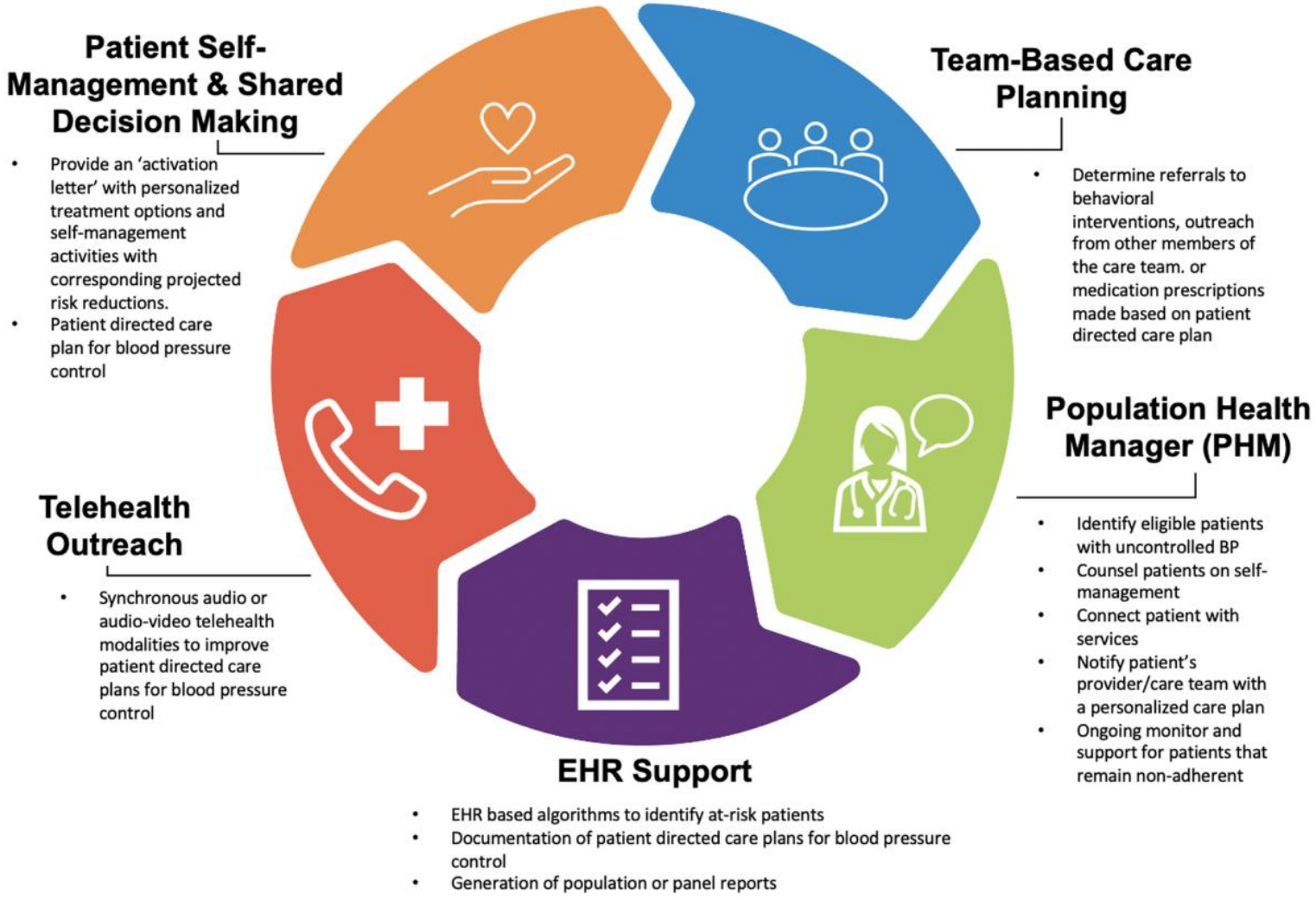
Team-base HTN care roles: primary care setting

Role	Activities
 **Quality Team**	• Monitor practice, team, provider performance • Create cohorts based on focus for intensification, pharmacy intervention, care manager engagement • Track & visualize impact of quality improvement efforts
 **Care Team**	• Review/discuss/manage patients with treatment inertia • Identify hypertension care needs at the point of care • Participate in Care Team huddles
 **Care Manager**	• Actively oversee/manage patients with changes in medication (cohort) • Provide home BP monitoring instruction/teach back • Self management goal setting / care planning • Address health-related needs • Provide education or enabling resources • Participate in Care Team huddles
 **Care Coordinator**	• Identify & outreach to patients with undiagnosed hypertension, high risk ASCVD without treatment, hypertensive tobacco users, etc.
 **CHW**	• Conduct health-related needs screens • Refer patients for health-related care needs • Monitor health-related needs screening rates for patients with HTN

Sample Team-Based Care Workflow



EHR design and workflows to support HTN TBC



Drake, C., Lewinski, A.A., Rader, A. *et al*. Addressing Hypertension Outcomes Using Telehealth and Population Health Managers: Adaptations and Implementation Considerations. *Curr Hypertens Rep* **24**, 267–284 (2022).

Legal & regulatory environment affecting team-based care in New York State

Pros:

- NYS Nurse Practitioners Modernization Act removed requirements for experienced NPs to have a written practice agreement with a physician; led to more effective team-based care
- New York has been a leader in building consensus on scope of CHW practice and training standards

Cons:

- However, limited reimbursement for nonphysician team members (e.g., pharmacists, community health workers); current payment models rarely support team-based hypertension care outside of physician-delivered services
- Non-physicians are still limited in their ability to independently manage hypertension or titrate medications

Lessons Learned: Team-Based Hypertension Care

Franklin Smith

Senior Director of Quality

Neighborhood Health Center of Western NY

The Full Care Team

NEIGHBORHOOD HEALTH CENTER

Healthcare that welcomes you.

The Full Care Team – Anyone Who Impacts Patient Experience

Background:

Maria is a 62-year-old Spanish-speaking patient with diabetes, hypertension and depression. She recently lost her housing and has missed multiple appointments.

- Operators schedule a same-day visit and flag need for Spanish interpretation.
- PSRs check her in, update housing status, income information and other demographic data.
- Billing & Finance help apply for sliding fee scale.
- CHWs connect Maria to housing resources and arrange transportation for follow ups
- Medical Records request previous cardiology records and update the chart.
- Nursing completes vitals, A1c testing and all applicable screenings.
- Provider updates care plan, adjusts meds, discusses internal BH and Nutrition services and makes updated referrals.
- Care Coordinators assist with updated cardiology and endocrinology referrals.
- Pharmacy checks for med interactions and arranges delivery.
- Quality identifies Maria as high risk and qualifies her for advanced care management.
- Wellness team takes enrolls her in Care Management and supports her ongoing engagement in her care

Result:

Maria receives timely, coordinated care that addresses her medical, behavioral and social needs — supported by every part of the health center team. Maria has gone from being “non-compliant” to being an active participant in her care with controlled chronic conditions

COMMUNITY HEALTH CARE ASSOCIATION of New York State

Poll

Part Two: Self-Monitored BP

Dr. Ian Kronish & Dr. Kelsey Bryant

What Is Self-Measured Blood Pressure (SMBP)?

- Replicates office BP in the home
- For initial diagnosis, ideally, measure twice in morning and twice before bed for 7 days, (**even 3 days should be enough)**
- For self-monitoring while being treated for hypertension, less clear recommendations on frequency of checking home BP

- Note: kiosks may overestimate BP

Bello et al. *JAHA* 2019; Green et al. *J Gen Intern Med* 2022

Why measure BP at home?

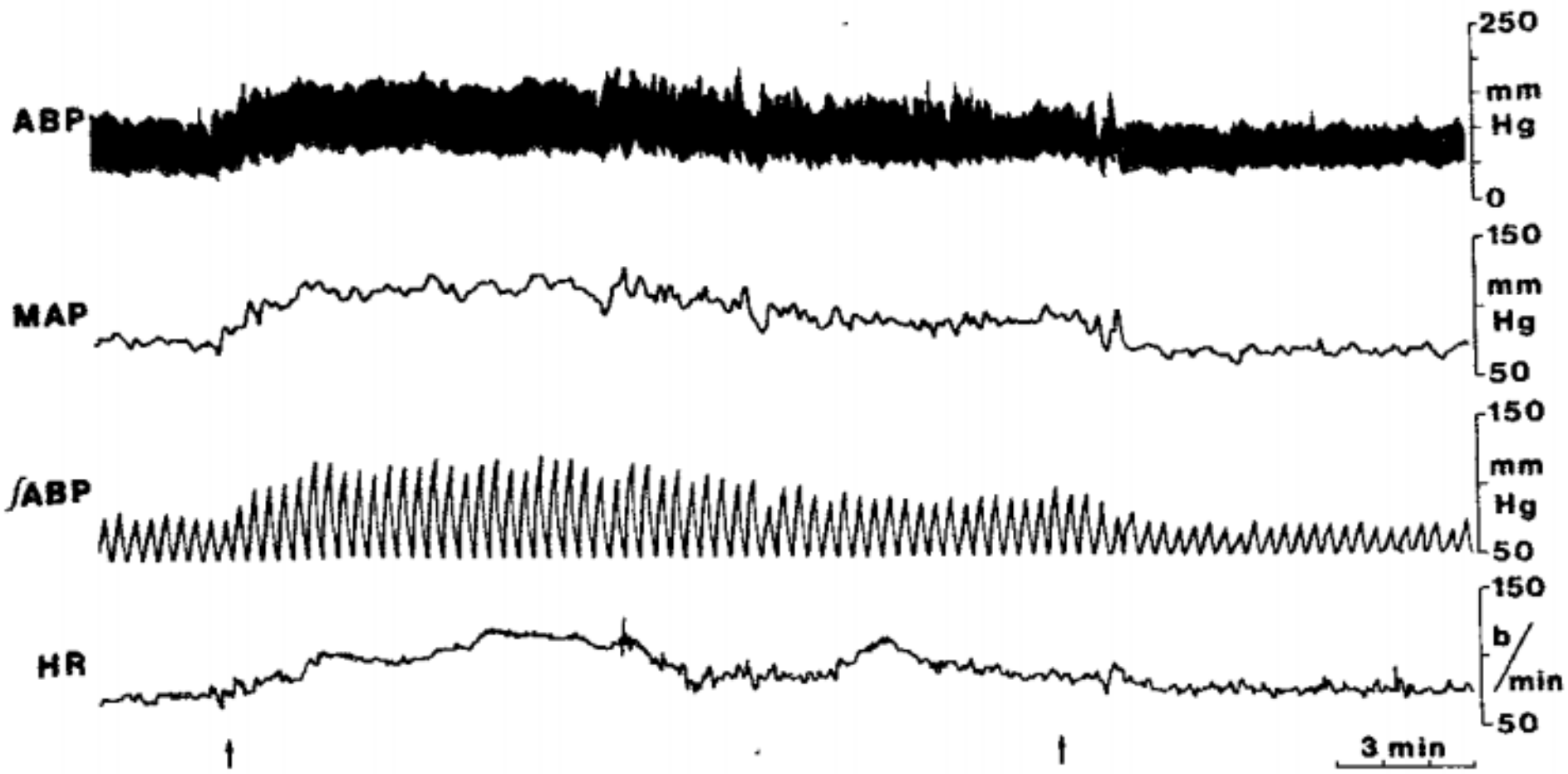
Inaccurate office methods

Limited number of office BP readings

Office BP may not reflect ‘true’ BP

Pickering et al. *Hypertension*. 2005; Rakotz et al. *J Clin Hypertens*. 2017

White-coat hypertension



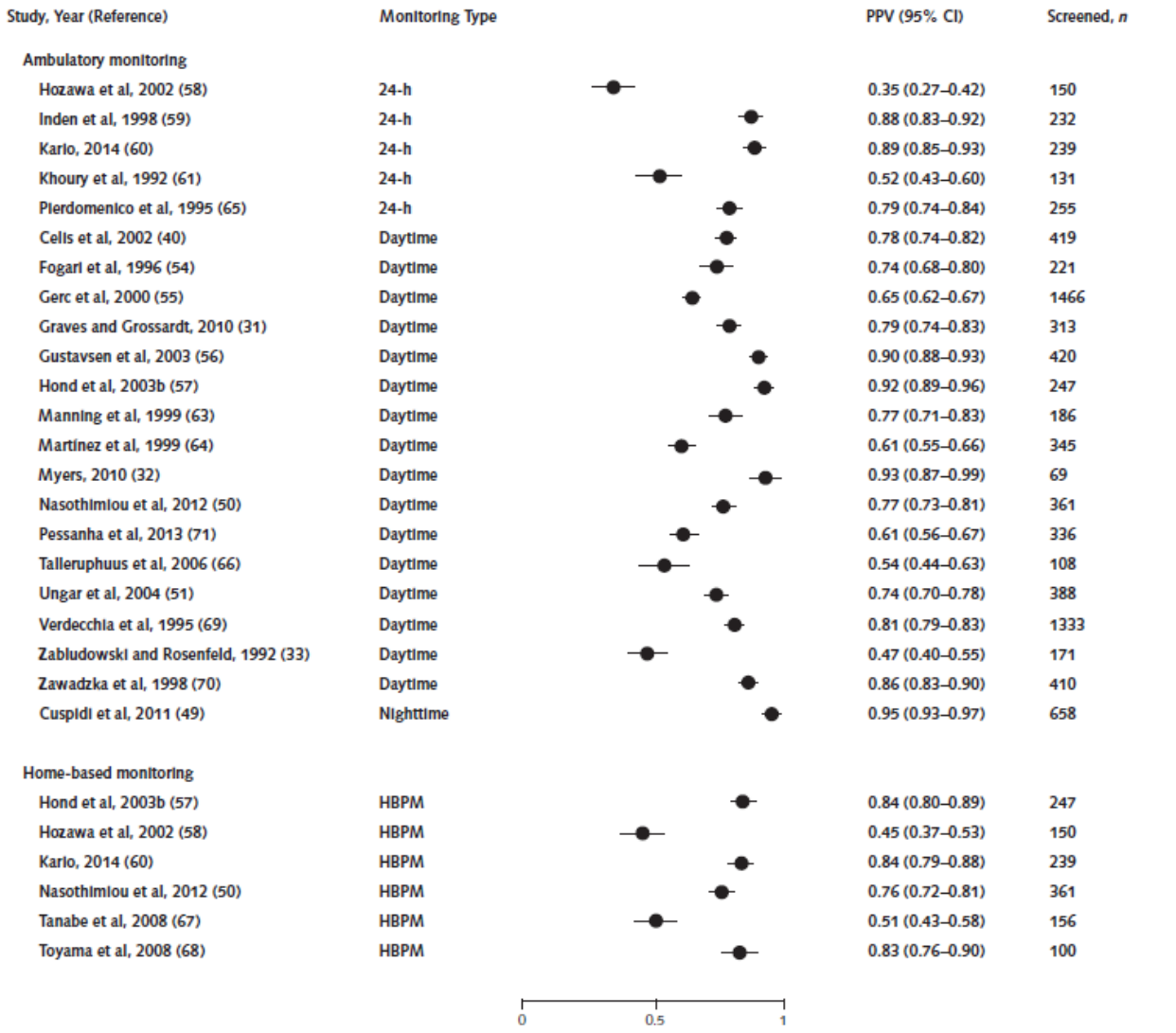
Mancia et al. *Lancet* 1983

White-coat hypertension is common

~1 in 5 patients with newly elevated office BP have white coat hypertension,

higher in routine care without research grade BP measurement

(range 5% - 65%)



Study, Year (Reference)	Monitoring Type	PPV (95% CI)	Screened, *n*
Ambulatory monitoring			
Hozawa et al, 2002 (58)	24-h	0.35 (0.27–0.42)	150
Inden et al, 1998 (59)	24-h	0.88 (0.83–0.92)	232
Karlo, 2014 (60)	24-h	0.89 (0.85–0.93)	239
Khoury et al, 1992 (61)	24-h	0.52 (0.43–0.60)	131
Pierdomenico et al, 1995 (65)	24-h	0.79 (0.74–0.84)	255
Celis et al, 2002 (40)	Daytime	0.78 (0.74–0.82)	419
Fogari et al, 1996 (54)	Daytime	0.74 (0.68–0.80)	221
Gerc et al, 2000 (55)	Daytime	0.65 (0.62–0.67)	1466
Graves and Grossardt, 2010 (31)	Daytime	0.79 (0.74–0.83)	313
Gustavsen et al, 2003 (56)	Daytime	0.90 (0.88–0.93)	420
Hond et al, 2003b (57)	Daytime	0.92 (0.89–0.96)	247
Manning et al, 1999 (63)	Daytime	0.77 (0.71–0.83)	186
Martínez et al, 1999 (64)	Daytime	0.61 (0.55–0.66)	345
Myers, 2010 (32)	Daytime	0.93 (0.87–0.99)	69
Nasothimiou et al, 2012 (50)	Daytime	0.77 (0.73–0.81)	361
Pessanha et al, 2013 (71)	Daytime	0.61 (0.56–0.67)	336
Talleruphuus et al, 2006 (66)	Daytime	0.54 (0.44–0.63)	108
Ungar et al, 2004 (51)	Daytime	0.74 (0.70–0.78)	388
Verdecchia et al, 1995 (69)	Daytime	0.81 (0.79–0.83)	1333
Zabludowski and Rosenfeld, 1992 (33)	Daytime	0.47 (0.40–0.55)	171
Zawadzka et al, 1998 (70)	Daytime	0.86 (0.83–0.90)	410
Cuspidi et al, 2011 (49)	Nighttime	0.95 (0.93–0.97)	658
Home-based monitoring			
Hond et al, 2003b (57)	HBPM	0.84 (0.80–0.89)	247
Hozawa et al, 2002 (58)	HBPM	0.45 (0.37–0.53)	150
Karlo, 2014 (60)	HBPM	0.84 (0.79–0.88)	239
Nasothimiou et al, 2012 (50)	HBPM	0.76 (0.72–0.81)	361
Tanabe et al, 2008 (67)	HBPM	0.51 (0.43–0.58)	156
Toyama et al, 2008 (68)	HBPM	0.83 (0.76–0.90)	100

Results of included studies for key question 3b. ABPM = ambulatory blood pressure monitoring; HBPM = home blood pressure monitoring; OBPM = office blood pressure measurement; PPV = positive predictive value.

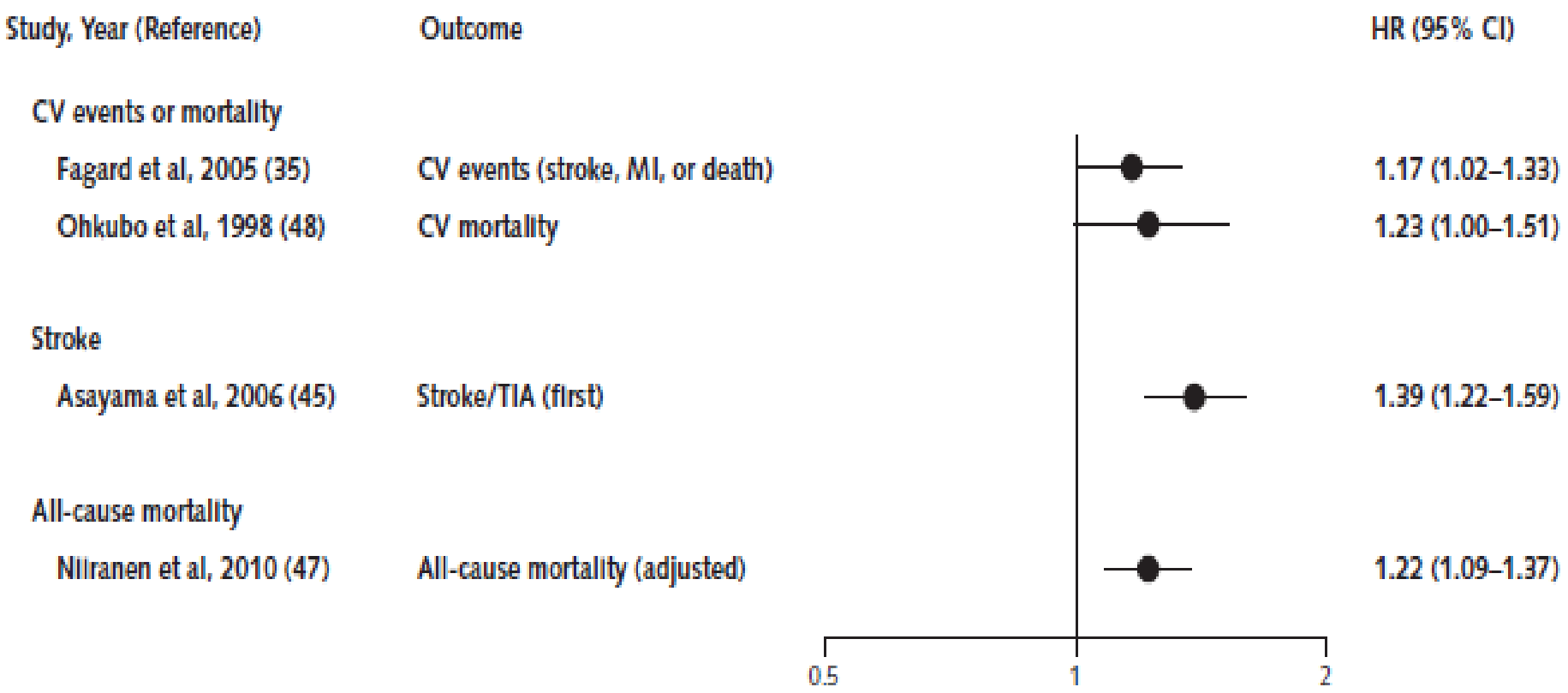
Piper et al. *Ann Intern Med*. 2014

Masked hypertension is common too!

- BP lower in the doctor's office than out of the office
- Occurs in ~12% of adults with non-elevated office BP
- Double the risk of CVD events compared to normotension

Wang et al. *Am J Epidemiol* 2017

Home BP predicts CVD risk better than office BP



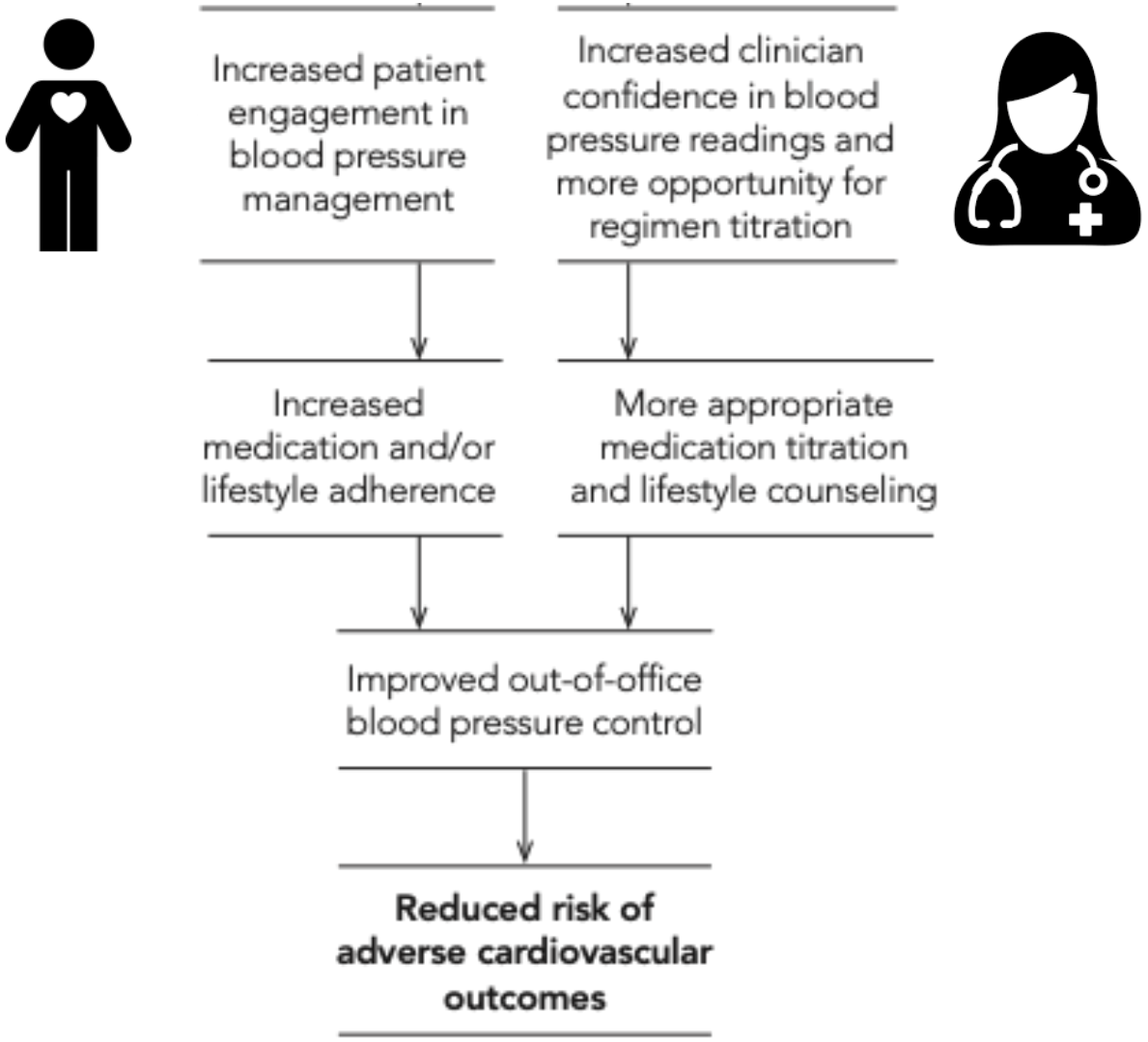
Piper et al. *Ann Intern Med*. 2014

USPSTF hypertension screening recommendations 2015, 2021

Population	Recommendation	Grade (What's This?)
Adults aged 18 years or older	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment (see the Clinical Considerations section).	A

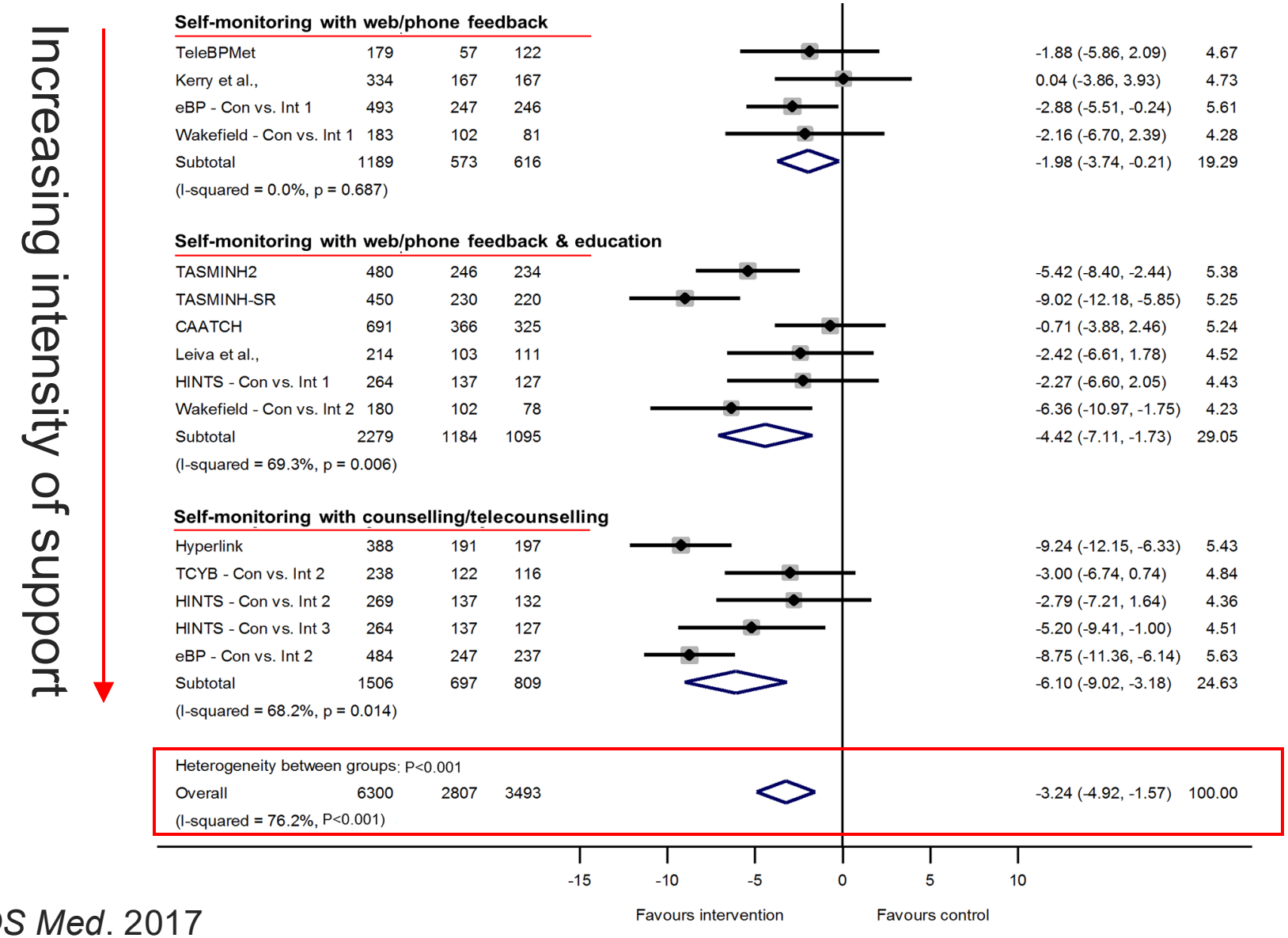
U.S. Preventive Services TASK FORCE

How SMBP improves hypertension outcomes



Liyanage-Don et al. *Curr Hypertens Rep*. 2019

What is the Evidence for SMBP?



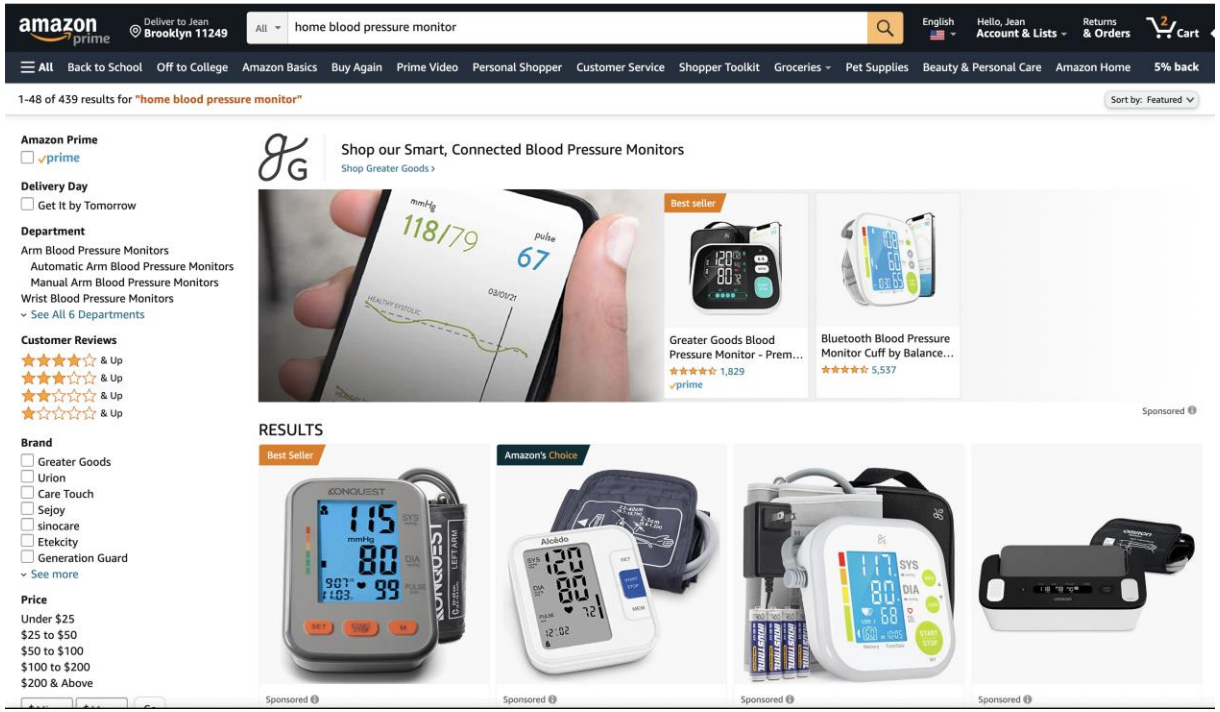
Tucker et al. *PLOS Med*. 2017

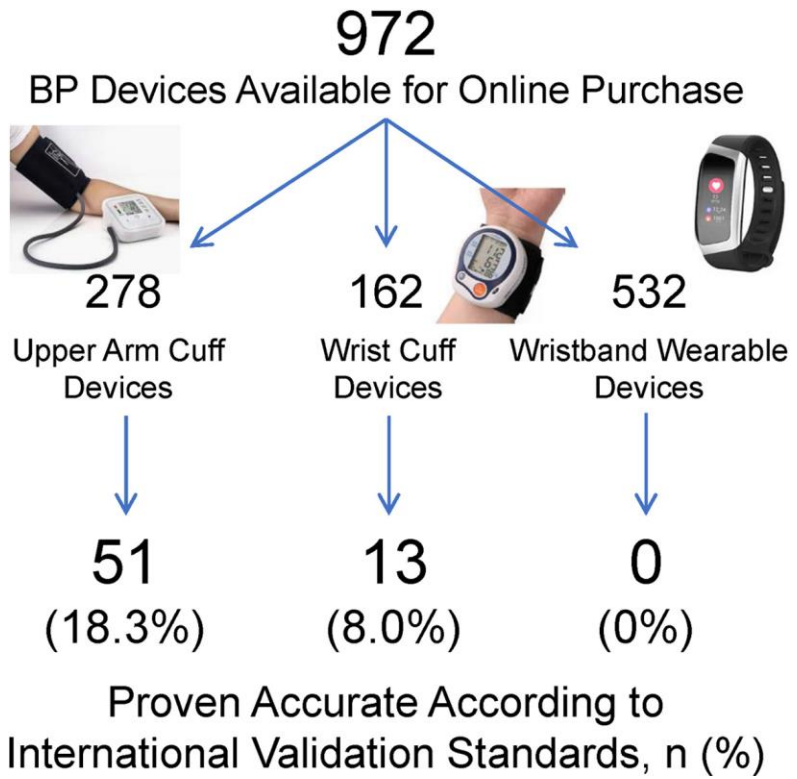
Translating SMBP into Practice

Common clinician challenges with SMBP

- Write a prescription but patient never gets home BP device
- Patient has a BP device but doesn't bring the BP readings
- Patient brings the readings, but the home BP readings don't match office BP readings
  - Is device accurate?
  - Does BP cuff fit correctly?
  - Is patient following correct measurement protocol?

Majority of home BP devices are not validated





Unvalidated devices are typically less expensive than validated ones

Unvalidated devices are less likely to be accurate

Picone et al. *Hypertension*. 2020; Picone et al *JAMA* 2023

Size (of BP cuffs) matters!

Table 2. Mean Difference in BP When a Regular BP Cuff Was Used Regardless of Appropriate BP Cuff Size

Table 2. Mean Difference in BP When a Regular BP Cuff Was Used Regardless of Appropriate BP Cuff Size

Cuff size	Mean (SD), mm Hg[a]		BP cuff size used relative to appropriate BP cuff size	BP difference (95% CI), mm Hg	*P* value for difference
	BP with appropriate BP cuff	BP with regular BP cuff			
Systolic BP					
Small (n = 35)	119.6 (23.5)	116.0 (23.4)	1 Size too large	−3.6 (−5.6 to −1.7)	<.001
Regular (n = 54)	120.9 (21.4)	120.9 (21.4)	Correct cuff size	0 [Reference]	NA
Large (n = 65)	122.7 (14.7)	127.5 (14.9)	1 Size too small	4.8 (3.0 to 6.6)	<.001
Extra large (n = 40)	124.5 (21.8)	144.0 (22.4)	2 Sizes too small	19.5 (16.1 to 22.9)	<.001
Diastolic BP					
Small (n = 35)	71.5 (10.4)	70.2 (10.5)	1 Size too large	−1.3 (−2.4 to −0.2)	.02
Regular (n = 54)	72.8 (11.5)	72.8 (11.5)	Correct cuff size	0 [Reference]	NA
Large (n = 65)	75.7 (7.0)	77.6 (7.7)	1 Size too small	1.8 (1.1 to 2.6)	<.001
Extra large (n = 40)	79.3 (12.2)	86.7 (14.2)	2 Sizes too small	7.4 (5.7 to 9.1)	<.001

Abbreviations: BP, blood pressure; NA, not applicable.

[a] BPs were based on the average of triplicate BP readings.

Ishigami et al. *JAMA Intern Med*. 2023

Team Member Roles within SMBP Program

Role	Responsibilities
Navigator	• Onboarding and reminders to track home BP • Trouble shoot device questions
Nurse (RN)	• Teach patients how to correctly measure BP at home • Lifestyle counseling and patient activation
Clinical Pharmacist	• Medication reconciliation and adherence counseling • Triage extreme readings • Titrate BP medications according to algorithm
Population Health Manager	• Outreach to patients with uncontrolled office BP
Community Health Worker	• Link patients to resources that address health related social needs

What could this look like in practice?

Remote Patient Monitoring

- Standard connected device, EHR flowsheets
- Regular visits with interdisciplinary care team - PharmD/NP/patient navigators – to support medication adherence, intensification
- Co-management with PCP
- Out of range notifications
- Program phases - enrollment - > management - > maintenance

Care Team

- Connected or non-connected device
- Can leverage EHR flowsheets depending on device, EHR, patient preference
- Consider already exiting resources to build the team – can include in-person, video, and/or telephone visits with NP/PharmD/RN to review home BP measurements, facilitate medication adherence, intensification

PCP

- Connected or non-connected device
- Can leverage EHR flowsheets depending on device, EHR, patient preference
- May occur between usual care visits to support medication adherence, titration or at the time of usual care

Data Inflow Strategies

Strategy	Pro	Cons
Patient brings log	Less between visit work	Patient may forget, need to average value during limited appointment time
Patient submits to HER Or web based software	Less work between visits, EHR may calculate average	Need to clarify follow up plan (between visit, just for review at next visit)
Team outreaches patient	Possible additional patient engagement, opportunity for education and titration (if MD, PharmD, NP, PA)	Time consuming for team, need dedicated time to conduct May have to calculate average in real time if patient device does not
Connected device **(Remote Patient Monitoring/RPM)** **"Genius Bar"**	Direct transmission/average to EHR	Need response/review protocol in place Expensive and sometimes reimbursement is complication

How to ensure your patients are getting accurate home BP readings

- Be familiar 1 or 2 low-cost home BP brands
- Consider lending validated devices to patients (or, better, give them away for free)
- Understand insurance policies (only Medicaid covers devices)
- Partner with your vendor
- Provide instructional materials
- Ask patient to bring device for teaching by nurse or other team member
- Check to see if device is on **ValidateBP.org**
- Compare home BP readings with those from a validated office device

www.homeBPsupport.org

Home blood pressure monitoring is a better way to manage your patient's hypertension

Which program is right for your patient?

MyCare Hypertension

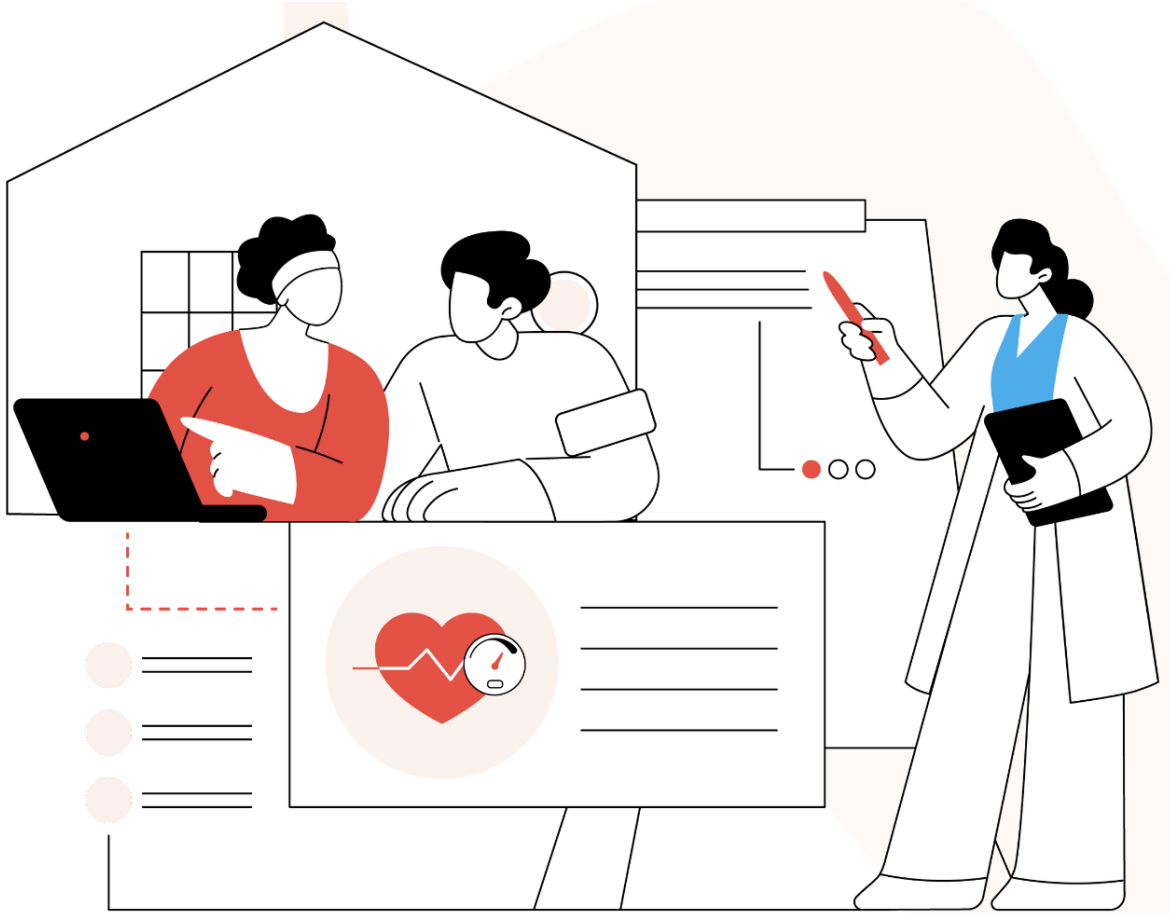
- Patients use their own home BP device
- Patients use MyChart/Connect to track home BP readings and view educational modules

Learn more

RPM Hypertension

- Patients are loaned a valid home BP device and tablet for 6 months
- Navigators help patients with onboarding and support
- Billable with copays

Learn more



Home BP readings integrated into Epic for you!

Weill Cornell Medicine · NewYork-Presbyterian · Columbia

Columbia-Cornell-NYP SMBP Program

- Validated home BP devices are delivered to patients' homes free of charge or patients use their own device

- Patients are taught how to measure correcly

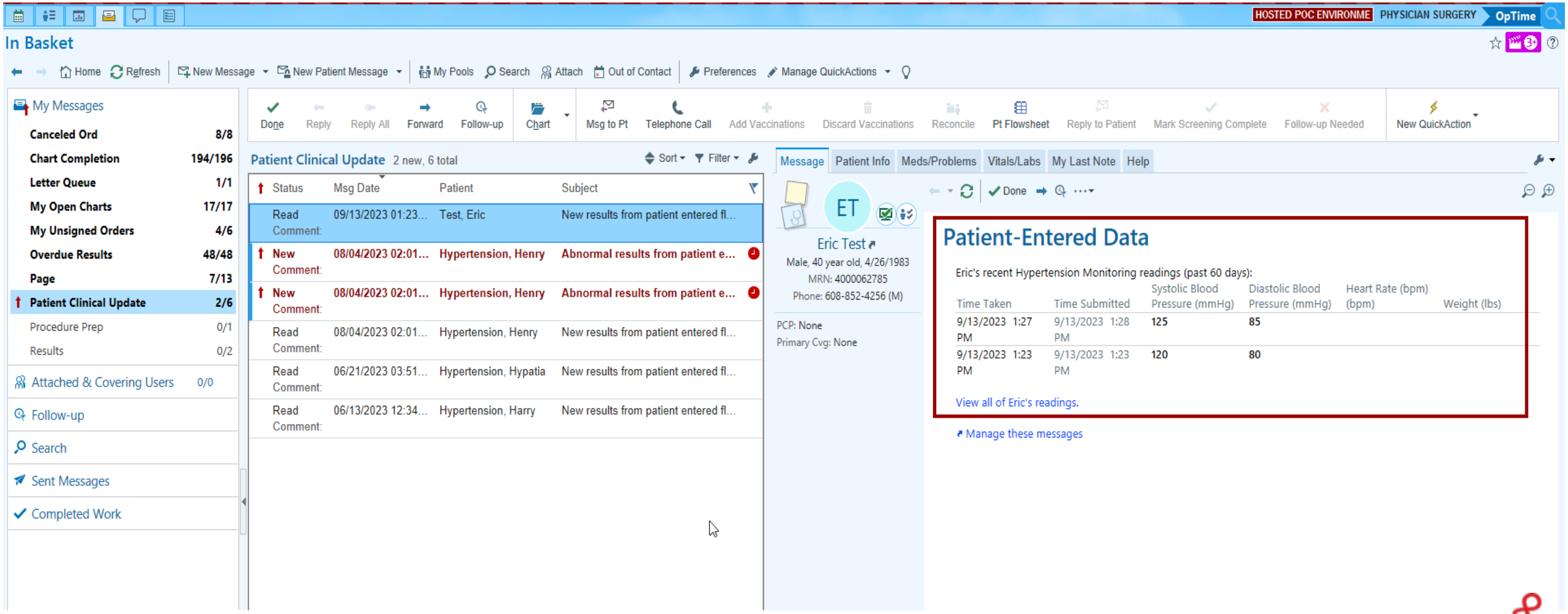
- Devices **wirelessly transmit BP data into Epic** or **patients self-enter readings through patient portal (MyChart)**

- Clinicians receive weekly in-basket message with list of prior week of readings and link to trends/average home BP for better clinical decision making

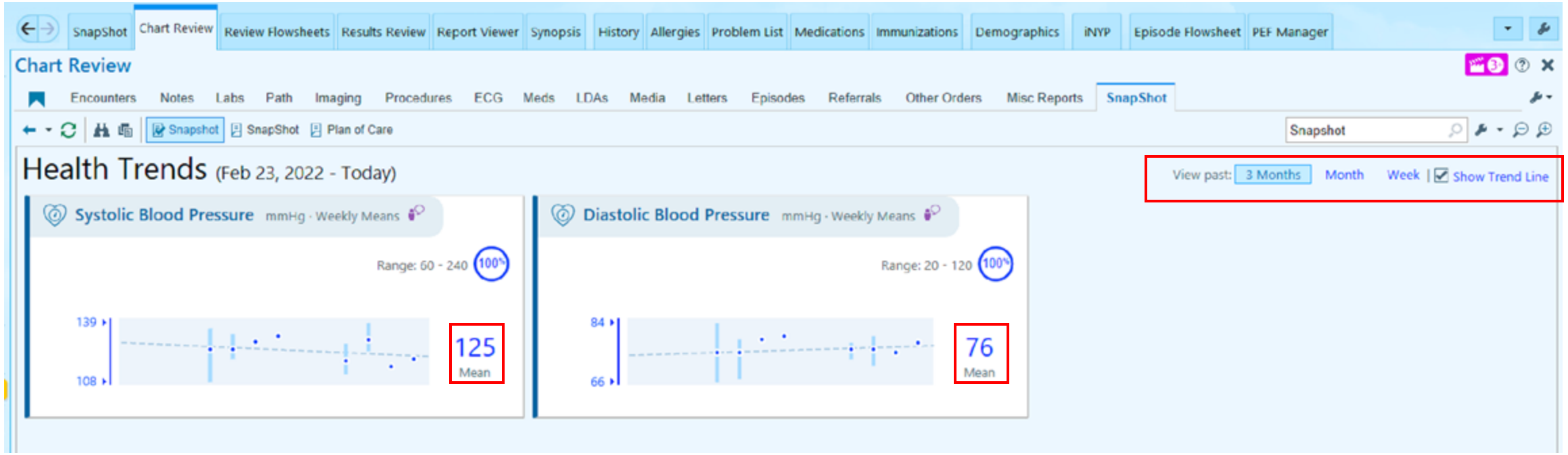
- Navigators and/or clinical pharmacists assist with patient enrollment, onboarding, reminders, and management

Weekly In Basket message with list of BP readings

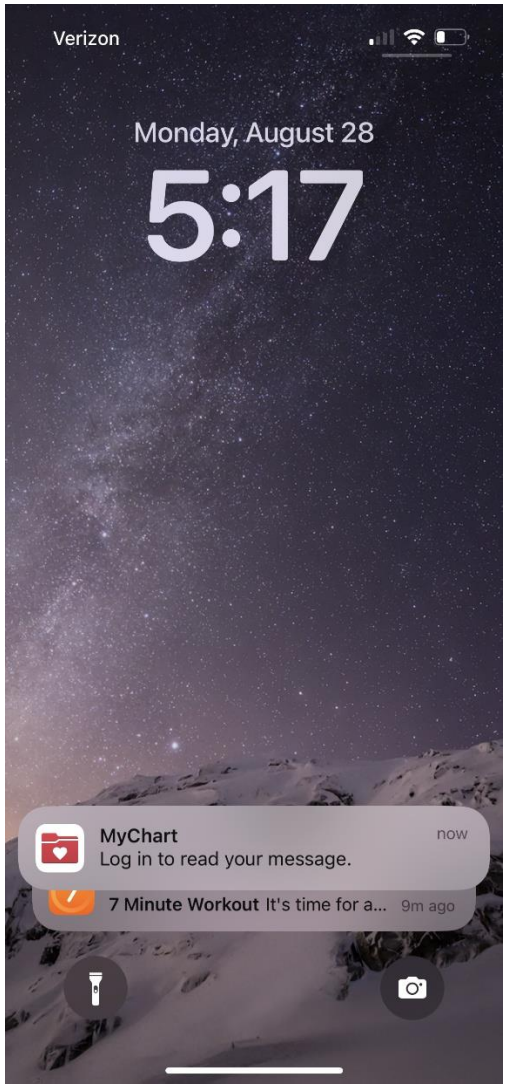
MyCare Hypertension

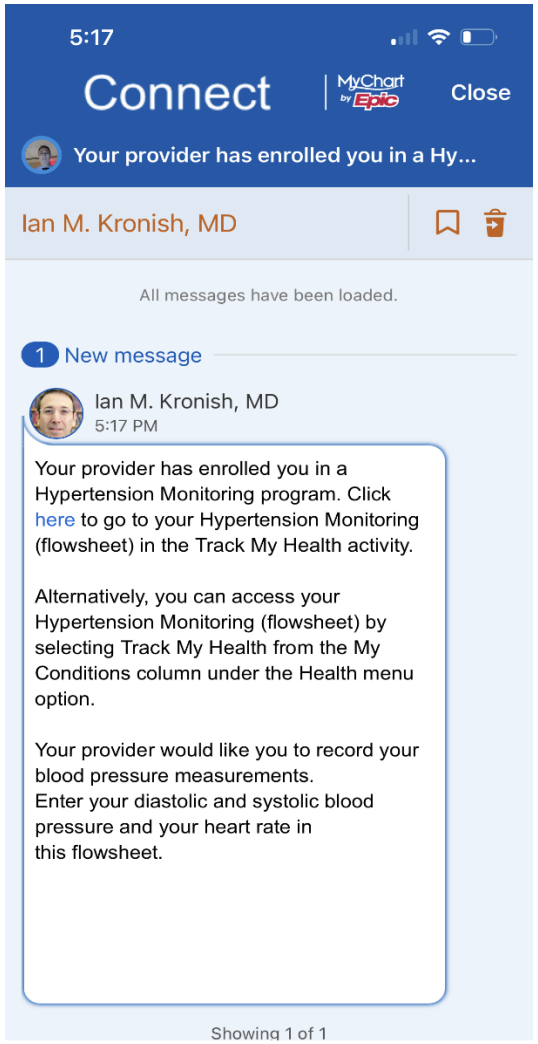


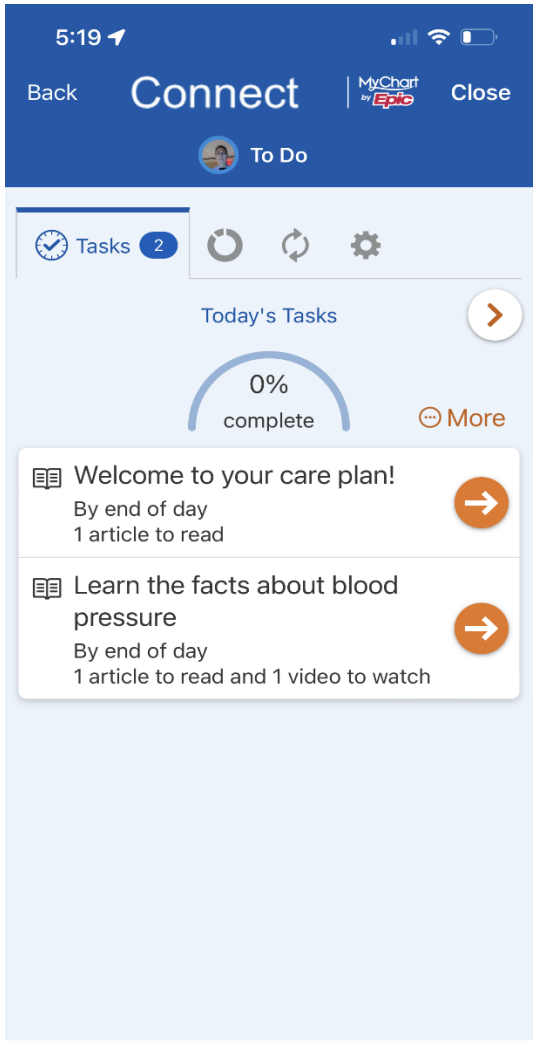
Trends and average BP for clinicians!

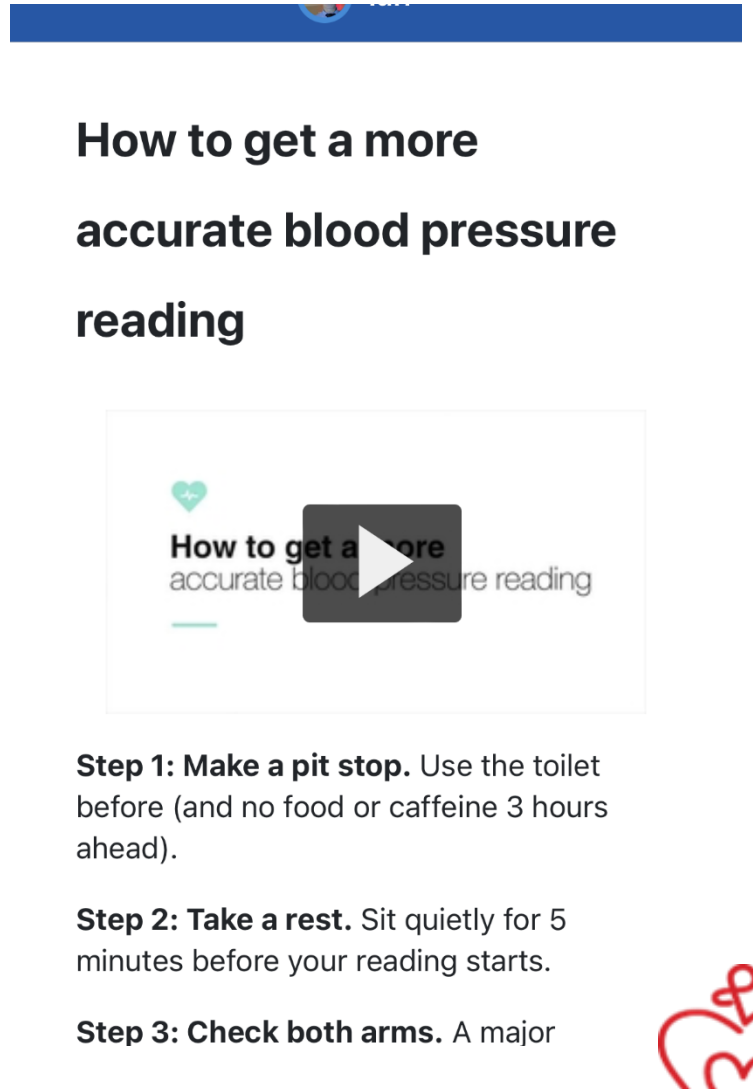


MyCare patient experience

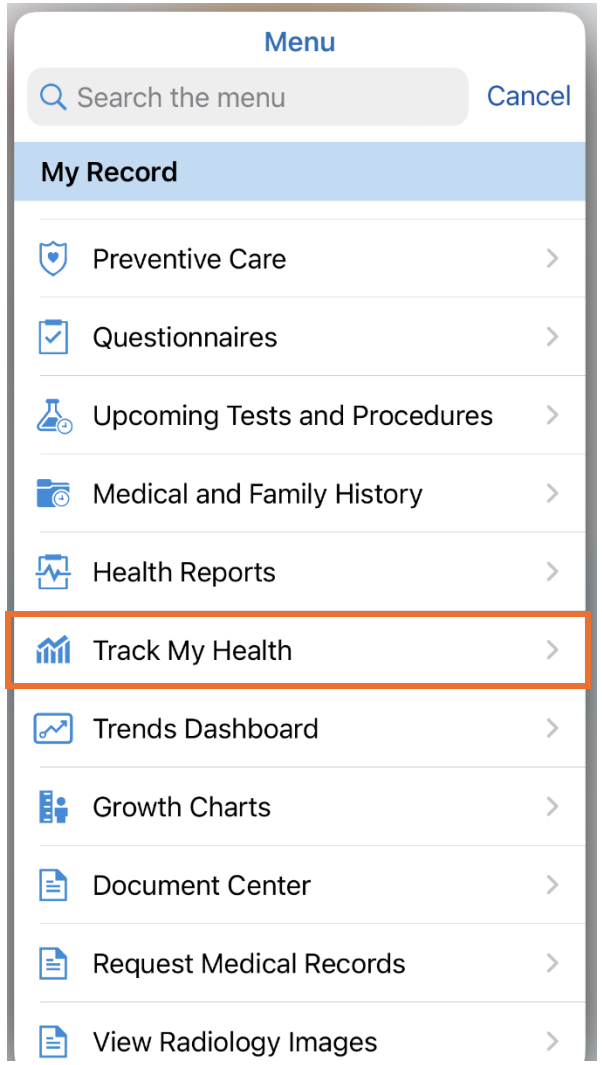


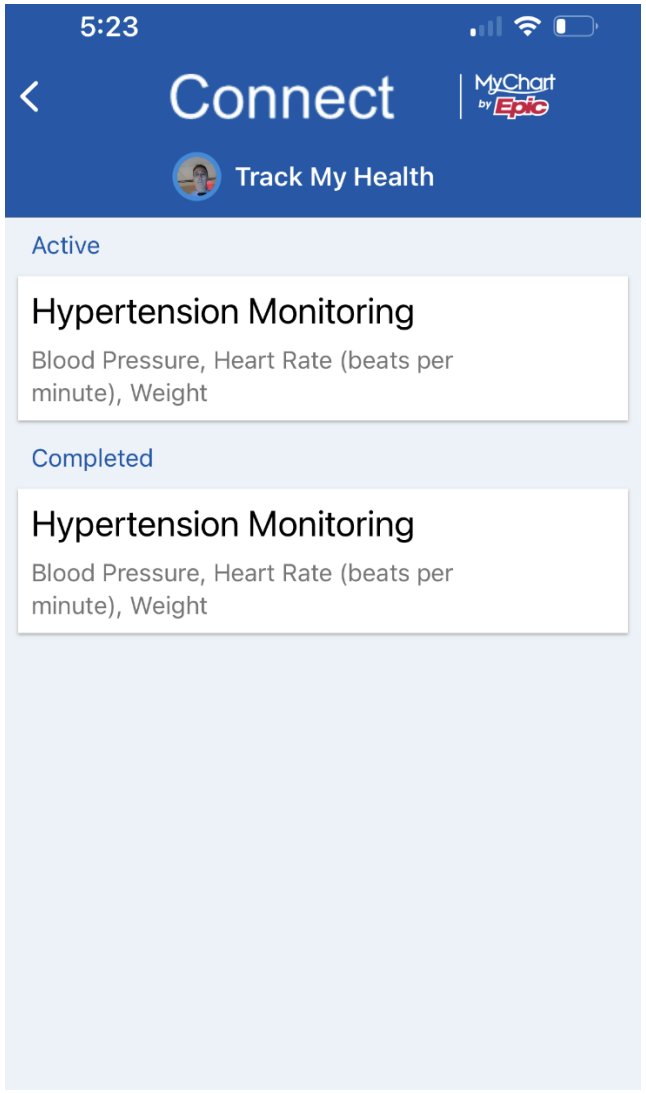


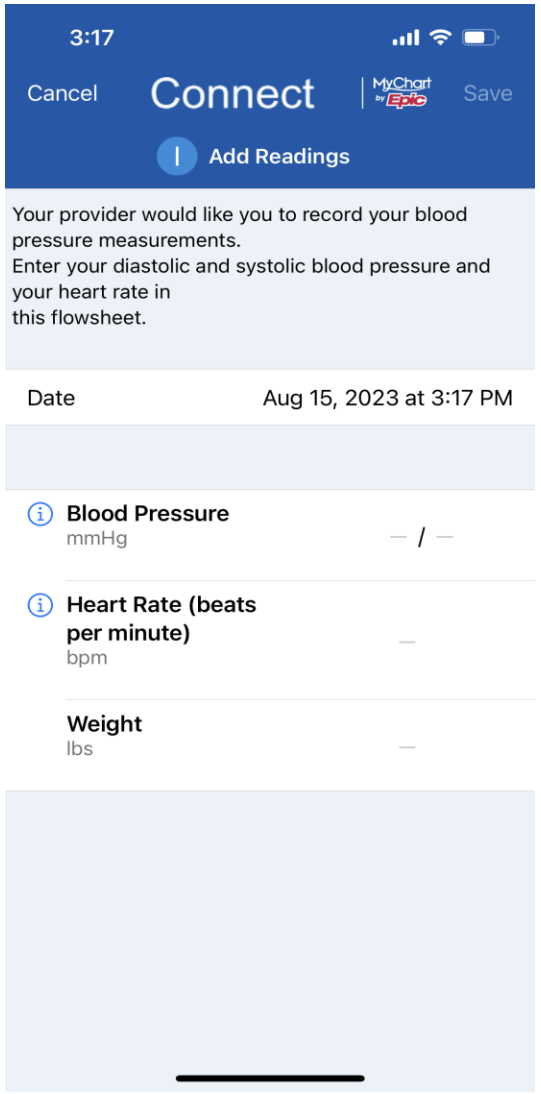


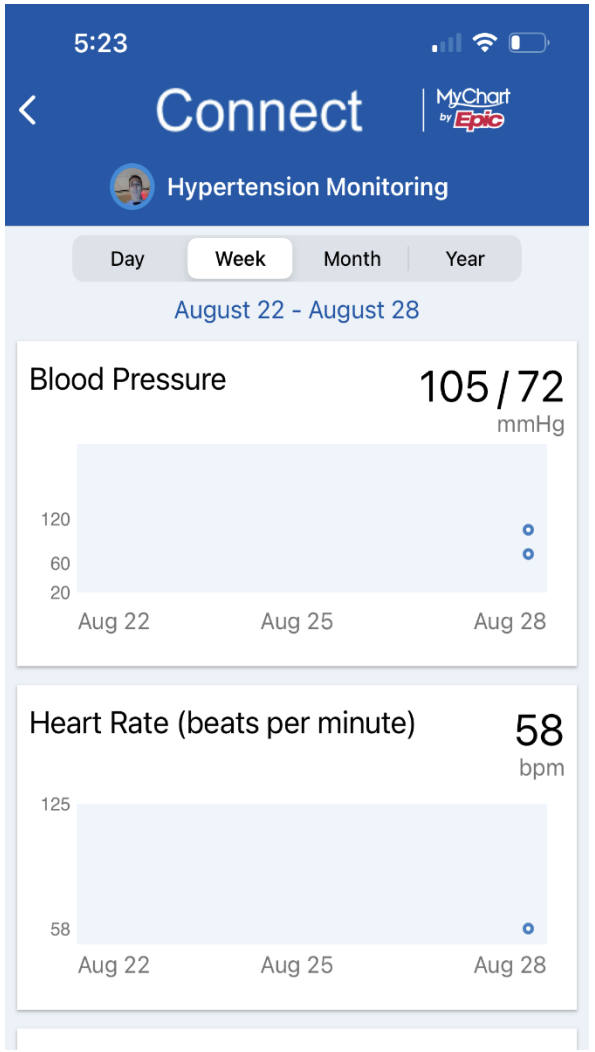


Patients track home BP readings









Effectiveness of MyCare/RPM Hypertension

- Over 1,000 patients referred since Nov 2023 across 20+ practices
- Patients say “MyCare is easy to use”, feel “cared for” by their clinicians
- When navigators are available to help with on-boarding, >75%
- 30-40% of patients have controlled BP (i.e., white-coat) in 1st week*
- 75% have controlled BP after 12 weeks
- Sustained referrals by clinicians in 2nd year of program
  - ongoing outreach and education to PCPs and medical directors
  - design program to be attractive to PCPs so they refer a 2nd time
  - ongoing proactive patient recruitment when resources permit
- Long-term outcomes to come

**Home BP readings count toward HEDIS BP Control metric*

2020 RPM Medicare CPT reimbursement codes

Need 16 days of wireless BP readings in 30 days		Need **20 min/month**	Need extra 20 min/mo
Set up fee	**Technology fee**	**Physician fee**	**Physician fee**
• Initial set up and patient education on equipment. • Remote monitoring of biometrics (e.g., weight, BP, pulse oximetry, respiratory flow rate)	• Daily recordings or programmed alerts, each 30 days • Remote monitoring of biometrics (e.g., weight, BP, pulse oximetry, respiratory flow rate)	• 20 min. per month of nurse/staff/physician time requiring interactive communication with patient/caregiver • RPM treatment management services	• 20 additional min. per month of nurse/staff/ physician time requiring interactive communication with patient/caregiver
99453 $18.77	99454 $62.44/month	99457* $52/month	99458* $52/month

*Physician practice with 300 Medicare patients X $54/month = $16,200/month or $194,400/year
Source: https://www.cms.gov/files/document/covid-final-ifc.pdf

Challenges with RPM billing

Physician fee

- Cannot bill physician fee on same day as office visit
- Compliance with time-based requirements
- Need for obtaining patient consent
- Need for synchronous communication

Technical fee

- Knowing when eligible to bill

2020 SMBP Medicare CPT reimbursement codes

Set Up

Patient education, training, and device accuracy check

Can be submitted once per device

99473
$11 once

Monthly Fee

Requires **12 BP** readings/month

Readings can be entered by patients or manually recorded

Treatment plan must be influenced by home BP readings

99474
$15/mo

https://www.ama-assn.org/system/files/2020-06/smbp-cpt-coding.pdf

Is RPM billing enough? Probably not

- Health system investment
  - Level of investment can vary
  - Requires buy-in from executive and clinical leadership
  - Vendors are unstable partners and often expensive
  - More likely/favorable in a value-based care environment - > incentivizes improved health outcomes, decreased utilization

- Grants and Philanthropy
  - Can be an initial strategy to demonstrate value and ROI to advocate for pilot program, or long-term plan
  - Level of investment can vary: loaner program <-> full-scale RPM program
  - Can ensure validated devices with built-in connectivity

Leverage existing partnerships

- Become familiar with health plans that work with your clinic/health system
- Map out RPM/SMBP benefits for plans with significant attribution* (*United Healthcare just announced they were no longer covering RPM)
- Partner with your clinic/health system contracting team to find a payer willing to support a pilot
- Advocate for expanded coverage
- Ease burdensome requirements, such as faxed Rx + letter of medical necessity + prior authorization for home BP devices – payers often do not realize what their requirements mean for clinical workflows

Take home lessons implementing SMBP

- **Design to minimize unscheduled care** and **interruptions**
  - Set high thresholds for alerts (e.g., >210/130!)
  - Encourage PCPs to schedule visits soon (~1 mo) after ordering
  - Advertise that programs **save time, make SMBP easier!**
- Integrate into workflow (especially the EHR) as much as possible
- Include multiple stakeholders on design team
- Select roles based on skill sets
- Build in flexibility
- Understand institutional priorities and desired metrics
- Be cautious about contracting with vendors
- Design with sustainability in mind

Lessons Learned: Self-Monitored Blood Pressure

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Director of Quality Improvement

Syracuse Community Health

Syracuse Community Health

1. We need a consistent process for SMBP.
When the workflow isn't followed the same way by everyone, the process breaks down — and patients don't get the support they need.
2. The Loaner Program must be clearly explained.
Once we reinforced expectations around returning cuffs and bringing logs, we immediately saw improvement in return rates.
3. Nursing involvement makes a meaningful difference.
When nurses consistently teach SMBP, patients understand what to do at home and feel more confident with the process.
4. Reminder calls truly matter.
Care Coordination outreach helped patients remember to bring cuffs, readings, and paperwork — which reduced missed opportunities during the visit.
5. Restarting the workflow helped reset expectations.
Re-educating staff and relaunching the SMBP process in October–November brought everyone back into alignment and set us up for stronger results going into 2026.

Summary

- **Team-based Care and Self-Monitored Blood Pressure** are both evidence-based and strongly recommended by 2025 US Hypertension Guidelines (both “A” rated)
- **SMBP** gathers substantially more BP measurements, empowers patients, and identifies patients with white-coat and masked hypertension
- TBD and SMBP both require **team-work** among health care providers, **system and work-flow re-design** and **electronic health record system modifications to be fully operational**
- **Reimbursement and regulatory environment** around TBC and SMBP is improving, but has a ways to go to be fully self-sustaining. Advocacy at national and state levels is a key to getting there!

References for Further Reading

2025 ACC/AHA Hypertension Guidelines

- Jones D et al., Circulation 2025

Team-based Care

- **Evidence:**
  - Effectiveness and Cost-Effectiveness of Team-Based Care for Hypertension: A Meta-Analysis and Simulation Study. *Hypertension*; 2023
  - Drake, C., Lewinski, A.A., Rader, A. *et al.* Addressing Hypertension Outcomes Using Telehealth and Population Health Managers: Adaptations and Implementation Considerations. *Curr Hypertens Rep* **24**, 267–284 (2022).

Self-Monitored Blood Pressure

- **Evidence**
  - McGrath D, Meador M, Wall HK, Padwal RS. Self-Measured Blood Pressure Telemonitoring Programs: A Pragmatic How-to Guide. Am J Hypertens. 2023 Jul 14;36(8):417-427.
  - Liyanage-Don N, Fung D, Phillips E, Kronish IM. Implementing Home Blood Pressure Monitoring into Clinical Practice. Curr Hypertens Rep. 2019 Feb 12;21(2):14.

- **Implementation resources**
- https://millionhearts.hhs.gov/tools-protocols/tools/smbp.html
- Video showing how SMBP is being used at community health centers: https://www.youtube.com/watch?v=XGO-I59UMDg

Please fill out our survey!

Find the survey link in the chat and at the close of the webinar.

Your feedback is very valuable and helps us to provide the CHCANYS network with relevant and engaging content.

Thank you!

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