Appendix 1-C
Cardiovascular

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Background of public health issue

Heart disease is the No. 1 cause of death among men and women across the nation. Each year, approximately 610,000 Americans die from heart disease, accounting for nearly 1 out of every 4 deaths[1]. Heart disease is also the number one cause of death for men and women in Indiana. Nearly 40 percent of Hoosiers adults have been told by a healthcare professional that their cholesterol is high, and one-third of Hoosier adults have been told by a healthcare professional that their blood pressure is high. High cholesterol and high blood pressure can increase the risk for heart disease. The good news is that these risk factors of heart disease and several other conditions can be improved or reduced with simple lifestyle changes.

Purpose

Heart disease is a serious health challenge in Indiana, and Hoosiers are encouraged to follow more heart healthy habits, as these small changes can make a big difference in health over time. Controlling and preventing risk factors is also important for people who already have heart disease. High blood pressure, also called hypertension, is one of the most important risk factors for heart disease; therefore, this grant opportunity will require interventions to control hypertension.

Description of proposal and funded activities

Applicants are required to choose one of the approaches from the CDCs Clinical Resources for Hypertension Control for implementation.

- Once you identify a program, please list the county or counties where the program will be offered
- Describe your outreach strategies
- Describe your clinical and non-clinical team composition
- Describe the methods you will use to implement the program
- Describe how COVID-19 will be incorporated into the screening process

Organizations eligible to receive funding

- Hospitals, especially those with Diabetes Self-Management Education Programs in place
- Federally-qualified health centers (FQHCs)
- Community health centers
- Associations serving specific populations, including people of color and people older than 65 years of age
- Other not-for-profit and for-profit community-based organizations

Health equity statement (required):
Describe populations disproportionately impacted by the specific topic area and how applicant will address these populations specifically.

Please refer to the General Grant Guidance for additional details.

Metrics and evaluation of funded activities
Measures to be collected regularly and submitted monthly to the Indiana Department of Health (IDOH):

1. Demographics:
    a. Number of individuals served by race (Black/African American, American Indian/Alaska Native/Native Hawaiian/Other Pacific Islander, Asian, Caucasian/White, etc.)
    b. Number of individuals served by ethnicity (Hispanic/Latin(a/o/x), other)
    c. Number of individuals served by gender/gender identity (males, females, those who prefer not to answer)
    d. Number of members of the LGBTQ+ community served
    e. Age ranges served
    f. Number of individuals served with a primary language other than English
    g. Number of unique individuals served that meet at least one of the following criteria:
        i. Current active enrollment in MEDICAID/ HIP; or
        ii. Current active enrollment in SNAP/Food Stamps; or
        iii. Current active enrollment in TANF; or
        iv. Residing in a household at or below 200% of poverty per the HHS Poverty Guideline as noted in the HHS Poverty Guidelines for 2022 (Poverty Guidelines | ASPE (hhs.gov))
    h. Additional factors, including but not limited to education level, disability, substance abuse, mental illness, etc.
2. Health Equity: Please share progress made toward achieving your health equity goals (as defined in your Health Equity Statement)
3. Participation:
    a. Number of unique individuals served
4. Program Area Metrics:
    a. Blood Pressure Control
        i. Number of participants with a previous diagnosis of hypertension who lowered their blood pressure
        ii. Number of participants who maintained their blood pressure goal
        iii. Number of participants self-monitoring their blood pressure
        iv. Number of participants that submit their self-monitored measures regularly

b. Screening
    i. Number of people participating in blood pressure screenings
    ii. Number of screenings provided by your program
    iii. Number of participants identified with hypertension (BP $\geq$ 130/80).
c. Access to Care
    i. Number of participants provided with health-related devices for self-monitoring
    ii. Number of participants provided with educational material to understand hypertension
    iii. Number of participants educated on the use of home blood pressure monitors, recording blood pressure measurements, and proper technique
d. Outreach
    i. Number of outreach activities (educational events, presentations, distribution of informational materials, etc.) performed for the purpose of promotion of early detection
    ii. Number of community partnerships formed
e. Health Outcomes:
    i. Number of participants with a recorded decrease in BMI
    ii. Number of participants with a recorded decrease in LDL levels
    iii. Number of participants with a reported increase of physical activity

Provide a plan for how you will evaluate the program over your grant project period.

The above measures may be altered at any time at the discretion of the Health Innovation Partnerships and Programs Division of IDOH.

Reference section (data sources, etc.)

1. https://www.acc.org/latest-in-cardiology/articles/2020/04/06/08/53/racial-disparities-in-hypertension-prevalence-and-management
2. https://www.cdc.gov/dhdsp/hmp-toolkit/Overview/HMP_Toolkit_508.pdf
3. https://millionhearts.hhs.gov/files/mh_cqm.pdf

Resource

- CDC Million Hearts Clinical Tools and Resources for Health Care Professionals: https://www.cdc.gov/heartdisease/american_heart_month_clinical.htm#who