COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION:

# Hypertension

Parkland
*Care. Compassion. Community.*

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## A. PROBLEM STATEMENT

Heart disease is the leading cause of death in Dallas County with African Americans suffering from particularly high mortality rates related to the condition

## B. STRATEGY

Establish a high blood pressure program that adheres to the State of Texas public strategies for addressing heart disease and stroke (2019-2023). The program will focus on patients residing in ZIP Codes 75210, 75211, 75215, 75216, 75217, 75241. In addition, the program will have a particular focus on African Americans as they have a significantly higher mortality rate related to hypertension than other race/ethnicities.

## C. METRICS

1. Number of patients from the targeted population screened for high blood pressure and follow-up documentation.

2. Percentage of patients from the targeted population whose blood pressure at the most recent visit is adequately controlled.

3. Percentage of patients with diabetes from the targeted population whose blood pressure at the most recent visit is adequately controlled.

## D. BUDGET (as of August 31, 2020)

### Hypertension Financial Summary

| | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Total |
|---|---|---|---|---|---|---|
| **Gross Revenue** | $0 | $0 | $0 | $0 | $0 | $0 |
| **Deductions from Revenue** | - | - | - | - | - | - |
| **Net Revenue** | - | - | - | - | - | - |
| **Expenses** | | | | | | |
| Salaries | 66,831 | 68,836 | 70,901 | 73,028 | 75,218 | **354,813** |
| Benefits | 14,435 | 14,868 | 15,315 | 15,774 | 16,247 | **76,640** |
| Drugs | - | - | - | - | - | **-** |
| Med/Surg Supplies-Baxter (10 arm cuffs & 3 wrist cuff) | 850 | - | - | - | - | **850** |
| Marketing | 19,200 | - | 9,600 | 9,600 | 9,600 | **48,000** |
| Educational Materials | 3,275 | 3,275 | 3,275 | 3,275 | 3,275 | **16,375** |
| IT Equipment (2 Laptops, 3 iPads) | 5,460 | - | - | - | - | **5,460** |
| Miscellaneous Supplies | 2,400 | 2,400 | 2,400 | 2,400 | 2,400 | **12,000** |
| **Total Expenses** | 112,451 | 89,379 | 101,490 | 104,077 | 106,741 | **514,137** |
| **Net Income** | (112,451) | (89,379) | (101,490) | (104,077) | (106,741) | **(514,137)** |
| **Indirect Expense Allocation (21.7% of Total Expenses)** | - | - | - | - | - | - |
| **Net Income after Indirect Expenses** | **$(112,451)** | **$(89,379)** | **$(101,490)** | **$(104,077)** | **$(106,741)** | **$(514,137)** |
| **Capital** | - | - | - | - | - | - |
| **Total** | **$(112,451)** | **$(89,379)** | **$(101,490)** | **$(104,077)** | **$(106,741)** | **$(514,137)** |
| **FTEs** | **0.80** | **0.80** | **0.80** | **0.80** | **0.80** | **0.80** |
| **Total Direct Expenses** | **112,451** | **89,379** | **101,490** | **104,077** | **106,741** | **514,137** |

## E. STAFFING (Year 1 FTEs approved as of 8/31/2020)

| # | FTE Description | Scope of Service | FTEs # by Year 1 |
|---|---|---|---|
| 1 | **Nurse Navigator** | The overall scope of services of this position is:<br>• Conducting comprehensive assessment of patient at the time of screening.<br>• Provide guidance to patients who are identified through the screening events on questions regarding their blood pressure follow-up.<br>• Determining financial and medical status by reviewing patient's diagnosis, recommended treatment, funding sources and special needs according to Parkland policies and procedures.<br>• Referring unfunded patients to PFS team for financial counseling.<br>• Regularly communicating with patients and their providers regarding plan of care (Parkland and outside).<br>• Ensuring patients are seen in the appropriate time according to the initial blood pressure.<br>• Provide on-site education to patient regarding their diagnosis and treatment plan. | 0.5 |
| 2 | **Clinical Educator** | • To assure that education materials are available and appropriate for the patients.<br>• Assist CHW in deploying education and literacy programs in the community. | 0.3 |
| | **Total FTEs** | | **0.8** |

## F. INTERVENTION DEPLOYMENT

| Goal 1: Increase the number of patients from the targeted population screened for high blood pressure and follow-up documentation (2020: 2,838, 2021: 3,265 and 2022: 3,998) | | | | | | |
|---|---|---|---|---|---|---|
| | **Intervention** | **Time of Services** | **Scope of Service** | **Staff** | **Outputs** | **Internal Capacity Impact** |
| 1 | Patient Identification | Community Screening<br>Access to Care visits<br>PCP visits | Complete blood screenings to identify patients with high blood pressure according to the following guidelines:<br>• Normal: <120/80<br>• Stage 1: Systolic 130 to 139 mmHg or diastolic 90 to 99 mmHg<br>• State 2a: Systolic 140 to 159 mmHg or diastolic 90 to 99 mmHg<br>• Stage 2b: Systolic at least 160-179 mmHg or diastolic at least 100-110 mmHg<br>Complete insurance coverage verification or referral to PFA | • CHW<br>• Registered Nurse<br>• PCP<br>• PFA | # of patients screened<br># of PFA enrollments<br># of patients referred to Parkland PCP<br># of patients sent to ED<br># of SDOH Assessments | **Screenings**<br>2020: 2,838<br>2021: 3,265<br>2022: 3,998<br>**Complete insurance coverage verification**<br>2020: 2,838<br>2021: 3,265<br>2022: 3,998<br>**PFA Referral**<br>2020: 539<br>2021: 620<br>2022: 770 |
| 2 | Normal BP | Real time | Provide Healthy Living education to the patient which highlights the following:[1]<br>• **Eat Healthy Foods:** Emphasis on low sodium and saturated fat diet<br>• **Move More:** Promotes physical activity 30 minutes a day, 5 days a week<br>• **Aim for a Healthy Weight:** Promotes losing 3 to 5 percent of body weight to improve blood pressure.<br>• **Manage Stress** Tips to improve stress management<br>• **Tobacco Cessation** Promotes tobacco cessation<br>No follow-up required when the reading is <120/80 mmHg<br>*1 Based on National Heart, Lung and Blood Institute guidelines https://www.nhlbi.nih.gov/health-topics/education-and-awareness/high-blood-pressure* | • CHW<br>• Clinical Educator | # of patients educated | **Screening for Normal BP**<br>2020: 1,286<br>2021: 1,796<br>2022: 2,199 |
| 3 | Document Referral for Stage 1 | At time of screening | Document referral for 6 months from screening as follows:<br>Parkland patient or patient without a PCP refer to Parkland PCP for follow-up via:<br>• Group visit<br>• Nurse led visit<br>• Education in Healthy Living<br>When a patient has a PCP external to Parkland, he or she is advised to follow-up with PCP in 6 months | • CHW<br>• Nurse Navigator | # of documented referral for Stage 1 to Parkland PCP<br># of patients without a PCP<br># of patients with external PCP | **Uncontrolled Hypertension[2]**<br>2020: 1,052<br>2021: 1,469<br>2022: 1,469 |

[1]Assumption: 19% of Dallas County population is uninsured as noted in the Community Health Needs Assessment
[2] 45% U.S. adult population has hypertension. CDC https://www.cdc.gov/bloodpressure/facts.htm

| Goal 1: Increase the number of patients from the targeted population screened for high blood pressure and follow-up documentation (2020: 2,838, 2021: 3,265 and 2022: 3,998) | | | | | | |
|---|---|---|---|---|---|---|
| | **Intervention** | **Time of Services** | **Scope of Service** | **Staff** | **Outputs** | **Internal Capacity Impact** |
| 4 | Stage 2a | At the time of screening | Document referral for 2 to 3 months from screening as follows:<br>If Parkland patient clinic visit or virtual visit with PCP/APP<br>Visit External PCP:<br>Recommended to follow-up in 2-3 months for the same | • Nurse Navigator<br>• CHW | # of documented referrals for Stage 2a to Parkland PCP<br># of patients without a PCP<br># of patients with external PCP | **TBD** |
| 5 | Follow-up patients' stage 2a without PCP | At the time of screening | Document follow-up scheduling 2-3 weeks post screening as follows:<br>• Recheck BP and confirm if patient is taking any medication<br>• Schedule clinical visit or virtual visit with MD or APP in 2-3 months | • Nurse Navigator<br>• CHW | # of BP rechecked documented | **TBD** |
| 6 | Stage 2b Parkland PCP | At the time of screening | Document follow-up for referral within 4-6 weeks post screening as follows:<br>• Schedule a clinic visit or virtual visit with PCP/APP<br>• If External PCP:<br>Recommend patients follow-up in no later than 2 weeks<br>• If without a PCP:<br>Advise to schedule clinic visit or virtual visit with PCP/APP in 4-6 weeks | • Nurse Navigator<br>• CHW | # of documented referral for Stage 2b to Parkland PCP<br># of patients without a PCP<br># of patients with external PCP | **Stage 2b**[3]<br>2020: 473<br>2021: 661<br>2022: 809 |
| 7 | Stage 3 | At the time of screening | Document referral to ED or Urgent Care and send patient to Urgent Care or Emergency Department | • RN | # of patients sent to ED | **Screening for Stage 3 BP**<br>TBD |

[3] 45% of U.S population with uncontrolled hypertension has stage 2b.

## Goal 2: Increase Percentage of patients from the targeted population whose blood pressure at the most recent visit is adequately controlled from 49.01% to 58% by 2022

| | Intervention | Time of Services | Scope of Service | Staff | Outputs | Internal Capacity Impact |
|---|---|---|---|---|---|---|
| 1 | Control patients in Stage 1 | 6 months from screening | Conduct clinic visit according to guidelines and provide the patient with the following:<br>• Group visit or Nurse led visit<br>• Education in Healthy Living<br><br>Schedule follow-up visit according to patients' clinical assessment | • MD/APP<br>• Nurse Navigator | # of established Parkland patients follow-up visits completed<br># of group visits<br># of Nurse led visits<br># of patients educated | **Screening for Stage 1 BP**<br>2020: 1,277<br>2021: 1,469<br>2022: 1,469 |
| 2 | Control patients in Stage 2a | 2 to 3 months from screening | If Parkland PCP:<br>Conduct clinic visit or virtual visit with PCP/APP as per guidelines and<br>• Monitor existing medications<br>• Conduct lab tests including but not limited to<br>• Serum Potassium<br>• Serum Sodium<br>• BUN<br>• Creatinine with eGFR<br><br>Schedule follow-up visit according to patients' clinical assessment<br>Patients are educated on hypertension relevant topics such as:<br>• Maintaining healthy weight<br>• Eat healthy diet with low sodium<br>• Increasing physical fitness<br>• Ways to manage stress<br>• Limiting alcohol<br>• Smoking cessation<br>• Take medications properly<br>• Working with healthcare team | • RN<br>• MD/APP<br>• CHW | # of established Parkland patients' follow-up visits completed<br># of patients educated | **Screening for Stage 2a BP**<br>2020: 1,277<br>2021: 1,469<br>2022: 1,469 |
| | Follow-up patients' stage 2a without PCP | 2-3 weeks post screening | Contact patient to confirm whether BP was rechecked and if appointment is needed | • RN | # of follow-up call<br># of appointments scheduled | TBD |
| 3 | Follow-up patients' stage 2a without PCP | 4-6 weeks post screening | Conduct clinic visit or virtual visit with PCP/APP as per guidelines and<br>• Monitor existing medications<br>• Conduct lab tests including but not limited to<br>• Serum Potassium<br>• Serum Sodium<br>• BUN<br>• Creatinine with eGFR<br><br>Schedule follow-up visit according to patients' clinical assessment<br>Patients are educated on hypertension relevant topics such as:<br>• Maintaining healthy weight<br>• Eat healthy diet with low sodium<br>• Increasing physical fitness<br>• Ways to manage stress<br>• Limiting alcohol<br>• Smoking cessation<br>• Take medications properly<br>• Working with healthcare team | • RN<br>• MD/APP<br>• CHW | # of established Parkland patients' follow-up visits completed<br># of patients educated | **Screening for Stage 2b BP**<br>2020: 1,277<br>2021: 1,469<br>2022: 1,469 |

## Goal 3: Increase the percentage of patients with diabetes from the targeted population whose blood pressure at the most recent visit is adequately controlled from 50.08% to 63%

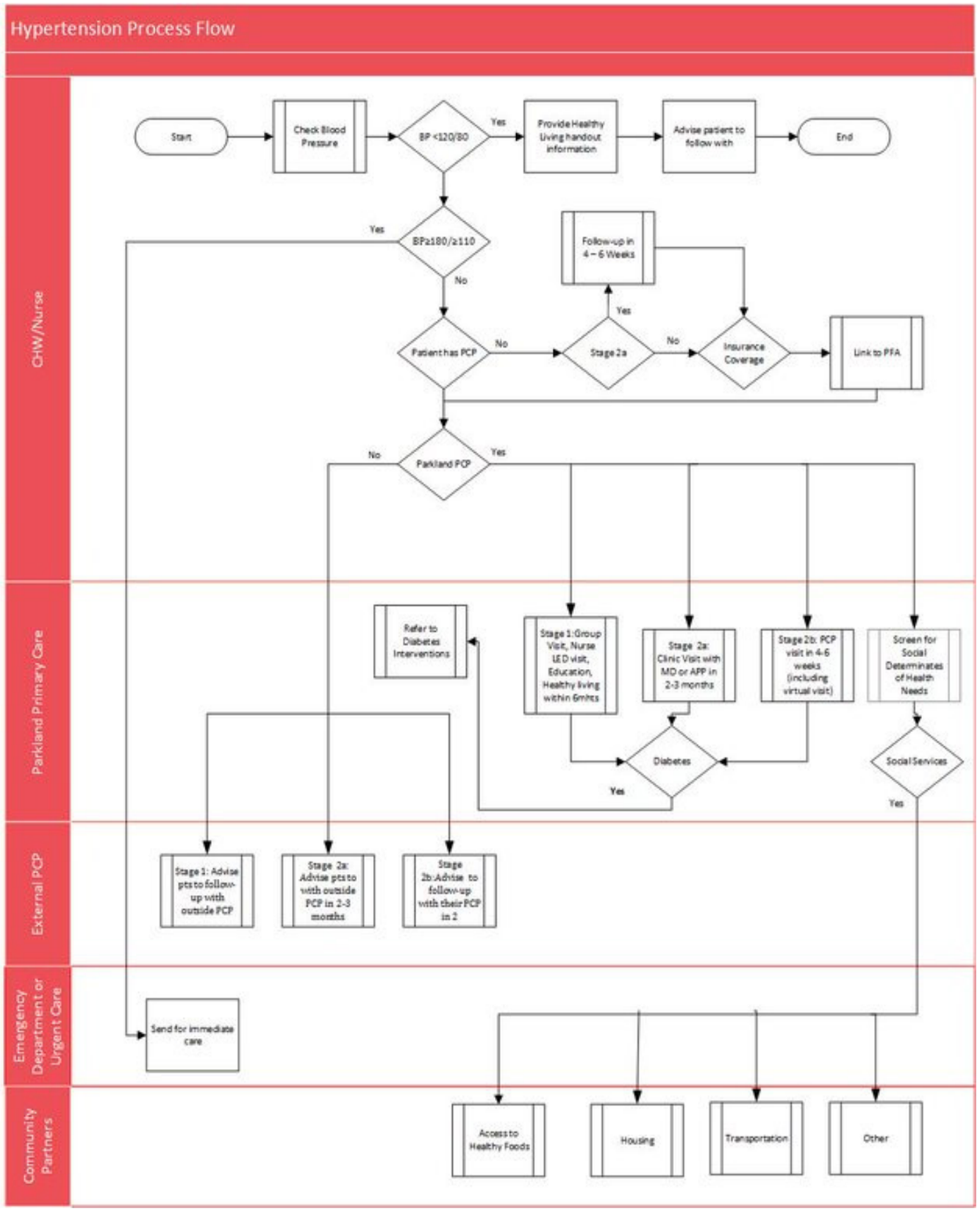
| | Intervention | Time of Services | Scope of Service | Staff | Outputs | Internal Capacity Impact |
|---|---|---|---|---|---|---|
| 1 | Control patients in Stage 1 with Diabetes | 6 months from screening | Conduct clinic visit* according to guidelines and provide the patient with the following:<br>• Group visit or Nurse led visit<br>• Education in Healthy Living<br>Schedule follow-up visit according to patients' clinical assessment<br>**See Diabetes intervention under Diabetes Program Description document* | • MD/APP<br>• Nurse Navigator | # of established Parkland patients follow-up visits complete<br># of group visits<br># of Nurse led visits<br># of patients educated | **Patient with Hypertension and Diabetes**<br>2021:105<br>2020: 147<br>2022: 179 |
| 2 | Control patients in Stage 2a with Diabetes | 2 to 3 months from screening | If Parkland PCP:<br>Conduct clinic visit or virtual visit with PCP/APP as per guidelines* and<br>• Monitor existing medications<br>• Conduct lab tests including but not limited to<br>  • Serum Potassium<br>  • Serum Sodium<br>  • BUN<br>  • Creatinine with eGFR<br>  • HbA1C<br>  • Microalbuminuria<br>• Schedule follow-up visit according to patients' clinical assessment<br>• Patients are educated on hypertension relevant topics such as:<br>  • Maintaining healthy weight<br>  • Eat healthy diet with low sodium<br>  • Increasing physical fitness<br>  • Ways to manage stress<br>  • Limiting alcohol<br>  • Smoking cessation<br>  • Take medications properly<br>  • Working with healthcare team<br>**See Diabetes intervention under Diabetes Program Description document* | • RN<br>• MD/APP<br>• CHW | # of established Parkland patients' follow-up visits completed<br># of patients educated | **TBD** |
| 3 | Follow-up patients' stage 2a with Diabetes and without PCP | 2-3 weeks post screening | Contact patient to confirm whether BP was rechecked and if appointment is needed*<br>**See Diabetes intervention under Diabetes Program Description document* | • RN | # of follow-up call<br># of appointments scheduled | TBD |

[1] Assuming 80% retention rate for the full year.

## Goal 3: Increase the percentage of patients with diabetes from the targeted population whose blood pressure at the most recent visit is adequately controlled from 50.08% to 63%

| | Intervention | Time of Services | Scope of Service | Staff | Outputs | Internal Capacity Impact |
|---|---|---|---|---|---|---|
| 4 | Control established Parkland patients in Stage 2b with Diabetes | 4-6 weeks post screening | Conduct clinic visit or virtual visit with PCP/APP as per guidelines* and<br>• Monitor existing medications<br>• Conduct lab tests including but not limited to<br>  • Serum Potassium<br>  • Serum Sodium<br>  • BUN<br>  • Creatinine with eGFR<br>  • HbA1C<br>  • Microalbuminuria<br>Schedule follow-up visit according to patients' clinical assessment<br>Patients are educated on Hypertension relevant topics such as:<br>  • Maintaining healthy weight<br>  • Eat healthy diet with low sodium<br>  • Increasing physical fitness<br>  • Ways to manage stress<br>  • Limiting alcohol<br>  • Smoking cessation<br>  • Take medications properly<br>  • Working with healthcare team<br>**See Diabetes intervention under Diabetes Program Description document* | • RN<br>• MD/APP<br>• CHW | # of established Parkland patients' follow-up visits completed<br># of patients educated | TBD |

## G. SERVICE DELIVERY PROCESS FLOW



## H. PARTNERSHIPS

| # | CBO Name | ZIP Codes | Scope of Service | Population | Services for Parkland Patients | MOU Status |
|---|---|---|---|---|---|---|
| 1 | **Inspired Vision Compassion Center** | 75217 | IVCC is a non-profit that provides access to basic needs in a grocery store format to residents of Dallas in need. Services provided include: food, clothing, furniture, personal hygiene, animal supplies, emergency baby items, medical/first aid supplies, school supplies, etc. Each spring – they host a "Free Prom Store." | • All ages<br>• Providing groceries for 1,400 – 1,900 families/day/5 days a week<br>• Majority Hispanic population<br>• No ZIP Code restrictions/no ID restrictions | Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care | Negotiation Phase/Outlining Agreement |
| 2 | **City of Dallas – Parks & Recreation: Larry Johnson** | 75210 | Recreation center features include: fitness center, gymnasium, kitchen, large meeting room, outdoor basketball court, parking, playground, small meeting room, youth programs, afterschool and summer camps, active adult and senior programs, adult sports programs. | • Heavy senior concentration<br>• 50-60 individuals daily (pre-COVID-19) | Community Hub:<br>Health Screenings, SDOH Screenings, On-Site Financial Services | Negotiation Phase/Outlining Agreement |
| 3 | **City of Dallas – Parks & Recreation: John C. Phelps** | 75216 | Recreation center features include: baseball field, fitness center, gymnasium, kitchen, large meeting room, outdoor basketball court, parking, playground, small meeting room, tennis court, walking trails, picnic area, youth dance instruction and cheerleading, after school programs, senior activities, and adult fitness classes. | • Larger senior population | Community Hub:<br>Health Screenings, SDOH Screenings, On-Site Financial Services | Negotiation Phase/Outlining Agreement |
| 4 | **City of Dallas – Parks & Recreation: Janie C. Turner** | 75217 | Recreation center features include: baseball field, fitness center, gymnasium, kitchen, large meeting room, outdoor basketball court, parking, small meeting room, tennis court, youth cheerleading & dance instruction, after school programs, adult fitness classes, senior activities, computer room, and popular boxing program for kids in partnership with DPD. | • All ages | Community Hub:<br>Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care | Negotiation Phase/Outlining Agreement |
| 5 | **Community Council of Greater Dallas** | HQ: 75247, however serves all of Dallas County and immediate areas | Community action agency/social services organization focusing on poverty alleviation – increasing awareness and access to services. Current programs include: 1. serving seniors with benefits counseling, nutritional services, care coordination, caregiver support & advocacy, meals, transportation and other senior assistance 2. Coordinating with a network of 1,000 agencies to deliver programs/services to low-income residents – removing barriers to employment and transitioning people out of poverty by providing job training, education, and wrap around services 3. 2-1-1- hotline information and referrals – fielding calls for meals, transportation, and assistance for aging, elderly, senior citizens and people with disabilities. | • Aging, elderly, senior citizens<br>• Low-income<br>• People with disabilities | PFA Training | Negotiation Phase/Outlining Agreement |

| # | CBO Name | ZIP Codes | Scope of Service | Population | Services for Parkland Patients | MOU Status |
|---|---|---|---|---|---|---|
| 6 | **Dallas Housing Authority (DHA)** | Various; starting with 75212 | DHA provides quality, affordable housing to low-income families and individuals through administration of housing assistance programs across North Texas. DHA is interested in providing access to supportive resources for families – creating housing solutions in healthy, inclusive communities that offer economic, educational and social growth opportunities. | • 46% of clients are seniors or persons with disabilities<br>• Average annual income: $14,000<br>• 83% female head of households<br>• 86% African American<br>• Average age: 49<br>• Serving ~55,000 individuals across 4,903 rental housing units | Community Hub:<br>Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care<br>PFA Training | Negotiation Phase/Outlining Agreement |
| 7 | **Los Barrios Unidos Community Clinic** | 75211, 75212 | Los Barrios operates a community health clinic in a high need area – known for having quality bilingual staff in English and Spanish. They do not turn away anyone for inability to pay, and accepts Medicaid, CHIP, Medicare, private insurance, offers a sliding fee scale based on federal poverty level guidelines. The clinic is a federally qualified health center that provides comprehensive primary care services to prevent illness and promote health. | • Economically disadvantages, low-income, and poor populations, minorities<br>• ~87,000+ annual patient visits | PFA Training | Negotiation Phase/Outlining Agreement |
| 8 | **Healing Hands Ministries** | 75243, 75231 | Healing Hands operates 7 clinics including a patient-centered community health center. It can serve as a permanent medical home for uninsured, underinsured, and has a goal to teach refugees how to care for their children. They also provide shared medical appointments where groups of 10-12 people are educated in a group setting allowing for peer discussion and support. They have 3 translators on staff and employ a language line. | • 20,000+ individual patients annually who speak 68 different languages<br>• 61,000+ patient visits annually<br>• Children and families<br>• 67% of patients are women | PFA Training | Negotiation Phase/Outlining Agreement |
| 9 | **Foremost Family Health Center** | 75215, 75180 | Foremost is a federally qualified health center offering access to affordable and comprehensive medical, dental and behavioral health services, regardless of ability to pay. | • ~6,161 patients | PFA Training | Negotiation Phase/Outlining Agreement |
| 10 | **Crossroads Community Services** | HQ: 75236, however serves Dallas, Ellis, and Navarro counties | Crossroads provides nutritious food and supportive education to low-income families and individuals. They have a main hub that serves as a food pantry and has partnered with 1200+ community distribution partners (CDPs) to expand their food assistance reach. Crossroads is also committed to meeting individuals' basic needs and works with local partners to improve economic and health outcomes for their clients (UTSW, NTFB, Sharing Life Community Outreach, Parkland through BUILD Health Challenge project, DCHHS, University of Dallas) | • ~75,000 people including 26,500 children<br>• Distributes ~9 million pounds of groceries annually<br>• Low-income/economically disadvantaged people, homeless, unemployed/underemployed | Virtual Care<br>PFA Training | Executed |

| # | CBO Name | ZIP Codes | Scope of Service | Population | Services for Parkland Patients | MOU Status |
|---|---|---|---|---|---|---|
| 11 | **Cornerstone Crossroads Academy** | 75215 | CCA's mission is to develop urban youth through education. They are a certified secondary/high school and host youth development program. Their primary target is older students who need a 2nd chance to earn a high school diploma or returning students. Many of CCA's students are transient. Tuition is free to students, and in lieu of tuition, students participate in community service opportunities. In addition to curriculum, students also meet 1:1 weekly with a life coach to identify areas of concern: social, emotional and physical support for students who are on the verge or already homeless/in crisis. CCA has purchased The Phyllis Wheatley School and plans to expand services at its new location in the coming years. CCA also provides community access to healthy foods by partnering with Crossroads Community Services. | • Ethnic/racial minorities<br>• Ages 16+ | Community Hub:<br>Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care | Negotiation Phase/Outlining Agreement |
| 12 | **Voice of Hope** | Physically located in 75212, but draws a large crowd from 75211 | Voice of Hope is a non-profit seeking to provide character building, education support, life skills and family support services to their clients. They work to equip families with resources and skills needed to overcome and break the poverty cycle. Youth programs include: ASPIRE after school program (homework help & a meal), Summer Day Camps, Kids Across America. Family and community support programs include: Food Pantry as a community distribution partner with Crossroads Community Services, Fruits and Vegetables Outreach (with Hardies), holiday outreach, neighborhood watch groups, and activities for senior citizens including Bible studies and knitting groups. Voice of Hope also partners with NTFB, DISD, World Vision, YMCA, Young Life, Mercy Street Dallas and the West Dallas Initiative. | • All ages with a focus on school aged children and senior citizens | Community Hub:<br>Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care | Negotiation Phase/Outlining Agreement |