OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☒ New	
☒ Application	☐ Continuation	* Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

* 3. Date Received:	4. Applicant Identifier:
Completed by Grants.gov upon submission.	FOA DP14-1419PPHF14

5a. Federal Entity Identifier:	* 5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name:	San Francisco Department of Public Health

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
94-6000417	103717336

d. Address:

* Street1:	101 Grove, Rm408
Street2:	
* City:	San Francisco
County:	
* State:	CA: California
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	94102

e. Organizational Unit:

Department Name:	Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:		* First Name:	Christine
Middle Name:			
* Last Name:	Siador		
Suffix:			

Title:	
Organizational Affiliation:	
* Telephone Number:	415-554-2832
Fax Number:	
* Email:	christine.siador@sfdph.org

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

** Other (specify):*

*** 10. Name of Federal Agency:**

Chronic Disease Prevention and Health Promotion

11. Catalog of Federal Domestic Assistance Number:

93.738

CFDA Title:

PPHF 2012: Racial and Ethnic Approaches to Community Health Program financed solely by 2012 Public Prevention and Health

*** 12. Funding Opportunity Number:**

CDC-RFA-DP14-1419PPHF14

* Title:

PPHF 2014: Racial and Ethnic Approaches to Community Health (REACH) - financed in part by Prevention and Public Health Funding

13. Competition Identification Number:

NCCDPHP-NR

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

*** 15. Descriptive Title of Applicant's Project:**

Racial and Ethnic Approaches to Community Health - Heart Healthy SF

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

* a. Applicant: CA-008 * b. Program/Project: CA-008

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 09/30/2014 * b. End Date: 09/29/2017

18. Estimated Funding ($):

* a. Federal	2,397,477.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	2,397,477.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on

☒ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)**

☐ Yes ☒ No Explanation

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an Internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name: Tomas

Middle Name:

* Last Name: Aragon

Suffix:

* Title: Director, Population Health Division (PHD)

* Telephone Number: 415-787-2583 Fax Number:

* Email: tomas.aragon@sfdph.org

* Signature of Authorized Representative: Completed by Grants.gov upon submission. * Date Signed: Completed by Grants.gov upon submission.

OMB Number: 0980-0204
Expiration Date: 08/31/2012

Project Abstract Summary

Program Announcement (CFDA)

93.738

Program Announcement (Funding Opportunity Number)

CDC-RFA-DP14-1419PPHF14

Closing Date

07/22/2014

Applicant Name

San Francisco Department of Public Health

Length of Proposed Project

3

Application Control No.

Federal Share Requested (for each year)

Federal Share 1st Year	Federal Share 2nd Year	Federal Share 3rd Year
$ 799,159	$ 799,159	$ 799,159

Federal Share 4th Year	Federal Share 5th Year
$ 0	$ 0

Non-Federal Share Requested (for each year)

Non-Federal Share 1st Year	Non-Federal Share 2nd Year	Non-Federal Share 3rd Year
$ 0	$ 0	$ 0

Non-Federal Share 4th Year	Non-Federal Share 5th Year
$ 0	$ 0

Project Title

Racial and Ethnic Approaches to Community Health - Heart Healthy SF

Project Abstract Summary

Project Summary

PROJECT ABSTRACT

San Francisco is known as a diverse and vibrant city with a population of more than 800,000, where African Americans and Latinos have contributed rich influence and cultural history. There are over 50,000 African Americans and 128,000 Latinos in San Francisco, and both groups have maintained strong positive influences through their values, cultures, spirituality, food, dance and music. They have also demonstrated strong multi-generational family ties and resiliency, which have held these groups together despite life challenges and discrimination. Through the REACH grant, the San Francisco Department of Public Health (SFDPH) will address health inequities in these two populations through a community-based approach, which aims to not only reduce cardiovascular disease but also enhance community engagement around chronic disease, improve social connectedness, and improve quality of life.

In San Francisco, our campaign will be called "Healthy Hearts SF: Million Hearts® Initiative Plus." Our proposed program will adapt and implement the national Million Hearts® Initiative in SF, focusing on Latinos and African Americans who have or are at risk for cardiovascular disease, particularly in census tracts where more than 30% of residents live below 200% of the Federal Poverty Level. Healthy Hearts SF will incorporate the addition of alcohol and diabetes to the campaign's focus in order to meet the health and cultural needs of San Francisco; we will focus on primary prevention and management of the ABCDS – Aspirin when appropriate / Alcohol moderation, Blood pressure control, Cholesterol management, Diabetes management, and Smoking cessation.

Healthy Hearts SF is built upon a specific framework designed to identify, improve, and link community prevention resources (CPRs) to patients' primary care medical homes (PCMHs). It does this through three major strategies: I) Identifying and ensuring the QUALITY of CPRs for patients from our PCMHs, II) Improving the ACCESS to CPRs and the FLOW of patients between CPRs and PCMHs, and III) Improving the QUALITY of referrals and PCMH processes to refer patients to CPRs.

Heart Healthy SF activities are designed to improve heart health and address the ABCDS in a variety of ways. Proposed activities include assessing the target population to determine the best systems of linkage to CPRs, hiring REACH Coordinators who will attend monthly quality improvement meetings at each PCMH, partnering with 211.org to improve the public database of CPRs, using Health IT to track patient engagement with CPRs and progress with ABCDS outcomes, offering tailored heart healthy activities (physical activity, nutrition, smoking cessation, etc.) by the community and for the community through REACH mini-grants, executing a communication plan to support these activities, and conducting ongoing evaluation and performance management to ensure high-impact of all Heart Healthy SF activities. These activities will improve the flow of patients between PCMHs and CPRs via quality linkages; increase access to environments that are tobacco-free, have healthy food and beverages, and/or have opportunities for physical activity; as well as creating positive changes in attitudes, beliefs, knowledge, awareness, and behavioral intentions for relevant strategies. These short-term outcomes will lead to reduced exposure to secondhand smoke, increased daily consumption of fruit, vegetables, and healthy beverages, improved social cohesion, and increased use of community-based resources related to better control of cardiovascular health.

Estimated number of people to be served as a result of the award of this grant.

30000

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 06/30/2014

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. SF - Reach	93.738, 93.304	$ 799,159.00	$	$	$	$ 799,159.00
2.						
3.						
4.						
5. Totals		$ 799,159.00	$	$	$	$ 799,159.00

Standard Form 424A (Rev. 7- 97)
Prescribed by OMB (Circular A -102) Page 1

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)	(4)	Total (5)
	SF - Reach				
a. Personnel	$ 43,244.00	$	$	$	$ 43,244.00
b. Fringe Benefits	18,162.00				18,162.00
c. Travel	1,450.00				1,450.00
d. Equipment	0.00				
e. Supplies					
f. Contractual	695,465.00				695,465.00
g. Construction					
h. Other	30,446.00				30,446.00
i. Total Direct Charges (sum of 6a-6h)	788,767.00				$ 788,767.00
j. Indirect Charges	10,392.00				$ 10,392.00
k. TOTALS (sum of 6i and 6j)	$ 799,159.00	$	$	$	$ 799,159.00
7. Program Income	$	$	$	$	$

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8.	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$	$	$	$	$
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$	$	$	$	$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. SF Reach	$ 799,159.00	$ 799,159.00	$ 799,159.00	$
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$ 799,159.00	$ 799,159.00	$ 799,159.00	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: 788,768

22. Indirect Charges: 10,392

23. Remarks: 24.03% of Total Salaries

CHECKLIST

OMB Approval No. 0920-0428

Public Burden Statement:

Public reporting burden of this collection of information is estimated to average 4 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428). Do not send the completed form to this address.

NOTE TO APPLICANT:

This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last age of the signed original of the application. This page is reserved for PHS staff use only.

Type of Application: ☒ NEW ☐ Noncompeting Continuation ☐ Competing Continuation ☐ Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

	Included	NOT Applicable
1. Proper Signature and Date	☒	
2. Proper Signature and Date on PHS-5161-1 "Certifications" page.	☒	
3. Proper Signature and Date on appropriate "Assurances" page, i.e., SF-424B (Non-Construction Programs) or SF-424D (Construction Programs)	☒	
4. If your organization currently has on file with DHHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS Form 690)		
☐ Civil Rights Assurance (45 CFR 80)		
☐ Assurance Concerning the Handicapped (45 CFR 84)		
☐ Assurance Concerning Sex Discrimination (45 CFR 86)		
☐ Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91)		
5. Human Subjects Certification, when applicable (45 CFR 46)	☐	☒

PART B: *This part is provided to assure that pertinent information has been addressed and included in the application.*

	YES	NOT Applicable
1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?	☐	☒
2. Has the appropriate box been checked on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)	☒	
3. Has the entire proposed project period been identified on the SF-424?	☒	
4. Have biographical sketch(es) with job description(s) been attached, when required?	☒	☐
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	☒	
6. Has the 12 month detailed budget been provided?	☒	☐
7. Has the budget for the entire proposed project period with sufficient detail been provided?	☐	☒
8. For a Supplemental application, does the detailed budget address only the additional funds requested?	☐	☒
9. For Competing Continuation and Supplemental applications, has a progress report been included?	☐	☒

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made

Name: Prefix: | * First Name: Christine | Middle Name:

* Last Name: Siador | Suffix:

Title:

Organization:

Address: * Street1: 101 Grove St, Rm408

Street 2:

* City: San Francisco

* State: CA: California | Province:

* Country: USA: UNITED STATES | * Zip / Postal Code: 94102

*** Telephone Number:** 415-554-2832

E-mail Address: christine.siador@sfdph.org

Fax Number:

APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN (If already assigned)

☐ - 94-6000417 - ☐

PART C (Continued): In the spaces provided below, please provide the requested information.

Program Director/Project Director/Principal Investigator designated to direct the proposed project

Name: Prefix: * First Name: Tomas Middle Name:

* Last Name: Aragon Suffix:

Title:

Organization:

Address: * Street1: 101 Grove St, Rm308

Street2:

* City: San Franciasco

* State: CA: California Province:

* Country: USA: UNITED STATES * Zip / Postal Code: 94102

* Telephone Number: 415-787-2583

E-mail Address: tomas.aragon@sfdph.org

Fax Number:

SOCIAL SECURITY NUMBER

HIGHEST DEGREE EARNED

PART D: A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.

☐ (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.

☐ (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.

☐ (c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.

☐ (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.

☐ (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of PHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: ** (Agency)* on ** (Date)*

INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported, or (3) a negative certification.

EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Inter-governmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review, (2) increase the ability of State and local elected officials to influence Federal decisions and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in *Federal Register* on June 24, 1983, along with a notice identifying the Department's programs that are subject to the provisions of Executive Order 12372. Information regarding PHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order, 12372 and, where appropriate, whether the State has been given an opportunity to comment.

Table of Contents
San Francisco Department of Public Health
Population Health Division
Racial and Ethnic Approaches to Community Health
Heart Healthy SF
FOA DP14-1419PPHF14

Note: CDC Form 0.1113 Assurance of Compliance and the Indirect Cost Rate Agreement are not included in the Table of Contents but are included with the application.

PROJECT NARRATIVE

A. BACKGROUND

Heart disease and stroke are two of the leading causes of death in the US, with 1.5 million heart attacks and strokes occurring annually.[1] However, many of the risk factors for heart attack and stroke are preventable or can be managed with appropriate medical care, including identification and management of high blood pressure, high cholesterol, diabetes, obesity, and smoking.[2] These risk factors are far more prevalent among African Americans (AAs) and Latinos in the U.S., leading to significant health inequity for cardiovascular disease in these populations.[3]

In September of 2011, the Department of Health and Human Services launched the Million Hearts® Initiative, with the goal of preventing one million heart attacks and strokes in the U.S. by 2017. This national campaign focuses on evidence-based strategies to address the "ABCS" – Aspirin when appropriate, Blood pressure control, Cholesterol management, and Smoking cessation. Million Hearts® unites federal agencies, private-sector partners, local health departments, nonprofit organizations, and communities to fight heart attack and stroke through clinical and community prevention, including innovative team-based care and health information technology (IT).

San Francisco (SF) is known as a diverse and vibrant city with a population of more than 800,000, where African Americans and Latinos have contributed rich influence and cultural history. There are over 50,000 AAs and 128,000 Latinos in SF,[4] and both groups have maintained strong positive influences through their values, cultures, spirituality, food, dance and music. They have also demonstrated strong multi-generational family ties and resiliency, which have held these groups together despite life challenges and discrimination. Through the REACH grant, the SF Department of Public Health (SFDPH) will address health inequities in these two populations through a community-based approach, which aims to not only reduce cardiovascular disease but also enhance community engagement around chronic disease, improve social connectedness, and improve quality of life.

In SF, our campaign will be known as "Healthy Hearts SF: Million Hearts® Initiative Plus." Healthy Hearts SF will incorporate the addition of alcohol and diabetes to the campaign's focus in order to meet the health and cultural needs of San Francisco; we will focus on primary prevention and management of the **ABCDS** – Aspirin when appropriate / Alcohol moderation, Blood pressure control, Cholesterol management, Diabetes management, and Smoking cessation. Our campaign framework is designed to identify, improve, and link community prevention resources (CPRs) to patients' primary care medical homes (PCMHs).

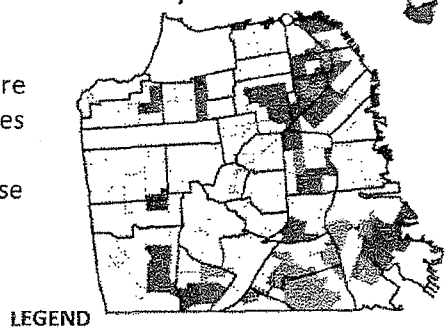
By design, this community-based initiative connects with our healthcare-based Black/AA Health Initiative (BAAHI), which was launched by SFDPH leadership in April 2014. The Director of Health recognized that in order to effectively address and significantly impact the health inequities and disparities among AAs, a focused and deliberate process must be prioritized across the SFDPH, so that appropriate staffing and resources can be aligned with key strategic activities. The BAAHI has identified and convened meetings with an Internal SFDPH "Think Tank", comprised of 50+ representatives from every Branch within the SF Health Network and the Population Health Division. The BAAHI is a department-wide initiative that will provide recommendations for action to SFDPH leadership and the SF Health Commission to focus specifically on reducing the percentage of AAs with heart disease.

B. APPROACH

i. PROBLEM STATEMENT

The City and County of San Francisco is a densely populated urban area of 837,441 residents within 49 square miles.[4] There are marked income, social, and health disparities across the County. The higher-income workforce generally lives in the western half of the County; new immigrants, those working in low-income jobs, and most public housing units are in the eastern half. About 45% of residents speak a language other than English at home.[4]

Figure 1. Map of priority census tracts for Healthy Hearts SF



Healthy Hearts SF will be implemented countywide; however, our efforts will be focused in the Census Tracts and surrounding areas where at least 30% of the population has an income below 200% of the Federal Poverty Level (FPL) and at least 25% of adults over 25 years of age do not have a high school education (see Figure 1). The income cutoff of 200% FPL was chosen as a better indicator of poverty and need in SF than 100% FPL due to the high cost of living resulting from, in part, high housing costs; 37.3% households spend more than 35% of their income on rent.[5] The Insight Center for Community Economic Development estimates that a family of two adults and two children would need to earn at least $54,222 and as much as $97,472 to be self-sufficient depending on the age of their children.[6] Furthermore, inclusion of those with an income under 200% FPL also aligns with local initiatives such as the Lifeline Transportation Program by Metropolitan Transportation Commission which uses a threshold of 200% FPL in defining their populations of concern.[7] Access to social programs such as the Supplemental Food Program for Women, Infants and Children (WIC) and free and reduced meals at school are also available to those earning up to 185% of the FPL.

The priority census tracts are contained within six contiguous areas. (A list of priority populations for Healthy Hearts SF and selected demographic data is provided in Appendix A). These priority populations represent 12% of the county's population but more than 30% of SF's African American and Latino populations. The median per capita income for 25/26 of the priority population census tracts ranges from $10,796 to $35,419, which is only 23% to 75% of SF's overall per capita income. In four of these census tracts, per capita income is below $15,000. About 50% of this priority population does not speak English fluently.[5]

Chronic Disease Burden in San Francisco

SF has stark health inequities in mortality rates by ethnicity. Disparity ratios for heart attack and stroke, calculated by dividing the highest race-specific age-adjusted death rate by the lowest, range from 1.3 to almost 4.9 among males and from 1.6 to 5.6 among women. Overall, AA men and women have the highest death rates in SF; death rates among AAs are about 2.5 times higher than rates among the ethnic groups with the lowest rates the same causes of death.[8]

Smoking is still too prevalent in SF, where approximately 14% of adults smoke. Prevalence is higher among AAs (21%) than other ethnic groups, and almost 20% of AAs who smoke report smoking indoors.[9] Smoking prevalence is also higher among the lowest-income adults in households earning less than 200% of the FPL.[10]

More than 20% of adults in SF have been diagnosed with high blood pressure at some point. This percentage is more than double among AAs. SF households with incomes under 200% of the FPL are more likely to have high blood pressure than those with higher income. High blood pressure prevalence is highest for AAs with incomes below 300% of the FPL.[10]

Population levels of obesity in SF are high among both youth and adults: 41.8% of adults and over 30% of youth are overweight or obese. There are also large inter-ethnic disparities in this burden. For example, AAs (33%) and Latinos (37%) are significantly more likely to be obese than whites (11%) and Asians (21%). Households earning less than the FPL are more likely to have obese members than those earning an income at least 200% of the FPL.[9,10]

Physical activity and healthy eating are powerful protective factors against obesity. Almost 40% of San Franciscans reported living a sedentary lifestyle. When including walking, only 23% of adults reported getting moderate physical activity for at least 30 minutes/day for 5 days/week. Only 18% of Latinos and 27% of AAs reported regular exercise. Households earning less than 300% of the FPL are less likely to get regular exercise than those who make more.[9,11] Fifty-two percent of Latino children ages 5-11 report no days of being physically active for a least one hour the week before being interviewed, compared to 14% of white children.[9,10]

Many San Franciscans regularly eat unhealthy food. Forty percent of San Franciscans eat fast food in a typical week, compared to 57% of AAs, 63% of Latinos and 50% of Asians. Only 41% of children and 24% of teens eat 5 or more servings of fruits and vegetables per day.[10]

The table below highlights some of the most relevant health inequities for AAs and Latinos in SF related to the focus of this proposed campaign.

Stroke
7% of AAs in SF report ever having a stroke compared to 1% of Latinos, 1% of Whites and 0.3% of Asians.[10]
1.8% of those living below 100% of the FPL have had a stroke.[10]
Heart Disease
More AAs (15%) in SF have been diagnosed with heart disease than Whites(7%), Asians (4%), and Latinos (2%).[10]
Diabetes
The prevalence of self-reported diabetes is higher among AAs (16%), Latinos (5%) and Asians (7%) than whites in SF (1%).[10]
More AAs (14%) report having pre-diabetes than Latinos (3%), Whites (4%) and Asians (11%).[10]
From 2007 to 2011 the rate of gestational diabetes increased for all San Franciscans; increases were greater among Latinas (5% to 8.2% of live births) and AAs (1.5% to 5.5% of live births).[12]

ii. PURPOSE

Our proposed program will adapt and implement the national Million Hearts® Initiative in SF, focusing on Latinos and African Americans who have or are at risk for cardiovascular disease, particularly in census tracts where more than 30% of residents live below 200% of the FPL. Healthy Hearts SF will expand upon the Million Hearts® Initiative to incorporate the addition of alcohol and diabetes to the campaign's focus in order to meet the health and cultural needs of San Francisco; we will focus on primary prevention and management of the **ABCDS** – **A**spirin when appropriate / **A**lcohol moderation, **B**lood pressure control, **C**holesterol management, **D**iabetes management, and **S**moking cessation.

iii. OUTCOMES

The table below explains how our proposed activities will address each of the outcomes required by the FOA.

Activities	OUTCOMES: Short-term* a	b	c	d	e	Intermediate† a	b	c	d	e	f
Assessment of target pop. to determine best system of linkage to CPRs				■					■		
Monthly quality improvement meetings at each PCMH				■					■		
Partnership with 211.org to improve CPR database	■	■	■	■		■	■	■	■		
Implementation of non-pharmaceutical prescription system	■	■	■	■		■	■	■	■		
Enhancement of EMR and tracking of patient engagement with CPRs and ABCDs outcomes using Health IT				■					■		
Tailored heart healthy activities (physical activity, nutrition, smoking cessation, etc.), by the community and for the community, funded through REACH mini-grants	■	■	■	■	■	■	■	■	■	■	■
Execution of communication plan	■	■	■	■	■	■	■	■	■	■	■
Ongoing evaluation and performance management				■	■					■	■

*Short-term outcomes per the REACH FOA:

a) *Increased access to smoke-free or tobacco-free environments*
b) *Increased access to environments with healthy food or beverage options*
c) *Increased access to physical activity opportunities*
d) *Increased opportunities for chronic disease prevention, risk reduction or management through clinical and community linkages*
e) *Positive changes in attitudes, beliefs, knowledge, awareness, and behavioral intentions for relevant strategies*

†Intermediate outcomes per the REACH FOA:

a) *Reduced exposure to secondhand smoke*
b) *Increased daily consumption of fruit*
c) *Increased daily consumption of vegetables*
d) *Increased consumption of healthy beverages*
e) *Increased physical activity*
f) *Increased use of community-based resources related to better control of chronic disease*

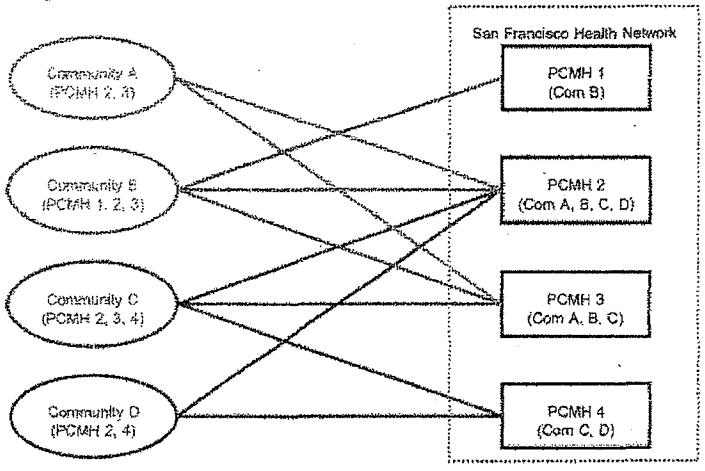
iv. STRATEGY AND ACTIVITIES: <u>This proposal is for a Comprehensive Implementation Award.</u>

Healthy Hearts SF is built upon a specific framework designed to identify, improve, and link CPRs to patients' PCMHs. It does this through three major strategies:

I. Identifying and ensuring the **QUALITY** of CPRs for patients from our PCMHs
II. Improving the **ACCESS** to CPRs and the **FLOW** of patients between CPRs and PCMHs
III. Improving the **QUALITY** of referrals and PCMH processes to refer patients to CPRs.

Figure 2 illustrates how these 3 strategies work in practice. In this illustration, SF Health Network patients that live in Community A seek medical care at PCMH 2 and 3. Looking at it another way, patients at PCMH 2 live in Communities A,B,C, and D. Given that SF patients do not have a linear relationship with PCMHs in their own communities, addressing the access and referral of patients between their PCMH and their CPRs is an essential part of supporting their health and wellness.

Figure 2.



1. Collaborations

The Activities described in the remainder of this section and in the work plan will be accomplished through collaboration between the SFDPH and the SF Health Improvement Partnership (SFHIP). A Letter of Involvement from SFHIP members as well as a number of other community organizations and coalitions that will support the project is included in this grant package.

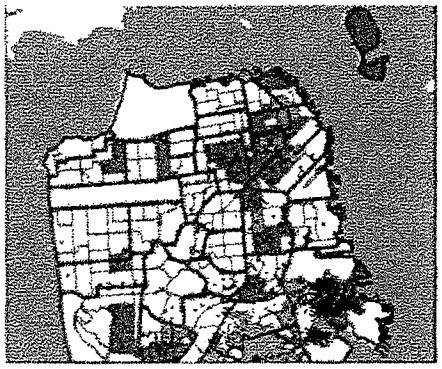
2. Target Population

San Francisco is a large city and urban county with a population of over 500,000. Our target population is Latino and AAs who currently have or are at high risk for cardiovascular disease (CVD), particularly those who reside in 26 census tracts where more than 30% of population has an income less than 200% FPL and 25% adults are without a high school education.

Given the scope of the REACH grant, we have decided to focus our clinic-based interventions on select PCMHs within the SF Health Network, with the ultimate goal of scaling our program citywide after opportunities for improvement have been addressed. The SF Health Network is comprised of PCMHs providing direct health services to thousands of insured and uninsured residents of SF, including those most socially and medically vulnerable. To determine the most appropriate PCMHs on which to focus, we conducted a systematic analysis of patient-level data at all SFDPH-run PCMHs throughout the city. Across all PCMHs, the greatest number of current smokers and people with high blood pressure (>140/90) were ages 45 – 64. Therefore, our interventions will be targeted toward AAs and Latinos in that age group. The majority of patients with diabetes, hypertension, high cholesterol, and/or active tobacco exposure seek care at the Southeast Health Center, as well as the Family Health Center and General Medicine Clinic at San Francisco General Hospital (SFGH). These PCMHs also see the highest percentage of AA and Latino patients across the SF Health Network.

Additionally, we analyzed the residential location of PCMH patients. Typically clinical teams have expertise in CPRs nearest to their PCMH, based on the assumption that patients seek medical care near to their home and would benefit from services in that same area. Rather than finding that patients were likely to access PCMHs based on their home location, however, we discovered that in fact, these four PCMHs routinely see patients from throughout the city – and that they are particularly concentrated in the same 26 priority census tracts discussed earlier. Figures 2-4 display maps pinpointing residential locations for each AA and Latino patients of the priority PCMHs (indicated by the black dots), overlaid on the priority census tract areas, identified in red, orange, and yellow.

Figure 2. Southeast Health Center



LEGEND

Census tracts with 30% of population below 200% FPL and 25% of adults lacking a high school education

Census tracts with 30% or more of households under 200% of the FPL

Census tracts with 25% or more adults lacking a high school education

Figure 3. Family Health Center (SFGH)

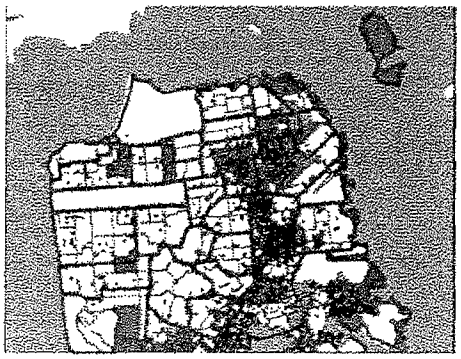
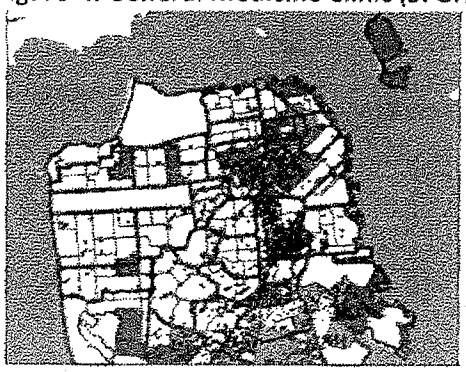


Figure 4. General Medicine Clinic (SFGH)



LEGEND

Census tracts with 30% of population below 200% FPL and 25% of adults lacking a high school education

Census tracts with 30% or more of households under 200% of the FPL

Census tracts with 25% or more adults lacking a high school education

3. Activities

To implement our strategies, we will conduct a number of specific activities. The first step will be to hire two full-time "REACH Coordinators", and identify members of an integrated team at each participating PCMH, which will include key clinical team members the patients may interact with during their visit – i.e., medical providers, behaviorists (social workers who support patients in meeting needs and changing behaviors to support their health), community health workers, medical assistants, phlebotomists, social workers, and registration staff. These teams will work collaboratively and partner with SFDPH staff to execute the following activities:

Assessment of African American and Latino Patients with Cardiovascular Disease

A critical lesson learned from the residential analysis by PMCH is that we cannot make assumptions about where people are most likely to seek services, and what services they may be interested in accessing. Simply placing a focus on providing community prevention resources (CPRs) nearby participating PCMHs may not be appropriate. Given this, we will spend much of the first 6 months of the REACH project period assessing priority patients – asking them where they would be most likely to participate in programs to improve their heart health, and what their barriers might be to accessing the CPRs. Would it be where they work? Where they play? Where their kids go to school? What would be critical features of the service? Once we have a better understanding of the geographic and programmatic needs of our priority patients, we will be in a greatly improved position to identify and support effective, culturally competent interventions.

With the input and support of the integrated PCMH teams, the REACH Coordinators will:

1. Recruit priority patients for focus groups and coordinate all of focus group logistics.
2. Assist in setting up the procedures for implementation of the PCMH-based surveys, including working with the PCMH staff to determine who will best implement the surveys.
3. Facilitate the Spanish translation of the assessment instrument with Spanish-speaking patients, coalition members, SFDPH staff, and other community partners.
4. Field test the assessment instrument for both AA and Latino patients, specifically testing literacy and cultural appropriateness as well as overall user friendliness.
5. Conduct the assessments simultaneously at each PCMH, and supervise data collection.

The form of the assessment—written survey, face-to-face interview, or other-- will be determined through consultation with the integrated clinical teams and designed to suit the target population. REACH coordinators will collect, analyze and distribute the results of the assessment, which will be used to identify and ensure the QUALITY of CPRs, and better understand how best to successfully REFER patients from PCMHs to CPRs, per our project framework. The information will also be used to enhance the existing CPR database hosted by 211.org, a program of United Way of the Bay Area (see the next section for more information).

To supplement the findings of this assessment, staff epidemiologists from the Community Health Assessment and Impact (CHAI) Unit of SFDPH will conduct a thorough analysis of participating PCMH data, to examine which health conditions and behavioral risk factors most affect AA and Latino patients, including but not limited to the ABCDS. Results of this analysis will be shared with clinical leadership and REACH staff, and used by PCMH teams to improve care.

Using Team-Based Care to Boost Linkages and Address the ABCDS

Once the assessment period is complete, the REACH coordinator role will transition to facilitating our team-based care strategy. Simply, the REACH coordinators will improve the FLOW of patients between CPRs and PCMHs; they will work with the PCMH-based integrated teams to improve QUALITY of referrals and PCMH processes to refer patients to CPRs for improved cardiovascular health (a continuous quality improvement process), per our project framework.

To do this, REACH Coordinators will attend existing monthly quality improvement meetings with key PCMH staff to share chronic disease data of their patients and provide them with updates about CPRs available to support their patients. Each PCMH will use time in these meetings to determine how they will incorporate referrals to new CPRs into their clinic flow.

In addition to the monthly quality improvement meetings, staff from the SFDPH Community Health Equity and Promotion (CHEP) Branch and the Office of Equity and Quality Improvement (OEQI) will support REACH Coordinators in working with PCMHs to identify and support improved QUALITY of PCMH processes to REFER patients to the rich network of CPRs available to promote health for San Franciscans at low to no cost to individuals. This integrated team will meet quarterly to discuss clinical guidelines, review practice-based evidence, and recognize best practices. At these meetings, clinical staff at each PCMH will be presented with feedback on continuous quality improvements to address the ABCDS among AA and Latino patients.

At the same time, REACH staff will work with at least 5 CPRs per year to support program participants without a PCMH to access health coverage options of the Affordable Care Act (ACA), through Covered California or with our local program, Healthy San Francisco. Having access to regular medical care through a PCMH is critical to successful management of chronic disease, including CVD. Yet many of the patients with highest need do not have health insurance and are not connected to regular medical care. To this end, REACH staff will work with CPRs to develop protocols for referral to ACA resources and tracking of linkage to health care access programs. With the support of SFHIP and the OEQI, REACH staff will develop and provide a tailored series of 3 trainings for CPR staff on ACA options and health care access opportunities, including barriers and supportive factors for accessing PCMHs in SF. They will meet with CPRs on a regular basis to discuss and adjust protocols as needed.

To support the identification and *active referral* of valuable CPRs that promote good cardiovascular health for AA and Latinos in SF, the REACH Coordinators will work closely with the

United Way of the Bay Area, which runs the website http://211bayarea.org/find-help/. This website features a CPR database to assist SF residents with food security, healthcare, housing, legal aid, senior services, and other supportive services at no cost. It is confidential and available in 150 languages, 24 hours a day, with the information also available via a phone call to 2-1-1. This information can be accessed by patients directly and also by healthcare providers while they are being seen at the PCMH. It can be searched by zip code, helping to find resources in close proximity to a patient's home, work, or the PCMH itself if desired. This 211.org data is also part of the *HealthyCity* lookup database, which provides data and mapping tools to help public health professionals and community members build a better community.[13] A part of this activity will involve REACH Coordinators partnering with 211.org staff (See Letter of Support) to update or complete missing resource information based on information received from AA or Latino patients or the PCMHs' integrated teams through this project, particularly for CPRs related to the ABCDS. REACH Coordinators will also regularly use the information found in 211.org to inform clinical teams about available resources in the monthly PCMH quality improvement meetings.

Finally, the REACH Coordinators will also work with each PCMH to implement a clinic-wide system to provide non-pharmaceutical prescriptions to further support their patients in reducing their risk for heart attack and stroke. This process would be tailored for each PCMH, but based on a model already piloted at Southeast Health Center, where a quality improvement team comprised of SFDPH managers and staff, community health workers, and clinicians provided physical activity prescriptions to AA patients diagnosed with hypertension, and referred those patients to the nearby YMCA to participate in free exercise classes. Patients were then tracked through follow up phone calls and clinic appointments to assess blood pressure outcomes. After just two months post-implementation, the pilot showed consistent physical activity participation among most participants. In addition, systems were created to establish a strong referral and feedback loop from PCMH to community site and back to the PCMH. We plan to build upon the successes and lessons learned from this pilot, to expand this strategy to all priority patients in our participating PCMHs (and ultimately to all SFDPH PCMHs citywide), aligning the non-pharmaceutical prescriptions with CPR agencies in each neighborhood.

Using Health Information Technology to Track Outcomes and Strategize Improvements

After the initial 6-month assessment period is complete, we recognize that it is important to continue assessing the health conditions and behaviors of AA and Latino patients, including where they live, seek medical and psychosocial care, and engage in health-promoting activities. This information is useful not only to track project outcomes but also to improve and adjust our strategies and activities as needed to maximize health impact during the project period. Through the REACH grant, we plan to develop systems for using health information technology (IT) to conduct this ongoing assessment. Activities within this strategy include:

- A staff epidemiologist in the SFDPH CHAI Unit will work with the IT staff of the OEQI to routinely extract data from SFDPH PCMHs to assess where AAs and Latinos seek healthcare, and where those patients reside.
- The REACH Coordinators, 211.org staff, and the CHAI epidemiologist will work together to conduct a quarterly environmental scan using SFDPH PCMH and CPR data in the 211.org database, to identify what CPRs are available near the PCMH and where PCMH patients live. This information will be shared with providers in the monthly quality improvement meetings.

- The REACH Coordinators will work with key IT staff at the SFDPH and participating PCMHs to systematically identify patients who need support to improve their ABCDS, and track their progress over time. For example, using the electronic medical record system to flag patients with ABCDS needs at the time of the visit and remind the clinician to refer to appropriate CPRs will support clinical teams in effectively linking patients to heart healthy CPRs.
- With the support of the REACH Coordinators, PCMH integrated teams, SFDPH OEQI, and SFHIP, the CHAI epidemiologist will use and develop IT systems within SFDPH to track patients' engagement with clinical services and CPRs, and will provide an ongoing status report each quarter for key project and PCMH staff.

Communications and Community Engagement

We are especially excited about our final strategy: the REACH Coordinators will coordinate provision of tailored CPRs for the AA and Latino communities. These will have a focus on physical activity, healthy eating and smoking cessation, as well as social cohesion. This will be accomplished by the REACH Coordinators working with SFHIP to execute a Request for Applications (RFA) process for community-based organizations to address the ABCDs in their community through mini-grants to conduct activities in support of the Million Hearts® Initiative. Almost 20% of the Healthy Heart SF budget will be distributed through the mini-grants process, which will be conducted annually. Ideas for activities to be funded by mini-grants will come from the community. However, some examples of activities we anticipate may be proposed are: "Wear Red Day," creating awareness and dialogue throughout the community about heart disease and high blood pressure; "a multi-generational "Dance a thon" event to inspire physical activity; and a "Cultural Food Cook Off," with healthy food options. We will leverage the expertise of the SFDPH Tobacco Free Project, Shape Up San Francisco, and other community organizations and coalitions to provide technical assistance on these programs, though the main point of this strategy is to promote community engagement and social cohesion through supporting heart-healthy activities **by the community, for the community**.

The SFDPH has a long history of mini-grant programs in the community, with established processes to ensure that community-based organizations have the necessary infrastructure and support to implement the programming and administrative requirements. To ensure that nonprofits of all sizes can apply, the RFA is a straightforward process; the RFA is distributed to existing CBOs, announced on local and neighborhood listservs, and distributed through City partner agencies. SFDPH staff conduct a technical review to ensure submissions meet criteria, then guide a diverse review panel comprised of residents and content experts to review and score mini-grant proposals. Once agencies are selected, SFDPH staff provides programmatic and fiscal technical assistance to ensure grantees succeed in conducting proposed activities.

Integrated with the programs resulting from the mini-grants will be a citywide communication strategy to engage AAs and Latinos who have or are at high risk for CVD and encourage widespread, equitable utilization of community activities to encourage heart health. This plan is intended to support the mini-grant recipients and encourage success of their planned activities. The communication plan will be designed and implemented by the Media Broker/PR Firm, in partnership with a Communication Advisory Board comprised of members of the target population, award recipient staff, SFHIP coalition members, and the SFDPH Communications Director. The following table outlines the details of the plan.

Key strategies and components of the Healthy Hearts SF communication plan:

Strategies
1. Build AA and Latino community engagement and ownership of Million Hearts® Initiative activities, using culturally competent, clear communication approaches to overcome barriers to health literacy about prevention of heart attack and stroke and to empower individuals to act as heart health-promoting communicators to their loved ones
2. Support Million Hearts® Initiative efforts and sustainability by capturing successes in a storytelling format to increase awareness in key audience, strengthen coalitions, create and sustain partnerships, and to educate and advocate with funders and policymakers
3. Promote the Healthy Hearts SF kick-off event in February 2015. This event will be developed in collaboration with the BAAHI team and a PR firm hired to coordinate event advertising
4. Convey unified, accurate and time-sensitive key messages to key audiences (see below)
5. Link abstract heart health concepts to action steps and specific CPRs
6. Monitor, track and report bi-annually on all communication activities and effectiveness
Key Messages
1. Heart attack and stroke are two of the leading causes of death and disability in SF's AA and Latino populations.
2. Scientific evidence shows that heart attacks and strokes *can be prevented*.
3. Healthy Hearts SF exists to create equal opportunity for and empowerment of SF AAs and Latinos to have access and to utilize *"healthy choices for healthy hearts."*
Components
1. Conduct gender-specific focus group-based formative research with AAs and Latinos to measure attitude, awareness and health beliefs, as well as to assess health literacy abilities
2. Using the formative research findings: a. Prepare and field test Healthy Hearts SF and Million Hearts® Initiative branding, key messages, plain language presentations and talking points for campaign spokespersons to brief AA and Latino community leaders and decision makers, b. Plan content and design of strategic and integrated paid, earned and partner media over the project period to communicate Healthy Hearts SF and Million Hearts® Initiative objectives, activities and successes to key audiences, and c. Prepare Healthy Hearts SF written materials with plain language and low-literate elements to make health information easier to understand and ensure culturally competent communication strategies.
2. Track and evaluate communication effectiveness bi-annually, and use findings for quality improvement of communication products
4. Report all paid, earned and partner media and communication activities twice yearly and complete online submittal of at least two success stories per year over the course of the project period. Success stories will also be highlighted in the quarterly reports as well as in meetings with clinical teams, coalition members and community partners; during quarterly presentations at brown bags lunch sessions; and through conference presentations.

Appendix B provides detail of the strategic media to be used in the communications plan, and Appendix C identifies resources for key message and material development.

Dissemination and Sustainability

We believe strongly in the importance of disseminating findings about best practices and impact of activities developed as a result of Healthy Hearts SF. To disseminate information about the outcomes of the REACH grant, we will:

- Present updates at least annually at SF Health Network meetings (meetings of all SFDPH PCMHs), SFHIP meetings, SFDPH Leadership meetings, and meetings of the SF BAAHI, as well as semi-annually at integrated team meetings at each participating PCMH
- Display visuals (e.g. a thermometer with a goal at the top) in various clinical and community locations that are most frequented by AAs and Latinos, such as Southeast Health Center, Family Health Center, Instituto de la Raza, and Bayview YMCA, of a) the number of patients participating in CPRs, and b) percent improvement in ABCDS for AA and Latino patients
- Share key project updates on SFDPH Monthly "Fast Facts" web-based announcements
- Present findings quarterly through the Public Health Division "Brown Bag Workshop Series"
- Identify two community-based locations frequented by the target population and engage community partners to present project findings/updates in non-scientific, simple language
- Write up the findings and submit abstracts for presentation at professional health conferences and articles to be published in high-impact peer-reviewed journals

We also recognize that the momentum built by the REACH grant will be valuable and it is critical to have a plan to sustain successful activities well after funding has ended. SFDPH leadership is committed to using REACH funding as a seed for expansion of the pilot project throughout the SF Health Network. During the project period, external funding will be sought to support the hiring of additional REACH Coordinators, who will be assigned to clinics not participating in the original REACH pilot and will oversee the expansion into those new locations, tailoring activities culturally and linguistically for each neighborhood and patient population they serve. REACH project staff duties will be eventually absorbed into the tasks performed by existing SFDPH behaviorists and community health workers. We expect a smooth transition, since they will be part of the team-based approach of the Healthy Hearts SF project.

C. APPLICANT EVALUATION AND PERFORMANCE MEASUREMENT PLAN

In collaboration with program partners, REACH Coordinators and staff of the SFDPH CHEP Branch, SFDPH staff epidemiologists and the OEQI will plan and conduct the evaluation and performance management plans for Healthy Hearts SF. The CDC's Framework for Program Evaluation in Public Health[14] – Engage stakeholders, describe the program, focus the evaluation design, gather credible evidence, justify conclusions, and ensure use and share lessons learned – will be employed to organize the evaluation process. The first step in our process will be the assembly of work groups comprised of key program partners who will play a role in activities for Healthy Hearts SF, including identification of appropriate indicators, development of data collection tools, as well as data collection and analysis. Following initial planning sessions, REACH Coordinators will lead monthly meetings for the duration of the grant. Appendix D lists key program partners for evaluation planning and implementation.

Healthy Hearts SF performance monitoring and evaluation will include both process and outcome components. Process monitoring will be focused on improving the quality, effectiveness, reach, and efficiency of program activities and will generally be used to

determine: (1) if the program is being implemented as intended and reaching the target populations (and adjusted to overcome barriers over their course), (2) what aspects of each program are working and for whom, and (3) delivery of short term objectives. Outcome evaluation will be informed by community partner data generated by Healthy Hearts SF and clinical measures designed to align with the Million Hearts® Clinical Quality Measures. All findings will be disseminated quarterly to all REACH community and clinical partners via email and changes made as needed to the process.

Specific measures will be developed for each Healthy Hearts SF activity based on resources, activities, outputs and outcomes identified in the activities' logic models, which will be required by the mini-grants RFA. Performance indicators may include meeting attendance logs and notes, and quantitative elements such as the percentage of patients with CVD receiving a non-pharmaceutical prescription, and of those, the percentage who reported actually participating in a heart healthy activity.

Evaluation Methods

Needs Assessment and Gap Analysis: Within six months of project start, a needs assessment will be completed identifying the patients' wants and needs near their PCMH or where they live, and any assets or barriers to participation in quality physical activity and nutrition opportunities. The needs assessment will also include questions on frequency and type of health behaviors, such as physical activity and nutrition, which are associated with cardiovascular health. This self-reported data will be used to define the baseline health behaviors of our target population. REACH Coordinators will collaborate with PCMH partners to identify patients for participation in the needs assessment as well as the methods for dissemination/participation and distribution of incentives (all patients who participate in the survey will receive a giftcard or other incentive for their time). To complement the needs assessment and further enhance the 211.org CPR database, a gap analysis will be completed by the REACH Coordinators in cooperation with project partners. The gap analysis will review the overall availability of services in regards to needs identified in the needs assessment and evaluate the quality of those services. The findings will be used to support the development of appropriate services by community partners.

Ongoing Assessment of ABCDS: Ongoing assessment of the gaps in availability, access to heart health activities, and the cultural and linguistic proficiency of materials and resources will occur through focus groups. Separate groups each including 8 to 10 participants will be formed for men and women and African Americans and Latinos (total 4 groups). Each focus group will be held at 6 month intervals for the first year and a half and annually thereafter.

Non-Pharmaceutical Prescription Issuance and Use and Clinical Outcomes: Through partnership with the SF Health Network, we will have the ability to routinely track the health outcomes of target population patients. REACH coordinators, with input from SFDPH epidemiologists, will work with the participating PCMHs to develop plans and protocols for the collection and analysis of clinical measures related to the REACH objectives. Clinical data will be collected at baseline and every six months thereafter. Tools will also be developed to track frequency of planned and actual appointment attendance. Clinical measures will be aligned with the Million Hearts Clinical Quality Measures (see Appendix E) for Aspirin use among those with Ischemic Vascular Disease, Blood pressure Screening and control, Cholesterol screening

and control, and Smoking cessation and be enhanced with the addition of Alcohol and Diabetes to address the health and cultural needs of the local jurisdiction. Non-clinical setting methods of obtaining biometric data and supporting self-measured blood pressure monitoring, such as placing blood pressure machines in public locations will also be considered.

Community Engagement Activity (Mini-Grant) Participation Tracking: In collaboration with coalition members and CPR partners, REACH Coordinators will develop methods to monitor programmatic data which indicates in which heart healthy activities AAs and Latinos participate. Particular attention will be paid to community members who participated as a result of one or more elements of the Heart Healthy SF communication plan. Options to track participation may include registration forms, health passport books, collection of non-pharmaceutical prescription referrals and follow-throughs, and barcode scanning. Association between clinical outcomes and participation in heart healthy activities will be assessed by SFDPH epidemiologists in coordination with the integrated clinical teams and the SF Health Network, for SFDPH Network Patients. However, these community level projects are not limited to our PCMH patients, because we want to improve the health of the community as a whole. For non-SFDPH Network patients, only measures of participation will be collected.

Key Evaluation Questions

Key evaluation questions to be answered by the Healthy Hearts Evaluation will be refined through collaboration with SFHIP. Key questions may focus on the following:

- Is the program being implemented as intended?
- What are the assets and barriers to participation in heart healthy activities for our patients?
- How can this work be sustained (policy change, capacity of partners)?
- What is the baseline ABCDS health status of the AA and Latino patients with cardiovascular disease at participating PCMHs and how does it change throughout the project?
- What CPRs (e.g. exercise classes, smoking cessation) do our patients use and how frequently?
- How many CPRs are available, what proportion of services are culturally and linguistically appropriate, and how does this change over time?
- What is the participation by African American and Latino patients and other community members in programs supported by REACH-funded mini-grants?

Data Sources

The performance management and evaluation team will collect organizational-level information from quarterly project reports, tracking forms used by key community partners, surveys with stakeholders (including on-site implementation staff), and data generated by the Healthy Hearts SF evaluation. There are a series of possible data sources for the evaluation, and details of those sources as well as the feasibility of collecting each are listed in Appendix F.

D. ORGANIZATIONAL CAPACITY OF APPLICANT TO IMPLEMENT THE APPROACH

The applicant and lead agency for the project is the SFDPH, the sole health department in San Francisco – the only consolidated city and county in the state of California. SFDPH is recognized as a public health leader with a track record of success in implementing innovative, effective, evidence-based strategies and enacting policies to build healthy, safe and equitable communities.

SFDPH has an extensive track record of developing and implementing policy, environmental, programmatic and infrastructure initiatives to promote health and prevent disease and reduce health inequities, including the ones detailed below:

Childhood Asthma: SFDPH has worked with the SF Asthma Task Force and Community Action to Fight Asthma to implement structural changes to reduce rates of asthma in SF over the last decade. Strategies include making school improvements using the EPA Tools for School Indoor Air Quality Program; screening out asthma-causing and asthma-exacerbating janitorial products purchased by the City and the SF Unified School District; building capacity of the SF Housing Authority, Department of Building Inspection, and Mayor's Office of Housing to use thermographic cameras to detect mold and moisture problems; and raising community awareness through television and internet video messaging. SFDPH has also administered six projects funded through SF Ordinance No. 217-11, appropriating $1,000,000 of Mirant Potrero LLC Settlement Funds for neighborhood improvement and mitigation in the neighborhoods most impacted by the Potrero Power Plant. Projects funded with this money include Asthma & Preventive Developmental Health Education and an Asthma Case Management and Education Program at SF General Hospital's Pediatric Asthma Clinic. These projects have led to an increase in over 477 lung health appointments for low-income residents with asthma by April 2014.

Healthy Eating and Active Living: The Bayview Hunters Point neighborhood was funded by Kaiser Permanente as a HEAL Zone in 2004. HEAL stands for "Healthy Eating Active Living," and the Bayview HEAL Zone promotes healthy eating and active living by focusing on a) Lowering calorie consumption, b) increasing fresh fruit and vegetable consumption, c) increasing physical activity in community settings such as parks and safe routes for walking and biking, and d) increasing physical activity in institutional settings such as schools and work sites. (See Appendix G for more on the Bayview HEAL Zone, including outcomes achieved). In addition to the HEAL Zone program, the SFDPH Nutrition Education and Obesity Prevention Branch has funded the *Feeling Good Project* for more than a decade. The Feeling Good Project develops and provides nutrition education materials and classes in English, Spanish, and Chinese, and supports local cultural and community events that promote healthy eating and physical activity. Feeling Good staff also collaborate with SNAP-Ed-funded local implementing agencies to improve fruit and vegetable intake, physical activity, and food security for SF residents who receive CalFresh (EBT). Through Shape Up SF, SFDPH also runs the Southeast Food Access Coalition (SEFA), a collaborative of residents, community based organizations, city agencies, and others working achieve a vibrant and robust food system for all residents of the Bayview Hunters Point neighborhood.[15] SEFA's Food Guardian program is a group of Bayview Hunters Point residents trained to educate, advocate, and mobilize to promote nutrition education and awareness, support urban agriculture, and address community food security and justice. And finally, from 2013 to 2014, the SFDPH Quality and Leadership Academy piloted a program with Southeast Health Center to reduce systolic blood pressure among AA patients with hypertension by an average of 3mm Hg by program end. This program worked to routinely refer AA patients to YMCA physical activity or nutrition classes, and as of April 2014 the average number of patients referred to these programs had jumped from 22/month to 52/month.

Violence Prevention: From 2000-2003, SFDPH staff worked in collaboration with members of the AA and Latino communities in SF to create a Violence Prevention Plan, which grew into the 501(c)3 agency now known as *Peace it Together*. Peace It Together offers affordable individual

counseling services to children, teens, and adults and provides community outreach programs to prevent violence. SFDPH has also been funded by the Substance Abuse and Mental Health Services Administration to implement YouthPOWER in the Bayview and Mission neighborhoods, providing mini-grants to community groups to conduct Community Action Teams to prevent violence – much in the same way the Healthy Hearts SF mini-grants will function.

Tobacco Use: SFDPH's Tobacco Free Project partnered with the SF Health Network to establish as system to assess tobacco use among PCMH patients, document the assessment in the system, and provide a referral if indicated through the electronic referral system. For patients participating in cessation classes at SFGH, the results of their participation are fed back to the clinical teams through the electronic system. That system and the process used to set it up to meet needs of the clinical team is a key foundational piece for the tracking and referral loop of REACH, and will be used as a model for programs of Healthy Hearts SF.

Program Infrastructure and Organizational Capacity

Healthy Hearts SF will be led by Tomás Aragón, MD, DrPH. Dr Aragón is the Health Officer of the City and County of San Francisco, and the Director of the Population Health Division (PHD) of SFDPH. As Health Officer, he exercises leadership and legal authority to protect and promote health; as PHD Director he directs public health services (environmental health, community health promotion, disease prevention and control, and epidemiology, surveillance, and research). Dr. Aragón will be responsible for overall planning, implementation, monitoring, and reporting of the program. Dr. Aragon is trained in primary care internal medicine (MD), epidemiology (DrPH), and research (UCSF fellowship). He teaches epidemiology at the UC Berkeley School of Public Health where he also directed a CDC public health research and training center for 10 years. He was Principal Investigator of San Francisco's Community Transformation Grant, and has extensive experience leading CDC program and research grants.

Dr. Aragón will be supported by Jacqueline McCright, MPH, who will serve as the Program Manager at .20 FTE. Ms. McCright is highly knowledgeable and experienced in Community-Based Participatory Approaches (CBPA), with 10+ years of experience conducting CBPA, focus groups and community needs assessments with AA and Latino populations of all ages. She most recently was part of the SFDPH Quality Improvement Academy Team that was developed and implemented the pilot AA Hypertension Project that provided non-pharmaceutical prescriptions for physical activity to reduce patients' blood pressure. Ms. McCright will be responsible for supervising and training and Project Coordinator and the REACH Coordinators; for monitoring all short-term outcomes with the support of other project staff, and maintaining smooth implementation of all project strategies. She will also be responsible for tracking and reporting all activities to CDC annually, under the supervision of Dr. Aragón.

Both Dr. Aragón and Ms. McCright will be supported by a .25 FTE Program Assistant that will provider overall administrative support to the project including scheduling meetings; answering calls from community partners, media, and providers; and materials distribution. There will also be a 1.0 FTE Project Coordinator, who will be responsible for the day-to-day activities of the grant. S/he will work with the Principal Investigator and Program Manager to develop the project charter, including the roles and responsibilities chart, identification of key stakeholders, programmatic administration and monitoring of the mini-grants including management the RFA

process and providing technical assistance to those who receive mini-grants. The Project Coordinator will be the main point of contact for all communication and evaluation activities.

Evaluation for Healthy Hearts SF will be headed by Michelle Kirian, MPH, REHS, an epidemiologist with nine years of experience in design and implementation of data collection and analysis. Ms. Kirian will be responsible for revising the original evaluation plan and sending it to CDC for review and approval within 30 days after the CAP is finalized with CDC. 18% of the annual project budget is allocated for evaluation.

Communication activities (See *Communications* in Section iv.3), will be overseen by Karen Cohn. Ms. Cohn has over 10+ years of experience in developing, implementing and evaluating communication plans for the SF Lead Prevention Program, and will provide technical assistance to the Media Broker/PR Firm and REACH team to support the planning, implementing, and evaluating communication activities, with the support of Ms. Kirian for evaluation. Over 15% of the annual project budget is allocated for strategic and integrated media and communication activities to help advance our program efforts.

SFDPH staff key to Healthy Hearts SF already have extensive, productive relationships with partners in SFHIP and the other coalitions that will collaborate on these activities. Coalition partners have been actively involved in the development of this proposal (including the development of the strategies and activities of the CAP) through in-person meetings, conference calls, and collaborative document sharing; these currently successful strategies will continue in order to facilitate the active participation of all partners in the implementation and evaluation of CAP strategies and activities through the three year REACH funding period.

Resumes of key coalition members and organizational staff, an organizational chart for the SFDPH, and a staffing plan that describes position titles, lines of supervision, and roles and responsibilities of all program staff are available as attachments to this application package.

Together, members of Healthy Hearts SF will work to develop a draft sustainability plan by year 2 of the award. The plan will be developed with SFHIP, and will include how accomplishments will be maintained and future improvements will be made. It may also include funding from other sources, such as other government, foundations, and the private sector.

Fiscal Management

SFDPH has extensive experience managing large government grants in the areas of health services, prevention, and transportation. Responsibility for fiscal monitoring and oversight of government grants lies with a six member team based in the SFDPH Grants Unit and led by the Accounting Manager. The Accounting Manager is supported by five Senior Systems accountants, each of whom supervises numerous accounting staff and oversees a range of program related grants and contracts. The Grant Unit's specific duties include analyzing and implementing grant accounting policies and procedures; supervising and directing grant staff; monitoring grant budget, revenue and expenditure accounts, preparing complex financial reports; and performing timely reconciliation of grant revenues, expenditures, and general ledger and other supporting documentation. The Accounting Manager establishes, evaluates and reviews fiscal procedures to ensure internal control and compliance with federal, state and local requirements and oversees and manages fiscal audits of Federal, State and private grants.

As stated in the *Activities* section of this grant, a major part of the Healthy Hearts SF strategy includes the provision of $150,000 worth of mini-grants to local entities or coalitions

who propose activities that will positively contribute to the goals and objectives of Healthy Hearts SF and the Million Hearts® Initiative. Recipients will be required by SFDPH to work closely with the Grant Unit to be sure they track and report expenditures in accordance with CDC Procurement and Grants Office federal guidelines and procedures.

Coalition

SF has been a home to many successful collaborative efforts designed to improve community health and wellness. However, these efforts have largely functioned independently of one another, resulting in missed opportunities for alignment and maximum impact. The SF Health Improvement Partnership (SFHIP) is a cross sector collaboration designed to improve the health and wellness of all San Franciscans by minimizing disconnected efforts. SFHIP combines the efforts of three successful community health improvement collaborators into one aligned framework: 1) SF's non-profit hospitals; 2) the Clinical and Translational Science Institute at UCSF, which supported the first phase of SFHIP; and 3) the SFDPH's process for community health improvement. SFHIP's current formal structure is designed to ensure better coordination, accountability, community engagement, and improved community health and wellness:

- The **Vision Council** provides governance and vision to SFHIP;
- The **Steering Committee** oversees SFHIP strategy;
- **Work Groups** are open, participatory, action-oriented bodies that focus on specific health issues or programs related to San Francisco's identified health priorities; and
- **Partners** are those who will actively align with and participate in the collaboration.

An information sheet about SFHIP as well as a current membership list as evidence of the wide representation of members is available in Appendix H. Evidence that the coalition has been in existence for 2 or more years is available in Appendix I.

Throughout the 3 years of Healthy Hearts SF, SFHIP will (1) serve as our advisory committee, (2) guide and promote the community mini-grant program, and (3) promote citywide expansion of Healthy Hearts SF. As can be seen in Appendix H, SFHIP members have already been working in partnership with the priority populations addressed through this proposal. Each of the organizations represented within SFHIP have many years of experience working with the Black/AA and Latino communities of SF, particularly in the priority census tracts identified in this proposal. SFHIP also brings representation from other coalitions such as the AA Community Health Equity Council and Chicano/Latino/Indígena Health Equity Coalition.

One of the key accomplishments in mobilizing partners to implement local policy, strategy, and environmental change improvements that address the priority areas of the REACH grant is the SFHIP-driven community health assessment (CHA) and Community Health Improvement Plan (CHIP). SFHIP partners engaged in a 14-month CHA process between July 2011 and August 2012. Through the CHA, SFHIP and SFDPH and its partners strove to foster a community-driven and transparent assessment aligned with community values.

The core method for our community based participatory approach was conducted by using a method called the Technology of Participation.[16] The Technology of Participation facilitation methods are practical tools that enable groups to have highly energized, productive, inclusive and meaningful participation. This kind of participation leads to follow-through and quality outcomes, as well as more effective team work. These methods are ideal for engaging teams, organizations and communities to identify, clarify, plan for and implement change.