Million Hearts Application – Word Mock Up

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Project Abstract

Briefly describe the proposed project, including overarching goals, and identify and describe the priority population(s) of focus to be reached with the proposed selected Million Hearts® strategies. Be sure to describe the intended accomplishments and impact of your project. (250-word limit)

Fort Bend County Health & Human Services (FBCHHS) intends to implement an internal referral program and a community outreach program with the goals of:

- Increasing the number of individuals in the community who are screened for hypertension
- Decreasing the number of adults in the community living with undiagnosed hypertension
- Increasing blood pressure control in adults identified with hypertension
- Improving food literacy, as it relates to this diet-related condition, in the adults identified with hypertension

The selected priority populations that will be impacted, based on the populations seen in the existing programs within FBCHHS and in the ongoing and planned outreach activities, are:

- Individuals with low income
- Individuals from racial and ethnic minorities
- Individuals living in health access deserts

Identified individuals will receive the following interventions:

- Promote access to care
    - Individuals identified with elevated blood pressure or with a history of hypertension will be connected to our primary care community partners for medical care and hypertension support if needed
- Improve use of and access to Self-Measured Blood Pressure Monitoring (SMBP)
    - Individuals will be trained to use validated, automated blood pressure measurement devices on a regular basis in familiar settings, such as their homes. Automated blood pressure measurement devices will be provided to participants as needed. Patients will be encouraged to share their blood pressure readings with their healthcare providers during clinic visits, by telephone, or electronically. These measurements will be monitored and used in treatment decisions to improve blood pressure control.

Proposal Overview
This section should answer the following questions: 1) Which Million Hearts® policies, processes, and/or practices does your organization plan to implement to reduce or prevent CVD in the community? 2) Why is this approach appropriate for your selected priority population? 3) If the primary applicant is not the implementing entity, please include your existing relationship with the implementor and intended collaboration.
(500-word limit)

Fort Bend County Health and Human Services (FBCHHS) will implement the practice of encouraging use of and providing access to self-measured blood pressure monitoring (SMBP) devices and the medical home support that will be needed. This approach will be part of the models of care intervention approach:

1) Blood pressure screening and Hypertension Health Education
2) Health education (educational materials: heart health, lifestyle modifications, self-measurement of Blood Pressure)
3) Use culturally tailored nutrition counseling to manage diet-related disease (educational materials: low sodium, DASH diet, understanding nutrition labels)
4) Outreach and information

The Community Health and Wellness Program will identify program clients:

1) From internal program client populations from the Tuberculosis Prevention and Control Program, the HIV and STI Prevention Programs, the Immunization Program Adult Safety Net, the Social Services Program and Indigent Health Care Program
2) From community outreach activities using the FBCHHS Community Outreach Team, Community Health Workers and Community Health and Wellness Team who will offer blood pressure screening at community events.

FBCHHS has established partnerships with churches in the community with large African American and Hispanic congregations. The FBCHHS Outreach Team will be targeting the following cities and zip codes in the county that have been identified as have individuals with low income and racial and ethnic minorities and that score high on the Social Vulnerability Index.

- Missouri City zip codes 77459 and 77489
- Sugar Land zip code 77498
- The part of Houston in Fort Bend County zip codes 77053 and 77083, and
- Rosenberg zip code 77471

FBCHHS has increased its outreach into the communities with the highest levels of preventable morbidities during the COVID-19 pandemic. Using data analysis of highest morbidity and mortality as well as lowest uptake of COVID-19 vaccines, the health department was able to mobilize teams into these areas using new or renewed community organization partnerships, including churches,

Other religious organizations, schools, and community service organizations. The outreach teams found that in many areas, lack of accurate information, lack of access to cares and lack of trust were important factors in the outcomes noted. Using a combination of social media presence, in-person outreach and trusted messengers providing accurate information as well as actually providing access to vaccines in the communities in trusted locations was able to impact the uptake of vaccines. This same approach is chosen for these efforts to address preventable cardiovascular disease in the same communities.

Priority Population Rationale

This section should answer the following questions: 1) Why are you choosing to focus on your selected priority population? How many within this population do you intend to reach? 2) How will the chosen Million Hearts® strategy(s) address the needs among this population? (250-word limit)

As part of FBCHHS recent Community Health Assessment (CHA) the following is noted: Healthy People 2030 aims to improve cardiovascular health and reduce deaths from heart disease and stroke[1]. Heart Disease and Stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

While Heart Disease has been on a decline over the past three decades, diseases of the heart are the leading cause of death in Fort Bend County. Stroke is the fourth leading cause of death in the county.

People who are Black/African American have the highest rate of deaths due to heart disease in Fort Bend County compared to other race/ethnicity groups. Also, Heart Disease was the fifth most commonly cited health issue by CHA survey respondents and key informants. 14.8% of survey respondents identified heart disease as a health concern.

Mapping the rates of Heart Disease over the county shows an increase in morbidity in many of the same populations as were found to have increased morbidity from COVID-19.

The Community Health and Wellness Program goal is to reach 250 individuals with newly diagnosed or untreated hypertension for the chosen interventions of outreach, screening, education, SMBP devices and monitoring over the seven-month period of this funding opportunity. If successful, the program will seek funding and program support to continue the outreach beyond the funding time frame for this initiative.

Organizational Capacity and Experience

Describe your organization and key staff responsible for completing your proposed work. include: 1) Experience engaging in cardiovascular disease efforts that involve implementing evidence-based and innovative programs, practices, and services; 2) Your organization's history of work among the selected priority population; 3) Your organization's history of and current capacity to implement effectively and rapidly upon receiving funding.
(500-word limit)

The mission of Fort Bend County Health & Human Services (FBCHHS) is to promote the health and well-being of the residents of Fort Bend County through community engagement, disease prevention and intervention, public health emergency preparedness and response and helping to assure the provision of basic human needs.

The department has a long history of working to provide core public health services to the economically and disenfranchised populations through its existing Tuberculosis Prevention and Control, Childhood Immunizations and Adult Safety Net vaccines, HIV Prevention, Social Services and Indigent Health Care (financial support) programs.

In keeping with one of the department's FY 2022 Goals (Expand fundamental disease prevention and intervention services), the Chronic Disease Program was established. The Fort Bend County CHA identified five chronic disease priorities: Cardiovascular Disease, Cancer, Diabetes, Stroke, and Alzheimer's disease. FBCHHS has promoted Monthly Chronic Disease Awareness campaigns. In addition, FBCHHS initiated internal coordination with HHS divisions and external coordination with community partners to address chronic disease priorities and to conduct comprehensive disease outreach activities within targeted communities. Another goal is to "Increase Community engagement through communications and outreach" including educating the public through a health equity lens about health conditions. The Community Health and Wellness Program is committed to using evidence-based best practices in continuing to build on the outreach experiences of COVID-19 to address these other areas of chronic diseases in our most vulnerable communities.

During COVID-19, a mobile health unit was purchased and a mobile health outreach and vaccination team was formed. This team has worked with partners and also initiated additional outreach opportunities in the noted communities with success and with good community feedback. One great lesson from the COVID-19 experience as noted by the community members is that tying outreach with other community events, especially others that are providing service to the community such as health fairs, food distribution programs, and religious organization events is a great way to reach large numbers of people in a trusted setting.

The Community Health and Wellness program is in place with a well -developed mobile health outreach team and they are ready to implement this program as soon as funding is awarded and the contract executed.

NACDD

Million Hearts Health Equity Implementation Project

Applicant: Fort Bend County (Health & Human Services)

Budget Justification

Salary		**$0**
25% of salary for seven months for one Community Health Worker $20 per hour x 7 months effort x 25%	$6,090	
25% of salary for seven months for one Chronic Disease Nurse $45 per hour x 7 months effort x 25%	$13,703	
Fringe		**$0**
Travel		**$0**
Reimbursement for travel between outreach sites 7,500 miles x current rate $0.625 / mile	$4688	
Equipment		**$0**
Supplies		**$0**
Educational materials re: cardiovascular health	46,769	
Blood Pressure Monitoring cuffs (average price $75) x 250	$18,750	
Contractual		**$0**
Other		**$0**
Total Direct Costs		**$0**
Indirect Costs		**$0**
Total Budget Request		**$50,000**